



State Fiscal Year 2024 External Quality Review Technical Report *for* Medicaid Health Plans

April 2025



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1. Executive Summary

Purpose and Overview of Report

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

The Behavioral and Physical Health and Aging Services Administration (BPHASA) within MDHHS administers and oversees the Michigan Medicaid managed care program; specifically, the Comprehensive Health Care Program (CHCP), which contracts with nine MCEs, referred to as Medicaid health plans (MHPs), to provide physical health and mild-to-moderate behavioral health services to Medicaid members in Michigan. The MHPs contracted with MDHHS during state fiscal year (SFY) 2024 are displayed in Table 1-1.

Table 1-1—MHPs in Michigan

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

Scope of External Quality Review Activities

To conduct the annual assessment, HSAG used the results of mandatory and optional external quality review (EQR) activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment that were performed by HSAG were conducted consistent with the associated EQR protocols developed by the Centers for Medicare & Medicaid Services (CMS) (referred to as the “CMS EQR Protocols”).¹ The purpose of these activities, in general, is to improve states’ ability to oversee and manage MCEs they contract with for services, and help MCEs improve their performance with respect to the quality, timeliness, and accessibility of care and services. Effective implementation of the EQR-related activities will facilitate state efforts to purchase cost-effective high-value care and to achieve higher performing healthcare delivery systems for their Medicaid members. For the SFY 2024 assessment, no MHPs were exempt from the EQR conducted by HSAG. HSAG used findings from the mandatory and optional EQR activities displayed in Table 1-2 that were performed during the preceding 12 months to derive conclusions and make recommendations about the quality, timeliness, and accessibility of care and services provided by each MHP. Detailed information about each activity’s methodology is provided in Appendix A of this report.

Table 1-2—EQR Activities

Activity	Description	CMS EQR Protocol
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by an MHP used sound methodology in its design, implementation, analysis, and reporting.	Protocol 1. Validation of Performance Improvement Projects (CMS EQR Protocol 1)
Performance Measure Validation (PMV) ²	This activity assesses whether the performance measures calculated by an MHP are accurate based on the measure specifications and state reporting requirements.	Protocol 2. Validation of Performance Measures (CMS EQR Protocol 2)

¹ Department of Health and Human Services, Centers for Medicare & Medicaid Services. External Quality Review (EQR) Protocols, February 2023. Available at: <https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf>. Accessed on: Jan 23, 2025.

² The MHPs contract with a National Committee for Quality Assurance (NCQA)-certified Healthcare Effectiveness Data and Information Set (HEDIS®) (HEDIS® is a registered trademark of the NCQA) vendor annually to undergo a full audit of their HEDIS reporting processes. As such, the results of each MHP’s HEDIS audit are used for the EQR in lieu of completion of the mandatory PMV activity described in 42 CFR §438.358(b)(ii).

Activity	Description	CMS EQR Protocol
Compliance Review ³	This activity determines the extent to which an MHP is in compliance with federal standards and associated state-specific requirements, when applicable.	Protocol 3. Review of Compliance With Medicaid and CHIP [Children's Health Insurance Program] Managed Care Regulations (CMS EQR Protocol 3)
Network Adequacy Validation (NAV)	This activity assesses the accuracy of network adequacy indicators reported by an MHP and the extent to which an MHP has met the quantitative network adequacy standards defined by the State.	Protocol 4. Validation of Network Adequacy (CMS EQR Protocol 4)
Encounter Data Validation (EDV)	The activity validates the accuracy and completeness of encounter data submitted by an MHP.	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®) ⁴ Analysis	This activity assesses member experience with an MHP and its providers, and the quality of care they receive.	Protocol 6. Administration or Validation of Quality of Care Surveys (CMS EQR Protocol 6)
Quality Rating	This activity assigns a quality rating (using indicators of clinical quality management; member satisfaction; and/or plan efficiency, affordability, and management) to each MHP serving Medicaid managed care members that enables members and potential members to consider quality when choosing an MHP.	Protocol 10. Assist With Quality Rating of Medicaid and CHIP Managed Care Organizations, Prepaid Inpatient Health Plans, and Prepaid Ambulatory Health Plans ⁵ (CMS EQR Protocol 10)

³ The compliance review activity was performed by MDHHS. MDHHS provided HSAG with the results of the compliance review activity to include in the annual EQR.

⁴ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

⁵ CMS has not yet issued the associated EQR protocol.

Michigan Comprehensive Health Care Program Conclusions and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from the SFY 2024 activities to comprehensively assess the MHPs' performance in providing quality, timely, and accessible healthcare services to Medicaid members. For each MHP reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the MHP's performance, which can be found in Section 3 of this report. The overall findings and conclusions for all MHPs were also compared and analyzed to develop overarching conclusions and recommendations for the Medicaid managed care program specific to the CHCP. Table 1-3 highlights substantive conclusions and actionable state-specific recommendations, when applicable, for MDHHS, to drive progress toward achieving the goals of Michigan's Comprehensive Quality Strategy (CQS)⁶ and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to its Medicaid managed care members. Table 1-3 displays each CQS goal and indicates whether the EQR activity results positively (✓), negatively (✗), or minimally (m) impacted the CHCP'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 Medicaid members. A dash (–) is noted in Table 1-3 if no trends were identified through an EQR activity that substantially impacted a goal; the EQR activity results could not be used to evaluate a goal; or a CQS goal did not include a quality measure for the CHCP's applicable populations.

Table 1-3—Michigan CHCP Conclusions and Recommendations

Performance Impact on Goals and Objectives ⁷		Performance Domain
Goal #1—Ensure high quality and high levels of access to care		
✓	CQS Objective 1.1: The CHCP reached the statewide 2026 performance target to achieve the national 75th percentile for the <i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i> quality measure. The CHCP ranked between the 75th and 89th percentiles and its rate demonstrated a statistically significant increase from the prior year.	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
✓	CQS Objective 1.1: The CHCP made progress toward reaching the statewide 2026 performance target to achieve the national 50th percentile for the <i>Childhood Immunization Status—Combination 3</i> quality measure. While the CHCP ranked between the 25th and 49th percentiles, its rate demonstrated a statistically significant increase from the prior year.	

⁶ Michigan Department of Health and Human Services. Comprehensive Quality Strategy 2023-2026, August 2024. 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=3add99dfefdf417fa4e12a2b346f4b3e. Accessed on: Jan 30, 2025.

⁷ All EQR activities were considered in HSAG's analysis, as applicable. However, HSAG's analysis did not include all CAHPS measures or performance measures and instead focused on the measures with a corresponding quality measure with the CQS.

Performance Impact on Goals and Objectives ⁷		Performance Domain
✓	CQS Objective 1.1: The CHCP reached the statewide 2026 performance target to achieve 67.98 percent for the <i>Global Rating of Health Plan</i> quality measure for CSHCS. The CHCP's rate was 68.83 percent and while not statistically significant, increased in performance from the prior year.	
✓	CQS Objectives 1.1 and 1.3: The CHCP reached the statewide 2026 performance target to achieve greater than or equal to 68.22 percent for the <i>Global Rating of Health Care</i> quality measure for CSHCS. The CHCP's rate was 69.57 percent and while not statistically significant, increased in performance from the prior year.	
✓	CQS Objective 1.1 and 1.2: The CHCP reached the statewide 2026 performance target to achieve greater than or equal to 70.6 percent for the <i>Composite Measure for Access to Specialized Services</i> quality measure for CSHCS. The CHCP's rate was 71.22 percent and while not statistically significant, increased in performance from the prior year.	
✓	CQS Objective 1.2: The CHCP made progress toward reaching the statewide 2026 performance target to achieve the national 75th percentile for the <i>Comprehensive Diabetes Care (CDC)—Eye Exams</i> quality measure. While the CHCP ranked between the 50th and 74th percentiles, its rate demonstrated a statistically significant increase from the prior year. ⁸	
✓	CQS Objective 1.2: The CHCP made progress toward reaching the statewide 2026 performance target to achieve the national 75th percentile for the <i>Controlling High Blood Pressure</i> quality measure. While the CHCP ranked between the 50th and 74th percentiles, its rate demonstrated a statistically significant increase from the prior year.	
m	CQS Objective 1.1: The CHCP made minimal progress toward reaching the statewide 2026 performance target to achieve the national 50th percentile for the <i>Prenatal and Postpartum Care—Postpartum Care</i> quality measure. The CHCP ranked between the 25th and 49th percentiles and while not statistically significant, the rate increased in performance from the prior year.	
m	CQS Objective 1.1: The CHCP made minimal progress toward reaching the statewide 2026 performance target to achieve 83.3 percent for the <i>Composite Measure for Transportation</i> quality measure for CSHCS. The CHCP's rate was 71.49 percent and while not statistically significant, increased in performance from the prior year.	
m	CQS Objective 1.2: The CHCP made minimal progress toward reaching the statewide 2026 performance target to achieve the national 50th percentile for the <i>Asthma Medication Ratio—Total</i> quality measure. While the CHCP's rate increased from the prior year, the increase was not statistically significant and the CHCP ranked below the 25th percentile.	
m	CQS Objective 1.2: The CHCP made minimal progress toward reaching the statewide 2026 performance target to achieve greater than or equal to 94.79 percent for the <i>Composite Measure</i>	

⁸ NCQA replaced the *Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed* performance measure with the *Eye Exam for Patients With Diabetes (EED)* performance measure, the performance impact was based on the MHP's reported rate for *Eye Exam for Patients With Diabetes (EED)*.

Performance Impact on Goals and Objectives ⁷		Performance Domain
	<i>for How Well Doctors Communicate</i> quality measure for CSHCS. The CHCP's rate was 94.42 percent and while not statistically significant, increased in performance from the prior year.	
m	CQS Objective 1.2: The CHCP made minimal progress toward reaching the statewide 2026 performance target to achieve 91.21 percent for the <i>Composite Measure for Customer Service</i> quality measure for CSHCS. The CHCP's rate was 87.53 percent and while not statistically significant, increased in performance from the prior year.	
m	CQS Objective 1.3: The CHCP made minimal progress toward reaching the statewide 2026 performance target to achieve 90.55 percent for the <i>Access to Prescription Medicines</i> quality measure for CSHCS. The CHCP's rate was 89.40 percent and while not statistically significant, increased in performance from the prior year.	
x	CQS Objective 1.1: The CHCP did not make progress toward reaching the statewide 2026 performance target to achieve greater than or equal to 73.83 percent for the <i>Global Rating of Specialist Seen Most Often</i> quality measure for CSHCS. The CHCP's rate was 71.50 percent and while not statistically significant, decreased in performance from the prior year.	
x	CQS Objective 1.3: The CHCP did not make progress toward reaching the statewide 2026 performance target to achieve the national 75th percentile for the <i>Getting Care Quickly Composite (Adult CAHPS)</i> quality measure. The CHCP ranked between the 50th and 74th percentiles and its rate was not statistically significantly different than the prior year.	
–	CQS Objective 1.3: The EQR activities do not produce data to assess the impact of the <i>Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies</i> quality measure under this objective.	
–	While the MHPs reported according to their methodologies and interpretations of MDHHS' expectations for calculating network adequacy standards, the MHPs used differing time frames for enrollment and provider data in their network adequacy calculations and employed varying methodologies to calculate ratios. The MHPs also submitted similar network adequacy summary results in different formats. Due to the inconsistent methodologies applied to network adequacy indicator reporting, network adequacy results could not be compared across MHPs or aggregated to provide programwide results. ⁹	
Goal #2—Strengthen person and family-centered approaches		
✓	CQS Objective 2.1: The CHCP made progress toward reaching the statewide 2026 performance target to achieve the national 75th percentile for the <i>Adults' Access to Preventive/Ambulatory Health Services—20–44 Years Old</i> quality measure. While the CHCP ranked between the 50th and 74th percentiles, its rate demonstrated a statistically significant increase from the prior year.	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access

⁹ While the CQS did not include a specific quality measure associated with the findings and results of the EQR activity, HSAG used the EQR activity results in its programwide assessment when it aligned with a goal and/or objective(s) within the CQS.

Performance Impact on Goals and Objectives ⁷		Performance Domain
✓	CQS Objective 2.1: The CHCP reached the statewide 2026 performance target to achieve 67.98 percent for the <i>Global Rating of Health Plan</i> quality measure for CSHCS. The CHCP’s rate was 68.83 percent and while not statistically significant, increased in performance from the prior year.	
✓	CQS Objectives 2.1: The CHCP reached the statewide 2026 performance target to achieve greater than or equal to 68.22 percent for the <i>Global Rating of Health Care</i> quality measure for CSHCS. The CHCP’s rate was 69.57 percent and while not statistically significant, increased in performance from the prior year.	
✓	CQS Objective 2.2: The CHCP reached the statewide 2026 performance target to achieve greater than or equal to 70.6 percent for the <i>Composite Measure for Access to Specialized Services</i> quality measure for CSHCS. The CHCP’s rate was 71.22 percent and while not statistically significant, increased in performance from the prior year.	
m	CQS Objective 2.1: The CHCP made minimal progress toward reaching the statewide 2026 performance target to achieve greater than or equal to 94.79 percent for the <i>Composite Measure for How Well Doctors Communicate</i> quality measure for CSHCS. The CHCP’s rate was 94.42 percent and while not statistically significant, increased in performance from the prior year.	
✗	CQS Objective 2.1: The CHCP did not make progress toward reaching the statewide 2026 performance target to achieve the national 90th percentile for the <i>Rating of Health Plan</i> quality measure. The CHCP ranked between the 50th and 74th percentiles and its rate was not statistically significantly different than the prior year.	
✗	CQS Objective 2.1: The CHCP did not make progress toward reaching the statewide 2026 performance target to achieve greater than or equal to 73.83 percent for the <i>Global Rating of Specialist Seen Most Often</i> quality measure for CSHCS. The CHCP’s rate was 71.50 percent and while not statistically significant, decreased in performance from the prior year.	
–	CQS Objective 2.1: The EQR activities do not produce data to assess the impact of the <i>Completion of Annual Health Risk Assessment</i> quality measure under this objective.	
–	CQS Objective 2.2: The EQR activities do not produce data to assess the impact of the <i>SDOH: Total Member Screening Rate, SDOH: Total Member Referral Rate, and Social Need Screening and Intervention</i> quality measures under this objective.	
Goal #3—Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)		
✓	CQS Objective 3.2: The CHCP reached the statewide 2026 performance target to achieve 67.98 percent for the <i>Global Rating of Health Plan</i> quality measure for CSHCS. The CHCP’s rate was 68.83 percent and while not statistically significant, increased in performance from the prior year.	

Performance Impact on Goals and Objectives ⁷		Performance Domain
✓	CQS Objectives 3.2: The CHCP reached the statewide 2026 performance target to achieve greater than or equal to 68.22 percent for the <i>Global Rating of Health Care</i> quality measure for CSHCS. The CHCP’s rate was 69.57 percent and while not statistically significant, increased in performance from the prior year.	☒ Quality ☒ Timeliness ☒ Access
–	CQS Objective 3.1: The EQR activities do not produce data to assess the impact of the <i>Follow-Up After Hospitalization for Mental Illness Within 30 Days (FUH) (Adults)</i> quality measure under this objective.	
–	CQS Objective 3.1: The EQR activities do not produce data to assess the impact of the <i>Coordination of Care</i> quality measure for CSHCS under this objective. ¹⁰	
–	CQS Objective 3.2: The EQR activities do not produce data to assess the impact of the <i>Implementation of Joint Care Management Processes</i> quality measure under this objective.	
Goal #4—Reduce racial and ethnic disparities in healthcare and health outcomes		
m	While MDHHS required the MHPs to continue with PIP topics focused on addressing disparities within their populations (i.e., prenatal care for eight MHPs and adult preventive care for one MHP), only one MHP was successful in eliminating the disparity without a decline in performance for the comparison group. ¹¹ Further, for the remaining eight MHPs, while no rates were statistically significantly different than the prior remeasurement period, five MHP rates declined and three MHP rates improved. ¹¹⁷	☒ Quality ☒ Timeliness ☒ Access
✗	CQS Objective 4.1: The CHCP made minimal progress toward reaching the statewide 2026 performance target to achieve 98 percent for the <i>Not Felt Treated Unfairly: Race and Ethnicity</i> quality measure for CSHCS. The CHCP’s rate was 96.60 percent and while not statistically significant, decreased in performance from the prior year.	
–	CQS Objective 4.1: The EQR activities do not produce data to assess the impact of the <i>Chlamydia Screening in Women—Total, Prenatal and Postpartum Care—Postpartum Care, Children Immunization Combo 3, Lead Screening in Children, Comprehensive Diabetes Care—Eye Exam, Adults' Access to Preventive/Ambulatory Health Services—20–44 Years Old</i> quality measures under this objective. While there are reported HEDIS rates that are stratified by race/ethnicity, the EQR deliverables did not include an analysis of this data.	

¹⁰ The *Coordination of Care* quality measure listed in the CQS did not align with HSAG's *Coordination of Care* CAHPS measure and was not included in the SFY 2024 CSHCS CAHPS activity. MDHHS has elected to include the *Coordination of Care* CAHPS measure in the SFY 2025 activity, and the results from this measure will be included in future technical reports.

¹¹ Two MHPs (**HCS** and **UNI**) identified no disparities within their populations.

Performance Impact on Goals and Objectives ⁷		Performance Domain
Goal #5—Improve quality outcomes through value-based initiatives and payment reform		
–	CQS Objective 5.1: The EQR activities do not produce data to assess the impact of the <i>Average Percentage of Plan Payments to Providers Who Are in APM Arrangements ("Big Numerator")</i> and <i>Average Percentage of Plan Payments to Providers That Are Tied to Quality ("Small Numerator")</i> quality measures under this objective.	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access
Recommendations		
<p>Based on findings identified through the EQR activities that impacted the goals and objectives in MDHHS' CQS, HSAG has identified the following recommendations to support improvement in the quality, timeliness, and accessibility of healthcare services furnished to CHCP members:</p> <ul style="list-style-type: none"> While the MHPs reported according to their methodologies and interpretations of MDHHS' expectations for calculating network adequacy standards, there are opportunities for closer collaboration with MDHHS to ensure provider network reporting follows a standardized methodology across all MHPs. HSAG recommends that MDHHS issue formal guidance specifying the time frame the MHPs should apply to the enrollment and provider data used in network adequacy calculations, and the methodology the MHPs should use to calculate ratios. Additionally, HSAG recommends that all MHPs update their reporting in accordance with any future MDHHS-issued guidance. While the MHPs submitted similar network adequacy summary results (i.e., similar MDHHS-required information was present), it was provided in different formats, including standalone files with screenshots from Quest, embedded Quest screenshots within the NAP under section 2.7-6a or at the end of the document, and in Microsoft Excel files. HSAG recommends standardizing the submission process to ensure consistency across all MHPs. A standardized format would improve clarity, streamline analyses, and facilitate the identification of any flaws or discrepancies. To comply with the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), MDHHS should update the contracts with its MHPs as follows within the required effective dates for each specific requirement: <ul style="list-style-type: none"> Require the MHPs to respond to prior authorization requests for covered items and services within seven calendar days for standard requests to improve patient care outcomes and ensure members have more timely access to services. Require the MHPs to publicly report prior authorization data for members and providers to better understand the types of items and services which require prior authorization and how each MHP performed over time for approvals and denials. This requirement is to assure transparency and accountability in the healthcare system and allow for the efficiency of prior authorization practices of each MHP, and it enables the MHPs to assess trends, identify areas for improvement, and work toward continuous process improvement while maintaining the necessary quality checks for quality and appropriateness of care. To comply with the Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule (CMS-2439-F), MDHHS should implement the following within the required effective dates for each specific requirement: <ul style="list-style-type: none"> Review the maximum appointment wait time standards (e.g., 15 business days for primary care and OB/GYN) and update its contracts with its MHPs, as applicable. As NCQA replaced the <i>Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed</i> performance measure with the <i>Eye Exam for Patients With Diabetes (EED)</i> performance measure, MDHHS should consider 		

Performance Impact on Goals and Objectives ⁷	Performance Domain
<p>updating the <i>Comprehensive Diabetes Care (CDC)—Eye Exams</i> quality measure under CQS Objective 1.2 to <i>Exam for Patients With Diabetes (EED)</i>.</p> <ul style="list-style-type: none"> NCQA’s <i>Medical Assistance With Smoking and Tobacco Use Cessation (MSC)</i> performance measure assesses whether current smokers were advised to quit and discussed cessation medication and strategies with their clinician. A new measure will expand to adolescents and will leverage electronic clinical data to incorporate prevention, screening, and receipt of evidence-based cessation interventions. As NCQA intends to retire the survey measure when the replacement measure is ready (planned for HEDIS Measurement Year 2026), MDHHS should consider updating the <i>Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies</i> quality measure under CQS Objective 1.3 when the new measure is released.¹² 	

¹² National Committee on Quality Assurance. *Retiring and Replacing HEDIS Measures, 2024-2026*. July 17, 2023. Available at: <https://www.ncqa.org/blog/retiring-and-replacing-hedis-measures-2024-2026/>. Accessed on: Feb 18, 2025.

2. Overview of the Michigan Medicaid Managed Care Program

Managed Care in Michigan

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

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 healthcare needs and their families.
<ul style="list-style-type: none"> Foster Children 		1915b	November 2010	Most categories of foster children are mandatorily enrolled in managed care.
<ul style="list-style-type: none"> Pregnant Individuals 		1915b	October 2008	Pregnant individuals are mandatorily enrolled in managed care.
Healthy Michigan Plan (HMP) (Medicaid Expansion)	MCO	1115 Demonstration	April 2014	HMP establishes eligibility for Michigan citizens up to 133% of the federal poverty level who are otherwise not eligible for Medicaid at the time of enrollment.
Flint Medicaid Expansion (FME) Waiver	MCO	1115 Demonstration	March 2016	The waiver provides Medicaid coverage and benefits to individuals affected by the Flint Water Crisis.
MI Health Link Demonstration (Integrated Care Organizations [ICOs])	ICO	1915(b) & 1915(c)	March 2015	Persons fully eligible and enrolled in both Medicare and Medicaid who are over the age

Medicaid Managed Care Program	MCE Type	Managed Care Authority	Date Initiated	Populations Served
				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.
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:				
<ul style="list-style-type: none"> Children’s Behavioral Health—Bureau of Children’s Coordinated Health Policy & Supports (BCCHPS) Adult Behavioral Health—Bureau of Specialty Behavioral Health Services (SBHS) 				
Prepaid Inpatient Health Plans (PIHPs)/Community Mental Health Services Programs (CMHSPs)	PIHP	Behavioral Health 1115 Demonstration Waiver	October 2019	Individuals with intellectual and developmental disability (I/DD), serious mental illness (SMI), serious emotional disturbance (SED), and substance use disorder (SUD)
		1915(i) SPA [State Plan Amendment]	October 2022	
		1115 HMP	April 2014	
		Flint 1115 Waiver or Community Block Grant	May 2016	
		1915(c) Habilitation Supports Waiver (HSW),	October 2019	

Medicaid Managed Care Program	MCE Type	Managed Care Authority	Date Initiated	Populations Served
		Children’s Waiver Program (CWP), and Children’s Serious Emotional Disturbance Waiver (SEDW)		

Comprehensive Health Care Program

MDHHS contracts with nine MHPs in targeted geographical service areas comprised of 83 counties (divided into 10 regions) and provides medically necessary services to over 1.7 million Medicaid managed care members in Michigan.¹³ Michigan’s waiver requires managed care members to obtain services from specified MHPs based on the county of residence. MDHHS enrolls a diverse set of populations into the CHCP managed care program, including the disabled, foster children, pregnant women, and children dually eligible for Title V and Title XIX under the Social Security Act. Individuals dually eligible for Medicare and Medicaid may enroll in MHPs voluntarily. Additionally, since 2016, MDHHS implemented the HMP, which is Michigan’s Medicaid expansion program. The HMP benefit package includes a comprehensive dental benefit in addition to primary, preventive, and behavioral healthcare. Michigan’s stand-alone CHIP, known as MICHild, is also administered through the CHCP.

¹³ Michigan Department of Health and Human Services. *Medicaid and Health Michigan Plan Enrollees*, December 2024. Available at: [https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/Monthly-MHP-Enrollment/JE02-\(122024\).pdf?rev=2cf0f68531604550b4f127f2531e2e2e&hash=BFB8BFE46B9F98CF880258B8F8F2BFBF](https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/Monthly-MHP-Enrollment/JE02-(122024).pdf?rev=2cf0f68531604550b4f127f2531e2e2e&hash=BFB8BFE46B9F98CF880258B8F8F2BFBF). Accessed on: Jan 23, 2025.

Overview of Medicaid Health Plans

During the SFY 2024 review period, MDHHS contracted with nine MHPs. These MHPs were responsible for the provision of medically necessary services to Medicaid members. Table 2-2 provides a profile for each MHP.

Table 2-2—MHP Profiles and Enrollment Data

MHP	Covered Services ¹⁴	Operating Region(s) ¹⁵	Number of Counties Served ⁹
AET	All MHPs cover medically necessary services such as the following: <ul style="list-style-type: none"> • Ambulance • Chiropractic • Dental services • Doctor visits • Doula services • Emergency services • Family planning • Health checkups • Hearing and speech • Home health care • Hospice care • Hospital care • Immunizations • Laboratory and X-rays • Medical supplies • Medicine • Mental health • Physical and occupational therapy • Podiatry • Prenatal care and delivery • Surgery • Vision 	8, 9, 10	16
BCC		4, 6, 7, 9, 10	32
HCS		6, 10	10
MCL		2, 3, 4, 5, 6, 7, 8, 9, 10	68
MER		2, 3, 4, 5, 6, 7, 8, 9, 10	68
MOL		2, 3, 4, 5, 6, 7, 8, 9, 10	68
PRI		4, 8, 10	23
UNI		2, 3, 4, 5, 6, 8, 9, 10	65
UPP		1	15

¹⁴ Michigan Department of Health and Human Services. *Medicaid*. Available at: [Medicaid](#). Accessed on: Feb 23, 2025.

¹⁵ The Operating Regions and Number of Counties Served are reflective of data from SFY 2024 as regions and counties were updated with SFY 2025 contracts.

Quality Strategy

The 2023–2026 MDHHS CQS provides a summary of the initiatives in place in Michigan to assess and improve the quality of care and services provided and reimbursed by MDHHS Medicaid managed care programs, including CHCP, long-term services and supports (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 2023–2026 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 aligns with the 2022 CMS National Quality Strategy’s (NQS’) eight goals, which aim to promote the highest quality outcomes and the safest care for all individuals and focuses on a person-centric approach as individuals journey across the continuum of care. The 2023–2026 MDHHS CQS also aligns with the MDHHS 2023–2027 Strategic Priorities and supports the MDHHS mission to provide services and administer programs to improve the health, safety, and prosperity of the residents of Michigan. The 2023–2026 MDHHS CQS establishes a new three-year vision to further integrate managed care program priorities to implement quality monitoring and improvement strategies to ensure Medicaid member experience of care is positive, appropriate, and timely. To accomplish the CQS vision, the Medicaid programs collaboratively identified and agreed upon five CQS goals that pursue an integrated framework for population health improvement and a commitment to address health equity and reduce disparate outcomes. These goals and their associated objectives are summarized in Table 2-3, and align with MDHHS’ vision to *deliver health and opportunity to all Michiganders, reducing intergenerational poverty and promoting health equity*.

Table 2-3—2023–2026 Michigan CQS Goals and Objectives

Aligned NQS Goals	MDHHS 2023—2027 Strategic Priorities	Objectives
Goal #1: Ensure high quality and high levels of access to care		
<ul style="list-style-type: none"> Goal 1: Embed Quality into the Care Journey Goal 2: Advance Health Equity Goal 3: Promote Safety 	<ul style="list-style-type: none"> Public health investment Racial equity Address food and nutrition, housing, and other social determinants of health (SDOH) Improve the behavioral health service system for children and families Improve maternal-infant health and reduce outcome disparities Reduce lead exposure for children Reduce child maltreatment and improve rate of permanency within 12 months Expand and simplify safety net access Reduce opioid and drug related deaths 	Objective 1.1: Monitor, track and trend the quality, timeliness and availability of care and services.
		Objective 1.2: Promote prevention, treatment, services, and supports to address acute and chronic conditions in at-risk populations.
		Objective 1.3: Ensure services are delivered to maximize beneficiaries’ health and safety.

Aligned NQS Goals	MDHHS 2023—2027 Strategic Priorities	Objectives
Goal #2: Strengthen person and family-centered approaches		
<ul style="list-style-type: none">Goal 1: Embed Quality into the Care JourneyGoal 2: Advance Health EquityGoal 4: Foster Engagement	<ul style="list-style-type: none">Racial equityAddress food and nutrition, housing, and other SDOHImprove the behavioral health service system for children and familiesEnsure all administrations are managing to outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances	Objective 2.1: Facilitate an environment where individuals and their families are empowered to make healthcare decisions that suit their unique needs and goals
		Objective 2.2: Ensure referrals are made to community resources to address SDOH needs.
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">Goal 4: Foster EngagementGoal 5: Strengthen ResiliencyGoal 6: Embrace the Digital Age	<ul style="list-style-type: none">Expand and simplify safety net accessAddress food and nutrition, housing, and other SDOHIntegrate services, including physical and behavioral health, and medical care with LTSSFully implement the Families First Preservation Services Act (FFPSA) state planEnsure all administrations are managing to outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances	Objective 3.1: Support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations
		Objective 3.2: Promote the use and adoption of health information technology and health information exchange to connect providers, payers, and programs to optimize patient outcomes.
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes		
<ul style="list-style-type: none">Goal 2: Advance Health EquityGoal 4: Foster EngagementGoal 5: Strengthen ResiliencyGoal 7: Incentivize Innovation and Technology Adoption to Drive Care Improvements	<ul style="list-style-type: none">Public health investmentRacial equityAddress food and nutrition, housing, and other SDOHImprove the behavioral health service system for children and familiesImprove maternal-infant health and reduce outcome disparitiesReduce lead exposure for childrenReduce child maltreatment and improve rate of permanencyFully implement the FFPSA state planExpand and simplify safety net accessReduce opioid and drug related deathsEnsure all administrations are managing to outcomes, investing in evidence-	Objective 4.1: Use evidence-informed approaches to address racial and ethnic disparities and health inequity.

Aligned NQS Goals	MDHHS 2023—2027 Strategic Priorities	Objectives
	based solutions, and ensuring program accuracy in benefit issuances	
Goal #5: Improve quality outcomes through value-based initiatives and payment reform		
<ul style="list-style-type: none"> Goal 7: Incentivize Innovation and Technology Adoption to Drive Care Improvements Goal 8: Increasing Alignment 	<ul style="list-style-type: none"> Ensure all administrations are managing to outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances 	Objective 5.1: Promote value-based models that improve quality of care.

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

- **Value-Based Payment**—MDHHS employs a population health management framework and intentionally contracts with high-performing plans to build a Medicaid managed care delivery system that maximizes the health status of members, improves member experience, and lowers cost. The population health framework is supported through evidence- and value-based care delivery models, health information technology/health information exchange, and a robust quality strategy. Population health management includes an overarching emphasis on health promotion and disease prevention and incorporates community-based health and wellness strategies with a strong focus on the SDOH, creating health equity and supporting efforts to build more resilient communities. MDHHS supports payment reform initiatives that pay providers for value rather than volume, with “value” defined as health outcome per dollar of cost expended over the full cycle of care. In this regard, performance metrics are linked to outcomes. The Medicaid managed care programs are at varying degrees of payment reform; however, all programs utilize a performance bonus (quality withhold) with defined measures, thresholds, and criteria to incentivize 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 Medicaid Health Plan Performance

HSAG used findings across mandatory and optional EQR activities conducted during the SFY 2024 review period to evaluate the performance of the MHPs on providing quality, timely, and accessible healthcare services to CHCP members. Quality, as it pertains to EQR, means the degree to which the MHPs increased the likelihood of members’ desired health outcomes through structural and operational characteristics; the provision of services that were consistent with current professional, evidenced-based knowledge; and interventions for performance improvement. Timeliness refers to the elements defined under §438.68 (adherence to MDHHS’ network adequacy standards) and §438.206 (adherence to MDHHS’ standards for timely access to care and services). Access relates to members’ timely use of services to achieve optimal health outcomes, as evidenced by how effective the MHPs were at successfully demonstrating and reporting on outcomes for the availability and timeliness of services.

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

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

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in SFY 2024 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. Table 3-1 provides HSAG’s timeline for conducting each of the EQR activities.

Table 3-1—Timeline for EQR Activities

Activity	EQR Activity Start Date	EQR Activity End Date
PIPs	May 15, 2024	October 28, 2024
PMV	February 1, 2024	November 4, 2024
Compliance Review	October 15, 2023	November 15, 2024

Activity	EQR Activity Start Date	EQR Activity End Date
NAV—Analysis	January 12, 2024	February 28, 2025
NAV—Survey	March 29, 2024	September 23, 2024
EDV	February 26, 2024	March 17, 2025
CAHPS	MHP: October 12, 2023 CSHCS: March 18, 2024	MHP: October 29, 2024 CSHCS: April 30, 2025
Quality Rating	March 4, 2024	October 3, 2024

Validation of Performance Improvement Projects

For the SFY 2024 PIP validation activity, the MHPs continued PIP topics that focused on disparities in care, reporting Remeasurement 2 data for each specified performance indicator. MHPs with an existing disparity have a minimum of two performance indicators (a disparate sub-group performance indicator and a comparison sub-group performance indicator), and MHPs without an existing disparity have one performance indicator. HSAG conducted validation on the PIP Design (steps 1 through 6), Implementation (Step 7 and Step 8), and Outcomes (Step 9) stages of the selected PIP topic for each MHP in accordance with CMS’ EQR protocol for the validation of PIPs (CMS EQR Protocol 1).

Table 3-2 outlines the selected PIP topics and performance indicator(s) as defined by each MHP.

Table 3-2—PIP Topic and Performance Indicator(s)

MHP	PIP Topic	Performance Indicator(s)
AET	<i>Addressing Disparities in Timeliness of Prenatal Care</i>	<ol style="list-style-type: none"> 1. Timeliness of prenatal care in rural designated ZIP Codes. 2. Timeliness of prenatal care in urban designated ZIP Codes.
BCC	<i>Reducing Racial Disparities Within Timeliness of Prenatal Care</i>	<ol style="list-style-type: none"> 1. Black women residing in Region 10 (disparate group). 2. White women residing in Region 10 (comparison group).
HAP	<i>Improving the Timeliness of Prenatal Care</i>	Measuring the percentage of Black/African-American pregnant women who have a prenatal visit within 42 days of enrollment or within the first trimester.
MCL	<i>Addressing Disparities in Timeliness of Prenatal Care</i>	<ol style="list-style-type: none"> 1. The percentage of deliveries that received a prenatal care visit as a member of an organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization for Black members.

MHP	PIP Topic	Performance Indicator(s)
		2. The percentage of deliveries that received a prenatal care visit as a member of an organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization for White members.
MER	<i>Addressing Disparities for Timeliness of Prenatal Care: Addressing Racial Health Disparities</i>	<ol style="list-style-type: none"> 1. Improve the PPC [Prenatal and Postpartum Care]-Timeliness of Prenatal Care rate for the Black (non-Hispanic) population residing in Region 6 in order to reduce the disparity to the comparison subgroup. 2. Maintain the performance of the HEDIS PPC-Timeliness of Prenatal Care performance result for eligible White (non-Hispanic) members residing in Region 6.
MOL	<i>Addressing Disparities for Timeliness of Prenatal Care</i>	<ol style="list-style-type: none"> 1. Timeliness of Prenatal Care—Black. 2. Timeliness of Prenatal Care—White.
PRI	<i>Improving Timeliness of Prenatal Care for African American Women</i>	<ol style="list-style-type: none"> 1. The percentage of African-American women that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment with Priority Health. 2. The percentage of Caucasian women that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment with Priority Health.
UNI	<i>Addressing Disparities in Timeliness of Prenatal Care</i>	Timeliness of prenatal care for African-American/Black members in Region 10.
UPP	<i>Reducing Racial Disparities in Adult Ambulatory and Preventive Access to Care in Members Ages 20–44</i>	<ol style="list-style-type: none"> 1. Annual Ambulatory or Preventative Visit for UPP Black members. 2. Annual Ambulatory or Preventative Visit for UPP White members.

Performance Measure Validation

Each MHP underwent an NCQA HEDIS Compliance Audit^{TM,16} conducted by an NCQA licensed organization. The NCQA HEDIS Compliance Audit followed NCQA audit methodology as set out in NCQA's MY 2023 Volume 5, *HEDIS Compliance Audit: Standards, Policies and Procedures*. The NCQA HEDIS Compliance Audit encompasses an in-depth examination of the MHPs' processes consistent with the CMS EQR Protocols. To complete the validation of the performance measure process according to CMS EQR Protocol 2 for the validation of performance measures, HSAG performed an independent evaluation of the HEDIS MY 2023 Compliance Audit Report, which contained findings related to the following four IS standards:

- IS R: Data Management and Reporting (formerly IS 6.0, IS 7.0)
- IS C: Clinical and Care Delivery Data (formerly IS 5.0)
- IS M: Medical Record Review Processes (formerly IS 4.0)
- IS A: Administrative Data (formerly IS 1.0, IS 2.0, IS 3.0)

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

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

- Child & Adolescent Care
- Women—Adult Care
- Access to Care
- Pregnancy Care
- Living With Illness
- Utilization

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

¹⁶ HEDIS Compliance AuditTM is a trademark of NCQA.

Table 3-3—Michigan Medicaid HEDIS MY 2023 Required Measures

Performance Measure	HEDIS Data Collection Methodology
Child & Adolescent Care	
<i>Childhood Immunization Status (CIS)</i>	
<i>Combination 3</i>	Hybrid
<i>Combination 7</i>	Hybrid
<i>Combination 10</i>	Hybrid
<i>Well-Child Visits in the First 30 Months of Life (W30)</i>	
<i>Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	Administrative
<i>Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i>	Administrative
<i>Lead Screening in Children (LSC)</i>	
<i>Lead Screening in Children</i>	Hybrid
<i>Child and Adolescent Well-Care Visits (WCV)</i>	
<i>Ages 3 to 11 Years</i>	Administrative
<i>Ages 12 to 17 Years</i>	Administrative
<i>Ages 18 to 21 Years</i>	Administrative
<i>Total</i>	Administrative
<i>Immunizations for Adolescents (IMA)</i>	
<i>Combination 1 (Meningococcal, Tdap)</i>	Hybrid
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	Hybrid
Women—Adult Care	
<i>Chlamydia Screening in Women (CHL)</i>¹	
<i>Ages 16 to 20 Years</i>	Administrative
<i>Ages 21 to 24 Years</i>	Administrative
<i>Total</i>	Administrative
<i>Cervical Cancer Screening (CCS-E)</i>	
<i>Cervical Cancer Screening</i>	Administrative
<i>Breast Cancer Screening (BCS-E)</i>	
<i>Breast Cancer Screening</i>	Administrative

Performance Measure	HEDIS Data Collection Methodology
Access to Care	
<i>Adults' Access to Preventive/Ambulatory Health Services (AAP)</i>	
<i>Ages 20 to 44 Years</i>	Administrative
<i>Ages 45 to 64 Years</i>	Administrative
<i>Ages 65 Years and Older</i>	Administrative
<i>Total</i>	Administrative
Pregnancy Care	
<i>Prenatal and Postpartum Care (PPC) ¹</i>	
<i>Timeliness of Prenatal Care</i>	Hybrid
<i>Postpartum Care</i>	Hybrid
Living With Illness	
<i>Hemoglobin A1c Control for Patients With Diabetes (HBD)</i>	
<i>Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*</i>	Hybrid
<i>HbA1c Control (<8.0%)</i>	Hybrid
<i>Blood Pressure Control for Patients With Diabetes (BPD)</i>	
<i>Blood Pressure Control for Patients With Diabetes</i>	Hybrid
<i>Eye Exam for Patients With Diabetes (EED) ¹</i>	
<i>Eye Exam for Patients With Diabetes</i>	Hybrid
<i>Kidney Health Evaluation for Patients With Diabetes (KED)</i>	
<i>Ages 18 to 64 Years</i>	Administrative
<i>Ages 65 to 74 Years</i>	Administrative
<i>Ages 75 to 85 Years</i>	Administrative
<i>Total</i>	Administrative
<i>Asthma Medication Ratio (AMR)</i>	
<i>Total</i>	Administrative
<i>Controlling High Blood Pressure (CBP)</i>	
<i>Controlling High Blood Pressure</i>	Hybrid
<i>Diagnosed Mental Health Disorders (DMH)</i>	
<i>Ages 1 to 17 Years</i>	Administrative
<i>Ages 18 to 64 Years</i>	Administrative
<i>Ages 65 Years and older</i>	Administrative
<i>Total</i>	Administrative

Performance Measure	HEDIS Data Collection Methodology
Utilization	
<i>Plan All-Cause Readmissions (PCR)</i>	
<i>Observed Readmissions—Total</i>	Administrative
<i>Expected Readmissions—Total</i>	Administrative
<i>O/E Ratio—Total</i>	Administrative

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

¹ Due to changes in the technical specifications for this measure, NCQA recommends trending between MY 2023 and prior years be considered with caution.

Compliance Review

MDHHS evaluated the MHPs’ compliance with federal Medicaid managed care regulations using an annual compliance review process. HSAG examined, compiled, and analyzed the results as presented in the MHP compliance review documentation provided by MDHHS. The SFY 2024 MDHHS compliance review included an evaluation of each MHP’s performance in six program areas, called standards, identified in Table 3-4. These standards are reviewed annually by MDHHS in accordance with an established timeline that spans the state fiscal year. Based on the findings of the compliance review, the MHPs were subject to a corrective action plan (CAP) process as outlined in Appendix A.

Table 3-4—Compliance Review Standards¹

MDHHS Compliance Review Standard		Federal Standard and Citation	
		Medicaid	CHIP
1	Administrative	§438.224	§457.1233(e)
2	Providers	§438.10	§457.1207
		§438.206	§457.1230(a)
		§438.207	§457.1230(b)
		§438.210	§457.1230(d)
		§438.214	§457.1233(a)
		§438.230	§457.1233(b)

MDHHS Compliance Review Standard		Federal Standard and Citation	
		Medicaid	CHIP
3	Members	§438.10 §438.100 §438.114 §438.206 §438.208 §438.210 §438.228 §438.230 Part 438, Subpart F	§457.1207 §457.1220 §457.1228 §457.1230(a) §457.1230(c) §457.1230(d) §457.1260 §457.1233(b)
4	Quality	§438.208 §438.210 §438.236 §438.330	§457.1230(c) §457.1230(d) §457.1233(c) §457.1240(b)
5	MIS [Management Information System]/Financial	§438.56 §438.242	§457.1212 §457.1233(d)
6	OIG [Office of Inspector General]/Program Integrity	§438.230 Part 438, Subpart H	§457.1233(b) §457.1285

¹ HSAG and MDHHS created a crosswalk to compare MDHHS compliance review standards to federal standards, but this crosswalk should not be interpreted to mean the State's standards include all specific federal requirements under 42 CFR §438.358(b)(1)(iii).

Network Adequacy Validation

Network Adequacy Analysis

The NAV activity for SFY 2024 included validation of network adequacy standards and indicators set forth by MDHHS. HSAG assessed the accuracy of MDHHS-defined network adequacy indicators reported by the MHPs and evaluated the MHPs' collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, and the systems and processes used in network adequacy calculations. HSAG then determined the overall validation rating, which identified the overall confidence that acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators. Table 3-5 lists the network adequacy standards and indicators HSAG validated. The NAV activity was conducted in accordance with CMS' EQR protocol for the validation of network adequacy (CMS EQR Protocol 4).

Table 3-5—MHP Network Adequacy Indicators Validated

Required Providers	Non-Rural Maximum Time and Distance Standard	Rural Maximum Time and Distance Standard	Provider Maximum Ratios**
Primary Care Providers (adult)*	30 minutes/30 miles	40 minutes/40 miles	1:500
Primary Care Providers (pediatric)*	30 minutes/30 miles	40 minutes/40 miles	1:500
OB/GYN	30 minutes/30 miles	40 minutes/40 miles	No Ratio Applies
Cardiology	30 minutes/30 miles	40 minutes/40 miles	No Ratio Applies
Outpatient Behavioral Health*	30 minutes/30 miles	75 minutes/75 miles	No Ratio Applies
Hospital	30 minutes/30 miles	60 minutes/60 miles	No Ratio Applies
Pharmacy	25 minutes/25 miles	30 minutes/30 miles	No Ratio Applies
General Dentistry*	30 minutes/30 miles	40 minutes/40 miles	Kalkaska [1:692] Missaukee [1:873] Schoolcraft [1:806] All other counties [1:650]
Endodontist	60 minutes/60 miles	120 minutes/120 miles	No Ratio Applies
Oral Surgeon	60 minutes/60 miles	120 minutes/120 miles	No Ratio Applies
Pediatric Dentist	60 minutes/60 miles	120 minutes/120 miles	No Ratio Applies
Periodontist	60 minutes/60 miles	120 minutes/120 miles	No Ratio Applies
Prosthodontist	60 minutes/60 miles	120 minutes/120 miles	No Ratio Applies

*To be counted in the PCPs or general dentistry ratio calculation, a provider must be enrolled in Medicaid and at least full-time (minimum of 20 hours per week per practice location).

Network Validation Survey

During April through June 2024, HSAG completed a network validation survey (NVS) among primary care providers (PCPs) (e.g., PCPs, pediatric providers, and obstetrics and gynecology [OB/GYN] providers) contracted with one or more MHP to ensure members have appropriate access to provider information.

The NVS included a provider directory validation (PDV) in which HSAG compared key indicators published in each online directory with the data in the MHPs' provider files to confirm whether each MHP's website met the federal requirements in 42 CFR §438.10(h) and the state-specific requirements outlined in the CHCP for the MDHHS contract. HSAG then validated the accuracy of the online directories by completing a secret shopper telephone survey to evaluate the accuracy of the provider information located in the directories. The secret shopper survey also collected information on appointment availability and wait times with the sampled providers for routine PCP and prenatal care visits. A secret shopper is a person employed to pose as a client or patient to evaluate the quality of customer service or the validity of information (e.g., accurate location information). The secret shopper approach allows for objective data collection from healthcare providers without the potential bias introduced by knowing the identity of the caller. Specific survey objectives included the following:

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

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

Encounter Data Validation

In SFY 2024, HSAG conducted and completed an EDV activity for all nine MHPs. The EDV activity included:

- Medical Record Review (MRR)—analysis of MDHHS' electronic encounter data completeness and accuracy by comparing MDHHS' electronic encounter data to the information documented in the corresponding members' medical records for physician services rendered from October 1, 2022, through September 30, 2023. This activity aligns with *Activity 4: Review Medical Records*, in the CMS EQR Protocol 5.

The goal of the MRR activity was to verify the completeness and accuracy of professional encounter data by cross-referencing provider-documented information for services rendered. The review encompassed medical records to validate the reported information within the encounter data.

Consumer Assessment of Healthcare Providers and Systems Analysis

The CAHPS surveys ask adult members and parents/caretakers of child members to report on and evaluate their experiences with healthcare. These surveys cover topics that are important to members, such as the communication skills of providers and the accessibility of services. The adult MHPs were responsible for obtaining a CAHPS vendor to administer the CAHPS survey on the MHPs' behalf. HSAG administered the CAHPS surveys to the child Medicaid population for the MHPs and child members enrolled in CSHCS. HSAG presents top-box scores, which indicate the percentage of adult members or parents/caretakers of child members who responded to the survey with positive experiences in a particular aspect of their healthcare. Table 3-6 outlines an overview of the populations and survey types used for each of the applicable programs.

Table 3-6—CAHPS Surveys

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

Quality Rating

The 2024 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2024 Michigan Consumer Guide.

External Quality Review Activity Results

Aetna Better Health of Michigan

Validation of Performance Improvement Projects

Performance Results

HSAG’s validation evaluated the technical methods of **AET**’s PIP (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-7 displays the overall validation rating, the baseline rate, Remeasurement 1, and Remeasurement 2 results for the performance indicators, and if a disparity existed within the most recent measurement period.

Table 3-7—Overall Validation Rating for AET

PIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
Addressing Disparities in Timeliness of Prenatal Care	High Confidence	Moderate Confidence	1. Timeliness of prenatal care in rural designated ZIP Codes.	47.5%	58.6% ↗	56.9% ↗	No
			2. Timeliness of prenatal care in urban designated ZIP Codes.	63.9%	61.7% ↗	64.1% ↗	

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).

The goals of **AET**’s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (rural population) will demonstrate a statistically significant increase over the baseline rate without a decline in performance for the comparison subgroup (urban population). Table 3-8 displays the barriers identified through quality improvement (QI) and causal/barrier analysis processes and the interventions initiated by the MHP to support achievement of the PIP goals and address the barriers.

Table 3-8—Remeasurement 2 Barriers and Interventions for AET

Barriers	Interventions
Lack of innovative, technological interventions to impact prenatal care rates. Leveraging mailings, text campaigns, incentives, and live outreach calls year over year is not impacting outcomes as expected.	Execution of contract with Health Intelligence Platform to offer pregnant members solutions to improve their quality of care and engagement in the healthcare system. The Health Intelligence platform will allow pregnant women access to the Baby Smart coaching program that supports appointment and transportation scheduling, pregnancy and parenting education, pregnancy monitoring and postpartum health goals, quick connections to any needed critical resources for social risks/social determinants of health as well as virtual doula pairing for high-risk pregnant women.
Access to timely prenatal care in rural areas.	Provider Services Team members are making strides to improve the network by attracting and retaining obstetrical healthcare providers specializing in prenatal care. Increasing the number of credentialed obstetrical provider types in rural-designated ZIP Codes is critical to achieving and maintaining improved prenatal healthcare outcomes and for women to get timelier prenatal care.
Access and use of timely prenatal care from non-traditional providers and practices.	Engage maternal health through promotion and availability of non-traditional prenatal care services such as doulas, telehealth, and midwives.
Obtain accurate monthly reporting for both rural and urban populations.	Conduct monthly disparity reporting and rate monitoring of rural and urban to ensure the appropriate outreach initiatives are on target.
Up-to-date knowledge of proximity of healthcare facilities and services for rural communities.	Conduct regular quality-led community mapping exercises to identify available facilities for rural members.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PIP 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: AET initiated timely interventions that were reasonably linked to their corresponding barriers. The interventions were evaluated to determine the effectiveness of each effort, with decisions to continue, discontinue, or revise an effort being data driven. **[Quality, Timeliness, and Access]**

Strength #2: AET met the state-specific goal for the PIP, which is that there will no longer be a statistically significant rate difference between the two subgroups. [Quality, Timeliness, and Access]

Weaknesses and Recommendations

Weakness #1: No substantial weaknesses were identified.

Recommendation: Although the disparate population did not achieve statistically significant improvement, improvement over the baseline was demonstrated. HSAG recommends that **AET** implement intervention strategies that have demonstrated improvement on the performance indicator and continue to evaluate the success of each intervention.

Performance Measure Validation

Performance Results

AET was evaluated against NCQA’s IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2023 Compliance Audit Report findings, **AET** was fully compliant with all four IS standards.

According to the auditor’s review, **AET** followed the NCQA HEDIS MY 2023 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-9 displays the MDHHS-selected performance measures, HEDIS MY 2022 and MY 2023 rates, MY 2022 and MY 2023 comparisons, and MY 2023 performance levels based on comparisons to national percentiles¹⁷ for **AET**. Additional performance measures and performance measure results for **AET** can be referenced in Appendix B.

Table 3-9—HEDIS MY 2023 Performance Measure Results for AET

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
Child & Adolescent Care				
<i>Childhood Immunization Status (CIS)</i>				
<i>Combination 3</i>	45.01%	48.91%	+3.89	★
<i>Combination 7</i>	37.47%	36.98%	-0.49	★
<i>Combination 10</i>	16.55%	13.87%	-2.68	★

¹⁷ HEDIS MY 2023 performance measure rates are compared to NCQA’s Quality Compass National Medicaid Health Maintenance Organization (HMO) percentiles for HEDIS MY 2022 (referred to as “percentiles” throughout this section of the report).

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
Well-Child Visits in the First 30 Months of Life (W30)				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	46.55%	49.72%	+3.17	★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	52.30%	50.85%	-1.45	★
Lead Screening in Children (LSC)				
Lead Screening in Children	42.58%	50.70%	+8.12 ⁺	★★
Child and Adolescent Well-Care Visits (WCV)				
Ages 3 to 11 Years	52.67%	54.61%	+1.94 ⁺	★★
Ages 12 to 17 Years	43.72%	44.81%	+1.09	★★
Ages 18 to 21 Years	24.46%	26.37%	+1.91	★★★
Total	44.17%	46.57%	+2.41 ⁺	★★
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	70.80%	77.86%	+7.06 ⁺	★★
Combination 2 (Meningococcal, Tdap, HPV)	24.57%	28.71%	+4.14	★
Women—Adult Care				
Chlamydia Screening in Women (CHL)³				
Ages 16 to 20 Years	65.99%	68.53%	+2.54	★★★★★
Ages 21 to 24 Years	67.43%	70.10%	+2.67	★★★★★
Total	66.78%	69.35%	+2.57	★★★★★
Cervical Cancer Screening (CCS-E)				
Cervical Cancer Screening	47.69%	44.16%	-3.53	★
Breast Cancer Screening (BCS-E)				
Breast Cancer Screening	47.53%	49.59%	+2.05	★★
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Ages 20 to 44 Years	64.22%	66.87%	+2.65 ⁺	★★
Ages 45 to 64 Years	77.24%	79.82%	+2.58 ⁺	★★
Ages 65 Years and Older	89.13%	89.72%	+0.59	★★★★★
Total	70.34%	73.56%	+3.22 ⁺	★★★

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
Pregnancy Care				
<i>Prenatal and Postpartum Care (PPC)</i>³				
<i>Timeliness of Prenatal Care</i>	64.48%	72.75%	+8.27 ⁺	★
<i>Postpartum Care</i>	61.80%	65.21%	+3.41	★
Living With Illness				
<i>Hemoglobin A1c Control for Patients With Diabetes (HBD)</i>				
<i>HbA1c Control (<8.0%)</i>	52.55%	61.80%	+9.25 ⁺	★★★★★
<i>Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*</i>	37.96%	29.93%	-8.03 ⁺	★★★★★
<i>Blood Pressure Control for Patients With Diabetes (BPD)</i>				
<i>Blood Pressure Control for Patients With Diabetes</i>	59.12%	62.77%	+3.65	★★
<i>Eye Exam for Patients With Diabetes (EED)</i>³				
<i>Eye Exam for Patients With Diabetes</i>	54.26%	60.83%	+6.57	★★★★★
<i>Kidney Health Evaluation for Patients With Diabetes (KED)</i>				
<i>Ages 18 to 64 Years</i>	23.13%	29.35%	+6.22 ⁺	★★
<i>Ages 65 to 74 Years</i>	28.85%	34.97%	+6.12 ⁺	★★
<i>Ages 75 to 85 Years</i>	25.00%	33.03%	+8.03	★★
<i>Total</i>	24.11%	30.55%	+6.44 ⁺	★★
<i>Asthma Medication Ratio (AMR)</i>				
<i>Total</i>	52.77%	51.26%	-1.50	★
<i>Controlling High Blood Pressure (CBP)</i>				
<i>Controlling High Blood Pressure</i>	57.91%	59.12%	+1.22	★★
<i>Diagnosed Mental Health Disorders (DMH)</i>				
<i>Ages 1 to 17 Years</i>	17.96%	19.01%	+1.05 ⁺	★★
<i>Ages 18 to 64 Years</i>	27.53%	30.07%	+2.54 ⁺	★★
<i>Ages 65 Years and Older</i>	37.31%	38.23%	+0.92	★★★★★
<i>Total</i>	25.19%	27.31%	+2.12 ⁺	★★★★
Utilization				
<i>Plan All-Cause Readmissions (PCR)</i>				
<i>Observed Readmissions—Total</i>	13.85%	13.39%	-0.46	NC

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
<i>Expected Readmissions—Total</i>	10.73%	10.73%	0.00	NC
<i>O/E Ratio—Total</i>	1.2912	1.2484	-0.04	★

¹ HEDIS MY 2022 to HEDIS MY 2023 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2022–MY 2023 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2022–MY 2023 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

² Performance Levels for MY 2023 were based on comparisons of the HEDIS MY 2023 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2022 benchmark

³ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

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

Please note that for the *Diagnosed Mental Health Disorders (DMH)* measure, a higher or lower rate does not indicate better performance, as the measure provides information on the diagnosed prevalence of mental health disorders. Therefore, this measure is not included in the evaluation of strengths and weaknesses below.

Green Shading⁺ Indicates that the HEDIS MY 2023 rate demonstrated a significant improvement from the HEDIS MY 2022 rate.

Red Shading⁺⁺ Indicates that the HEDIS MY 2023 rate demonstrated a significant decline from the HEDIS MY 2022 rate.

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

HEDIS MY 2023 Performance Levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PMV 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: AET's performance ranked above the 90th percentile for the *Chlamydia Screening in Women (CHL)—Ages 16 to 20 Years* and *Total* measure indicators and ranked between the 75th and 89th percentiles for the *Chlamydia Screening in Women (CHL)—Ages 21 to 24 Years* measure indicator, indicating women 16 to 24 years of age identified as sexually active had at least one test for chlamydia during the measurement year most of the time. Untreated chlamydia infections can lead to serious and irreversible complications. Screening is important, as approximately 75 percent

of chlamydia infections in women are asymptomatic and 95 percent of infections in men are asymptomatic. This results in delayed medical care and treatment.¹⁸ [Quality]

Strength #2: AET's performance ranked between the 75th and 89th percentiles for the *Adults' Access to Preventive/Ambulatory Health Services (AAP)—Ages 65 Years and Older* measure indicator, indicating that members 65 years of age and older had an ambulatory or preventive care visit most of the time. Healthcare visits are an opportunity for individuals to receive preventive services and counseling on topics such as diet and exercise. These visits also can help them to address acute issues or manage chronic conditions.¹⁹ [Quality and Access]

Strength #3: AET's performance ranked above the 90th percentile for the *Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Control (<8.0%)* measure indicator and ranked between the 75th and 89th percentiles for the *Hemoglobin A1c Control for Patients With Diabetes (HBD)—Hemoglobin A1c (HbA1c) Poor Control (>9.0%)* measure indicator. In addition, both measure indicator rates demonstrated significant improvement from MY 2022 to MY 2023, indicating members with diabetes had controlled HbA1c levels most of the time during the measurement year. Glycemic control is management of blood sugar levels to reduce the risk of microvascular complications (eye, kidney, and nerve diseases). Many complications such as heart disease, stroke, blindness, kidney failure, and amputation can be prevented if diabetes is detected and addressed in the early stages.²⁰ [Quality and Access]

Strength #4: AET's performance ranked between the 75th and 89th percentiles for the *Eye Exam for Patients With Diabetes (EED)* measure indicator, indicating members with diabetes had an eye exam to screen or monitor for diabetic retinal disease most of the time. Adults with diabetes should receive regular eye exams to help detect and manage visual complications. Regular eye exams are the best way to reduce the risk of blindness and maintain a healthy and productive life.²¹ [Quality and Access]

Strength #5: AET demonstrated overall strength in its HEDIS data reporting, as AET was fully compliant with all four IS standards and all performance measure rates were determined to be Reportable. [Quality]

¹⁸ National Committee for Quality Assurance. Chlamydia Screening in Women (CHL). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/chlamydia-screening-chl/>. Accessed on: Apr 1, 2025.

¹⁹ National Committee for Quality Assurance. Adults' Access to Preventive/Ambulatory Health Services (AAP). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/adults-access-to-preventive-ambulatory-health-services-aap/>. Accessed on: Apr 1, 2025.

²⁰ National Committee for Quality Assurance. Glycemic Status Assessment for Patients With Diabetes (GSD). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/glycemic-status-assessment-for-patients-with-diabetes-gsd/>. Accessed on: Apr 1, 2025.

²¹ National Committee for Quality Assurance. Eye Exam for Patients With Diabetes (EED). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/eye-exam-for-patients-with-diabetes-eed/>. Accessed on: Apr 2, 2025.

Weaknesses and Recommendations

Weakness #1: AET’s performance for the *Childhood Immunization Status (CIS)*—*Combination 3*, *Combination 7*, and *Combination 10* measure indicators ranked below the 25th percentile, indicating that children 2 years of age were not receiving some vaccinations by their second birthday.

Immunizations are essential for disease prevention and are an important component of preventive care for children. Childhood immunizations help prevent serious illnesses such as polio, tetanus, and hepatitis. Vaccines are a proven way to help a child stay healthy and avoid the potentially harmful effects of childhood diseases like mumps and measles.²² [Quality and Timeliness]

Why the weakness exists: The rates for the *Childhood Immunization Status (CIS)*—*Combination 3*, *Combination 7*, and *Combination 10* measure indicators ranked below the 25th percentile, suggesting barriers exist for children 2 years of age to receive some vaccinations by their second birthday. Potential barriers to improved measure performance that were identified by AET include, but are not limited to, provider challenges with vaccination storage protocols, providers obtaining necessary vaccination certifications, provider cost deterrents related to the short shelf life for vaccines/maintaining inventory, and parental vaccination hesitancy.

Recommendation: HSAG recommends that AET explore avenues to increase awareness of vaccination importance among parents to reduce vaccination hesitancy, such as a “speculation versus fact” pamphlet, which includes a phone number for care management support. AET could also consider issuing provider incentives for maintaining a complete inventory of vaccinations.

Weakness #2: AET’s performance for the *Well-Child Visits in the First 30 Months of Life (W30)*—*Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicators ranked below the 25th percentile, indicating children who turned 15 months old during the measurement year were not having at least six well-child visits with a PCP during their first 15 months of life and that children who turned 30 months old during the measurement year were not having at least two well-child visits with a PCP in the last 15 months. Research shows that early intervention treatment services can greatly improve a child’s development. Early intervention services help children from birth through 3 years of age (36 months) learn important skills.²³ [Quality, Timeliness, and Access]

Why the weakness exists: The rates for the *Well-Child Visits in the First 30 Months of Life (W30)*—*Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicators ranked below the 25th percentile, suggesting some barriers exist for children to have well-care visits. Potential barriers to improved measure performance that were identified by AET include incorrect member contact

²² National Committee for Quality Assurance. Childhood Immunization Status (CIS-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/childhood-immunization-status-cis-e/>. Accessed on: Apr 2, 2025.

²³ National Committee for Quality Assurance. Well-Child Visits in the First 30 Months of Life (W30). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/well-child-visits-in-the-first-30-months-of-life-w30/>. Accessed on: Apr 2, 2025.

information for outreach and providers not referencing its Quick Reference Guide, which resulted in missed compliance opportunities for the measure.

Recommendation: While **AET** noted several interventions currently in place to target improvement, such as interactive text messaging services to provide health education on well-child visits, care gap reminders, collecting barrier assessment data, offering appointment scheduling assistance to members, and member gift card incentives for successful completion of well-child visits, performance remains low for the *Well-Child Visits in the First 30 Months of Life (W30)* measure indicators. Therefore, HSAG recommends that **AET** continue its efforts to improve performance for the *Well-Child Visits in the First 30 Months of Life (W30)* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified. **AET** could consider reeducating providers on the importance of well-child visits and utilization of the Quick Reference Guide. Increased provider and member incentives for well-child visits may be another option to consider.

Weakness #3: **AET**'s performance for the *Immunizations for Adolescents (IMA)—Combination 1* and *Combination 2* measure indicators ranked between the 25th and 49th percentiles, and below the 25th percentile, respectively, indicating that members 13 years of age were not always receiving one dose of the meningococcal vaccine, one Tdap vaccine, and the complete human papillomavirus vaccine series by their 13th birthday during the measurement year. These vaccines are available for adolescents to prevent them from acquiring serious diseases and help protect against disease in populations that lack immunity, such as infants, the elderly, and individuals with chronic conditions.²⁴ [Quality, Timeliness, and Access]

Why the weakness exists: The rates for the *Immunizations for Adolescents—Combination 1* and *Combination 2* measure indicators ranked between the 25th percentile and 49th percentiles, and below the 25th percentile, respectively. Potential barriers to improved measure performance that were identified by **AET** include, but are not limited to, provider challenges with vaccination storage protocols, providers obtaining necessary vaccination certifications, provider costs deterrents related to the short shelf life for vaccines/maintaining inventory, and parental vaccination hesitancy.

Recommendation: HSAG recommends that **AET** explore avenues to increase awareness of vaccination importance among parents to reduce vaccination hesitancy, such as a “speculation versus fact” pamphlet, which includes a phone number for care management support. **AET** could also consider issuing provider incentives for maintaining a complete inventory of vaccinations for the *Immunizations for Adolescents* measure.

Weakness #4: **AET**'s performance for the *Cervical Cancer Screening (CCS-E)* measure ranked below the 25th percentile, indicating women were not always being screened for cervical cancer during the specified time frame. Cervical cancer can be detected in its early stages by regular

²⁴ National Committee for Quality Assurance. Immunizations for Adolescents (IMA-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/immunizations-for-adolescents-ima-e/>. Accessed on: Apr 2, 2025.

screening. Due to the success of cervical cancer screening in the U.S., dramatic decreases have been observed in both mortality and incidence of invasive cervical cancer.²⁵ [Quality and Access]

Why the weakness exists: The rate for the *Cervical Cancer Screening (CCS-E)* measure ranked below the 25th percentile. Some barriers noted by AET included inaccurate contact information for members, appointment availability, a high rate of no-show appointments resulting in loss of providers, SDOH taking precedence over healthcare needs for members, and transportation issues.

Recommendation: While AET noted several interventions currently in place to target improvement, such as member incentives, partnerships with health organizations to increase member engagement, mailings, outreach to noncompliant members, and not requiring prior authorization for continuity of care in women's health initiatives, performance remains low for the *Cervical Cancer Screening (CCS-E)* measure. Therefore, HSAG recommends that AET continue its efforts to improve performance for the *Cervical Cancer Screening (CCS-E)* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified. AET could consider the development and deployment of a digital notification system for members needing cervical cancer screening and incorporating screening reminders into current care coordination member touchpoints. Another option to consider would be to develop partnerships with local partners or vendors for transportation services.

Weakness #5: AET's performance for both of the *Prenatal and Postpartum Care (PPC)*—*Timeliness of Prenatal Care* and *Postpartum Care* measure indicators ranked below the 25th percentile, indicating that pregnant women were not always having a prenatal visit in the first trimester and not always having a postpartum visit on or between seven and 84 days after delivery during the measurement year. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.²⁶ [Quality, Timeliness, and Access]

Why the weakness exists: While the rate for the *Prenatal and Postpartum Care (PPC)*—*Timeliness of Prenatal Care* measure indicator demonstrated significant improvement from MY 2022 to MY 2023, both rates for *Prenatal and Postpartum Care (PPC)*—*Timeliness of Prenatal Care* and *Postpartum Care* ranked below the 25th percentile, suggesting that barriers exist for some pregnant women to have timely prenatal and postpartum visits.

Recommendation: HSAG recommends that AET continue developing targeted interventions to improve the performance of the *Prenatal and Postpartum Care (PPC)* measure indicators. Initiatives should be monitored and expanded upon as additional contributing factors are identified. AET could consider creating member incentives to promote increased prenatal and postpartum engagement, such a baby registry for pre-approved baby items and supplies.

²⁵ National Committee for Quality Assurance. Cervical Cancer Screening (CCS-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/cervical-cancer-screening-ccs-e/>. Accessed on: Apr 2, 2025.

²⁶ National Committee for Quality Assurance. Prenatal and Postpartum Care (PPC). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/prenatal-and-postpartum-care-ppc/>. Accessed on: Apr 2, 2025.

Weakness #6: AET's performance for the *Asthma Medication Ratio (AMR)* measure ranked below the 25th percentile, indicating that some members 5–64 years of age, who were identified as having persistent asthma, did not have a ratio of controller medication to total asthma medication of 0.50 or greater during the measurement year. Appropriate medication management for patients with asthma could reduce the need for rescue medication, the costs associated with emergency department (ED) visits, inpatient admissions, and missed days of work or school.²⁷ [Quality]

Why the weakness exists: The rate for the *Asthma Medication Ratio (AMR)* measure ranked below the 25th percentile. Potential barriers to improved rate performance may include, but are not limited to, utilization of ED services for management of asthma symptoms, and underutilization of primary care services for treatment and management of asthma.

Recommendation: HSAG recommends that AET develop targeted interventions to improve performance for the *Asthma Medication Ratio (AMR)* measure. Initiatives should be monitored and expanded upon as contributing factors to rate performance are identified. AET could consider providing education to members on proper medication management in order to avoid ED visits.

Weakness #7: AET's performance for the *Plan All-Cause Readmissions (PCR)—O/E Ratio—Total* measure indicator ranked below the 25th percentile, indicating that there were more unplanned acute readmissions within 30 days after discharge than expected for members 18 to 64 years of age. A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination. Unplanned readmissions are associated with increased mortality and higher healthcare costs. Unplanned readmissions can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management.²⁸ [Quality, Timeliness, and Access]

Why the weakness exists: The rate for the *Plan All-Cause Readmissions (PCR)—O/E Ratio—Total* measure indicator ranked below the 25th percentile. Potential barriers may include but are not limited to unaddressed medical need during initial acute inpatient admission, limited informal support systems for members, SDOH factors not included in discharge planning, or member compliance challenges with follow-up appointments or discharge instructions.

Recommendation: HSAG recommends that AET develop targeted interventions to help reduce unplanned acute readmissions for members. Any initiatives implemented should be monitored and expanded upon as contributing factors to rate performance are identified.

²⁷ National Committee for Quality Assurance. Asthma Medication Ratio (AMR). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/asthma-medication-ratio-amr/>. Accessed on: Apr 2, 2025.

²⁸ National Committee for Quality Assurance. Plan All-Cause Readmissions (PCR). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/plan-all-cause-readmissions-pcr/>. Accessed on: Apr 2, 2025.

Compliance Review

Performance Results

Table 3-10 presents the total number of criteria for each standard that received a score of *Met*, *Satisfied*, or *Not Met*. Table 3-10 also presents AET’s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. *NA* was used when MDHHS determined the review element was not applicable during the compliance review. For elements scored as *Not Met*, AET was subject to a corrective action review process outlined in Appendix A.

Table 3-10—Compliance Review Results for AET

Standard		Number of Scores				Compliance Scores	
		<i>Met</i>	<i>Satisfied</i> ¹	<i>Not Met</i>	<i>NA</i>	AET ²	Statewide ³
1	Administrative	5	0	0	0	100%	100%
2	Providers	23	0	1	0	96%	95.4%
3	Members	29	0	0	1	100%	98.9%
4	Quality	24	0	0	0	100%	100%
5	MIS/Financial	51	0	0	0	100%	94.6%
6	OIG/Program Integrity	9	0	1	0	90%	85.6%
Overall		141	0	2	1	99%	96.0%

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

¹ A score of *Satisfied* was only allowable for select elements under the MIS/Financial standard.

² MDHHS calculated the total compliance score for each standard by totaling the number of *Met* (i.e., 1 point) elements and the number of *Not Met* and *Satisfied* (i.e., 0 points) elements, then dividing the summed score by the total number of elements for that standard.

³ MDHHS calculated the statewide performance scores to the tenth decimal place; however, MHP performance scores were calculated using whole number percentages.

Additionally, to supplement the compliance review activity, MDHHS conducted staff interviews, referred to as focus studies, in the following three areas: CSHCS, Operations, and Quality. While the results of the focus studies are not incorporated into the scoring of the compliance review, AET met MDHHS’ expectations for participation in the studies.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the compliance review 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: AET achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. [Quality]

Strength #2: AET achieved full compliance in the Members standard, demonstrating the MHP maintained sufficient policies and procedures to support its membership, which included, but was not limited to, access to service authorization processes; care coordination procedures; fair grievance and appeal systems; member information materials such as the handbook, newsletters, and website; and choice of PCPs. [Quality, Timeliness, and Access]

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

Strength #4: AET achieved full compliance in the MIS/Financial standard, demonstrating that the MHP maintained a health information system that collected, analyzed, integrated, and reported data in various program areas and functions, including, but not limited to, financial statements and reports; third-party recovery and subrogation requests; claims and encounter data processes; provider data; and a physician incentive program. [Quality]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial weaknesses for **AET** through the compliance review activity.

Why the weakness exists: NA

Recommendation: NA

Network Adequacy Validation

Network Adequacy Analysis

Performance Results

Based on the results of the Information Systems Capabilities Assessment (ISCA) combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MHP's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each MHP according to Table 3-11.

Table 3-11—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	<i>High Confidence</i>
50.0% to 89.9%	<i>Moderate Confidence</i>
10.0% to 49.9%	<i>Low Confidence</i>
Less than 10% and/or any <i>Not Met</i> element has significant bias on the results	<i>No Confidence</i>

No indicators were identified as *Low Confidence* or *No Confidence* designations.

HSAG determined that **AET** met both the time and distance standards and the ratio standard requirements for 100 percent of its members across all indicators or submitted an exception to MDHHS. The exceptions indicated that **AET** was aware of a gap and, while corrective steps were underway, the issue had not been fully resolved at the time of reporting. Adequacy was determined based on the MHP's compliance with MDHHS' time and distance and ratio standards, with an assessment conducted for each provider type according to county. Table 3-12 outlines the counties and provider specialties for which exceptions were submitted. Results are presented by provider specialty in Table 3-13.

Table 3-12—AET Submitted Exceptions

County Exception Submitted	Specialty Exception Submitted
Berrien	Cardiology
Berrien	Hospital
Berrien	OB/GYN
Berrien	General Dentistry
Berrien	Endodontist
Calhoun	Periodontist

County Exception Submitted	Specialty Exception Submitted
Cass	Periodontist
Kalamazoo	Periodontist
Berrien	Oral Surgeon
Berrien	Periodontist
Berrien	Prosthodontist

Table 3-13—AET Network Adequacy Compliance

Provider Specialty	Non-Rural Time and Distance	Rural Time and Distance	Non-Rural Ratio	Rural Ratio
PCPs (Adult)	Compliant	Compliant	Compliant	Compliant
PCPs (Pediatric)	Compliant	Compliant	Compliant	Compliant
OB/GYN	Compliant	Compliant	NA	NA
Cardiology	Compliant	Compliant	NA	NA
Outpatient Behavioral Health	Compliant	Compliant	NA	NA
Hospital	Compliant	Compliant	NA	NA
Pharmacy	Compliant	Compliant	NA	NA
General Dentistry	Compliant	Compliant	Compliant	Compliant
Endodontist	Compliant	Compliant	NA	NA
Oral Surgeon	Compliant	Compliant	NA	NA
Periodontist	Compliant	Compliant	NA	NA
Prosthodontist	Compliant	Compliant	NA	NA

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: AET demonstrated its capability of maintaining an adequate provider network to service its members that included comprehensive contracting, provider data maintenance, and reporting methods. **AET** addressed any gaps in its network by submitting exception requests to MDHHS and increasing contracting efforts to fill network gaps. [Access]

Weaknesses and Recommendations

Weakness #1: HSAG identified a discrepancy in **AET**'s Pediatric PCP provider count in the submitted Network Access Plan (NAP) report. **AET** attributed the issue to a retroactive provider loading, which led to the exclusion of this provider from the original report. In response, **AET** provided a revised report and outlined a series of initiatives, including meetings, weekly audits, ongoing reviews of the provider network, and additional ad hoc reporting to address this loading issue and ensure timely and accurate provider data in future network adequacy reports. After reviewing the revised report, there are no concerns regarding the data submitted or the analysis of the ratio and time and distance standards. [Access]

Why the weakness exists: While preparing the report, **AET** encountered a delay regarding a provider's in-network status, resulting in the provider being omitted from the final report. Additionally, there were no verification measures in place to identify this discrepancy before submission to MDHHS.

Recommendation: HSAG recommends **AET** continue to implement the noted safeguards, along with an additional layer of review for areas showing non-compliance in the upcoming reporting year.

Network Validation Survey

Performance Results

HSAG's reviewers evaluated 360 randomly sampled cases by comparing provider data submitted to HSAG by **AET** against **AET**'s online provider directory. The sample included 161 PCPs, 161 pediatric providers, and 38 OB/GYN providers.²⁹ Overall, 68.9 percent of the sampled providers were located in the online directory at the sampled location, while 12.2 percent of the sampled providers located in the online directory were not at the sampled location. Additionally, 18.9 percent of the overall sampled providers could not be located in the online directory.

Table 3-14 summarizes the findings regarding the number of sampled providers and provider locations (i.e., "cases") that HSAG's reviewers located in the MHP's online directory.

Table 3-14—Summary of Providers Present in Online Directory by Provider Category

Provider Category	Number of Sampled Providers	Providers Not Found in Directory		Providers Found in Directory—Not at Sampled Location		Providers Found in Directory—At Sampled Location	
		Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
PCPs	161	26	16.1%	10	6.2%	125	77.6%

²⁹ A low number of OB/GYN providers was sampled due to the eligible population criteria (i.e., providers with the PCP indicator) which reduced the number of eligible OB/GYN providers. Caution should be exercised when interpreting OB/GYN results for **AET**.

Provider Category	Number of Sampled Providers	Providers Not Found in Directory		Providers Found in Directory—Not at Sampled Location		Providers Found in Directory—At Sampled Location	
		Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
Pediatric Providers	161	34	21.1%	28	17.4%	99	61.5%
OB/GYN Providers	38	8	21.1%	6	15.8%	24	63.2%
AET Total	360	68	18.9%	44	12.2%	248	68.9%

¹ The denominator includes the number of sampled providers.

Table 3-15 displays the total number and percentage of cases with matched data values for indicators that were reviewed between data values shown in AET’s provider data submission to HSAG and AET’s online provider directory. Cases with unmatched results may include incorrect information or information not listed in the directory (e.g., the provider data included a data value for a study indicator, but the online provider directory did not include a data value for the study indicator).

Table 3-15—Provider Demographic Indicators Matching Online Provider Directory

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		Overall	
	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
Provider Name	135	100%	127	100%	30	100%	292	100%
Provider Street Address	125	92.6%	99	78.0%	24	80.0%	248	84.9%
Provider Suite Number	131	97.0%	122	96.1%	28	93.3%	281	96.2%
Provider City	126	93.3%	110	86.6%	25	83.3%	261	89.4%
Provider State	134	99.3%	126	99.2%	30	100%	290	99.3%
Provider ZIP Code	127	94.1%	106	83.5%	24	80.0%	257	88.0%
Provider Telephone Number	122	90.4%	94	74.0%	23	76.7%	239	81.8%
Provider Type/Specialty	135	100%	127	100%	30	100%	292	100%
Provider Accepting New Patients	131	97.0%	119	93.7%	25	83.3%	275	94.2%
Provider Gender	134	99.3%	127	100%	30	100%	291	99.7%
Provider Primary Language ²	134	99.3%	127	100%	30	100%	291	99.7%
Non-English Language Speaking Provider (including American Sign Language) ²	135	100%	127	100%	30	100%	292	100%

¹ The denominator for each study indicator includes the number of cases in which the provider was found in the directory.

² The PDV review evaluated whether the indicator was present in the directory, but specific values were not validated.

For the secret shopper telephone survey, HSAG attempted to contact 224 sampled provider locations for **AET**, with an overall response rate of 51.3 percent. Table 3-16 summarizes the survey response rates (i.e., cases reached) for all MHPs and for **AET**, by provider category.

Table 3-16—Response Rates

Provider Category	Number of Total Cases ¹	Cases Reached	Response Rate
PCPs	113	53	46.9%
Pediatric Providers	90	49	54.4%
OB/GYN Providers	21	13	61.9%
AET Total	224	115	51.3%
All MHPs Total	2,633	1,775	67.4%

¹ Total number of cases includes cases that were found in the online directory and matched on eight key indicators (i.e., name, address, city, state, ZIP Code, telephone number, provider type/specialty, and new patient acceptance).

Table 3-17 summarizes the provider data validation and accuracy results for all MHPs and **AET**, by provider category.

Table 3-17—Provider Data Validation and Accuracy Results

Provider Category	Denom ¹	Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance		Accepting New Patients	
		Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
PCPs	53	32	60.4%	30	56.6%	30	56.6%	25	47.2%	25	47.2%
Pediatric Providers	49	30	61.2%	29	59.2%	28	57.1%	23	46.9%	23	46.9%
OB/GYN Providers	13	4	30.8%	2	15.4%	1	7.7%	1	7.7%	1	7.7%
AET Total	115	66	57.4%	61	53.0%	59	51.3%	49	42.6%	49	42.6%
All MHPs Total	1,775	1,280	72.1%	1,215	68.5%	1,082	61.0%	822	46.3%	731	41.2%

¹ The denominator includes cases reached.

Table 3-18 displays the number of survey respondents who offered appointments to new patients for routine PCP and prenatal care visits for all MHPs and **AET**, by provider category.

Table 3-18—Appointment Availability for Routine PCP and Prenatal Care Visits¹

Provider Category	Cases Reached	Cases Offered an Appointment	
		Count	Rate ²
PCPs	53	14	26.4%
Pediatric Providers	49	13	26.5%
OB/GYN Providers	13	1	7.7%
AET Total	115	28	24.3%
All MHPs Total	1,775	424	23.9%

¹ Appointment availability rates were calculated using cases accepting new patients and total survey cases as the denominator in the 2022 and 2023 reports. However, the denominator used in the 2024 report was cases reached. Caution should be exercised when comparing 2024 appointment availability rates with the rates in the 2022 and 2023 reports.

² The denominator includes cases reached.

Table 3-19 displays the new patient wait time results for all MHPs and **AET**, by provider category.

Table 3-19—Appointment Wait Time Results

Provider Category	Appointment Wait Time (Business Days)				Rate of Cases Within Standard ^{1,2}
	Min	Max	Average	Median	
PCPs	1	71	19	17	92.9%
Pediatric Providers	1	54	14	4	76.9%
OB/GYN Providers	4	4	4	4	100%
AET Total	1	71	16	6	85.7%
All MHPs Total	0	261	18	8	80.9%

¹ The denominator includes cases offered an appointment.

² Rate of cases within standard represents the percentage of cases that were offered an appointment that was compliant with the 30-business-day standard for routine appointments and seven-business-day standard for prenatal care appointments.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NVS 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: Of the providers located in **AET**'s online provider directory, eight of the 12 indicators had a match rate above 90.0 percent. [**Quality and Access**]

Weaknesses and Recommendations

Weakness #1: Reviewers located only 81.1 percent of the sampled providers in **AET**'s online provider directory. Among the provider categories, 21.1 percent of pediatric providers, 16.1 percent of PCP providers, and 21.1 percent of OB/GYN providers could not be located in the online directory. [**Access**]

Why the weakness exists: While **AET** submitted provider data to HSAG, the providers listed in the data were not confirmed within the **AET** online provider directory. The mismatch indicates inaccurate provider information within the provider data and/or online provider directory.

Recommendation: HSAG recommends that **AET** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., inaccurate and/or missing provider information) to address the provider data deficiencies.

Weakness #2: Overall, only 51.3 percent of cases for the secret shopper telephone survey could be reached. [**Access**]

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

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

Weakness #3: Of the cases reached, only 57.4 percent confirmed affiliation with the sampled provider. Additionally, 53.0 percent confirmed accuracy of the sampled address, 51.3 percent confirmed the services were offered, and 42.6 percent confirmed acceptance of the requested insurance and new patients. [**Quality and Access**]

Why the weakness exists: **AET**'s provider data included invalid provider, address, specialty, new patient, and insurance acceptance information.

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

Weakness #4: Of the cases reached, 24.3 percent of locations offered an appointment date, including 26.4 percent of PCPs, 26.5 percent of pediatric providers, and 7.7 percent of OB/GYN providers. Of the cases that offered an appointment, 85.7 percent were compliant with the appointment wait time standards. [**Timeliness and Access**]

Why the weakness exists: For new **AET** members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent

limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included pre-registration as well as requiring additional personal information, a Medicaid identification (ID), or an MRR.

Recommendation: HSAG recommends that **AET** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **AET** 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 **AET** procured medical records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*, to identify discrepancies and ensure alignment between the medical records and the encounter data submitted to MDHHS.

Table 3-20 outlines the key findings for **AET** based on the assessment of encounter data completeness and accuracy conducted through a review of members' medical records for services rendered from October 1, 2022, through September 30, 2023.

Table 3-20—Key Findings for AET

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	<ul style="list-style-type: none"> The medical record procurement rate was 97.6 percent, indicating that most requested records were successfully procured and submitted.
Second Date of Service Submission Rate	<ul style="list-style-type: none"> Among the procured medical records, 42.4 percent included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	<ul style="list-style-type: none"> The <i>Procedure Code</i> and <i>Procedure Code Modifier</i> data elements had relatively high medical record omission rates at 14.7 percent and 20.8 percent, respectively. This indicates that the procedure codes and the modifiers in the encounter data were not adequately supported by the members' medical records.
Encounter Data Omission Rate	<ul style="list-style-type: none"> All key data elements exhibited relatively low encounter data omission rates, with <i>Procedure Code</i> having the highest omission rate at 4.1 percent.

Analysis	Key Findings
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Diagnosis Code</i> data element was accurate in 99.9 percent of instances where codes were present in both the medical records and encounter data, with all errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code</i> data element was accurate in 97.4 percent of instances where codes were present in both the medical records and encounter data, with all errors related to inaccurate coding.
Procedure Code Modifier Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code Modifier</i> data element was accurate in 99.7 percent of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	<ul style="list-style-type: none"> Dates of service with accurate values for all key data elements (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, and <i>Procedure Code Modifier</i>) were observed in 74.6 percent of the dates of service present in both data sources (i.e., encounter data and medical records).

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: A high percentage of *Date of Service* and *Diagnosis Code* data element values in the encounter data were supported by the members' medical records, as evidenced by the low medical record omission rates of 2.8 percent and 7.2 percent, respectively. [Quality]

Strength #2: The *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data element values identified in the medical records were generally present in the encounter data, as evidenced by the low encounter data omission rates of 2.7 percent, 1.9 percent, 4.1 percent, and 1.1 percent, respectively. [Quality]

Strength #3: When key data elements were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate with rates of at least 97.4 percent each. [Quality]

Weaknesses and Recommendations

Weakness #1: More than 14.0 percent of the *Procedure Code* and more than 20.0 percent of the *Procedure Code Modifier* data element values identified in the encounter data were not supported by the members’ medical records. [Quality]

Why the weakness exists: The findings where encounter data are not supported by the medical records can stem from several potential reasons, which can involve provider documentation practices (e.g., incomplete or inaccurate documentation, coding errors, lack of detail), data submission (e.g., incorrect coding during data submission or data entry errors), or processing issues (e.g., data mapping or translation issues, errors in data transmission).

Recommendation: AET should investigate the root cause(s) of these omissions, with a focus on both provider documentation practices and data handling processes. Periodic MRRs of submitted claims should be conducted to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should be used to develop and provide ongoing education and training for providers. Topics should include encounter data submissions, medical record documentation requirements, and coding practices to reduce future omissions and improve data accuracy.

Consumer Assessment of Healthcare Providers and Systems Analysis

Adult and Child Medicaid

Performance Results

Table 3-21 presents AET’s 2023 and 2024 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2024 scores were statistically significantly higher or lower than the 2023 national average. Triangles (▲ or ▼) indicate 2024 scores were statistically significantly higher or lower than the 2023 scores.

Table 3-21—Summary of Adult and Child Medicaid CAHPS Top-Box Scores for AET

	2023 Adult Medicaid	2024 Adult Medicaid	2023 Child Medicaid	2024 Child Medicaid
Global Ratings				
<i>Rating of Health Plan</i>	57.89%	62.12%	66.67%	66.05%
<i>Rating of All Health Care</i>	54.19%	55.97%	67.54%	67.44% ⁺
<i>Rating of Personal Doctor</i>	68.00%	68.34%	74.72%	72.86%
<i>Rating of Specialist Seen Most Often</i>	64.66%	65.63%	65.96% ⁺	75.00% ⁺
Composite Measures				
<i>Getting Needed Care</i>	83.11%	83.26%	82.12% ⁺	86.10% ⁺

	2023 Adult Medicaid	2024 Adult Medicaid	2023 Child Medicaid	2024 Child Medicaid
<i>Getting Care Quickly</i>	77.26%	80.76%	85.03% ⁺	90.23% ⁺
<i>How Well Doctors Communicate</i>	91.04%	91.01%	92.23%	89.78% ⁺
<i>Customer Service</i>	89.65%	89.99%	90.04% ⁺	87.50% ⁺
Individual Item Measure				
<i>Coordination of Care</i>	84.43%	76.87% ↓	83.02% ⁺	75.61% ⁺
Medical Assistance With Smoking and Tobacco Use Cessation Items*				
<i>Advising Smokers and Tobacco Users to Quit</i>	70.86%	73.28%	—	—
<i>Discussing Cessation Medications</i>	54.34%	55.46%	—	—
<i>Discussing Cessation Strategies</i>	51.20%	46.19%	—	—

⁺ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

* These rates follow NCQA's methodology of calculating a rolling two-year average.

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.

▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.

No triangles (▲ or ▼) indicate the 2024 score was not statistically significantly higher or lower than the 2023 score.

↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.

↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.

No arrows (↑ or ↓) indicate the 2024 score was not statistically significantly higher or lower than the 2023 national average.

— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the CAHPS 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: AET's 2024 top-box scores were not statistically significantly higher than the 2023 NCQA adult and child Medicaid national averages or the 2023 top-box scores for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: AET's 2024 top-box score was statistically significantly lower than the 2023 NCQA adult Medicaid national average for one measure, *Coordination of Care*. [Quality]

Why the weakness exists: When compared to national benchmarks, the results indicate that AET's members may feel that their doctors or other healthcare providers are not informed or up-to-date about their care. The MHP reported that it communicates CAHPS results with providers, specialists, and

care coordinators to better support members in navigating healthcare opportunities. However, HSAG was unable to identify the MHP-specific barriers or other factors impacting drivers for these measures based on the information provided through this EQR.

Recommendation: HSAG recommends that **AET** focus on improving members’ overall experiences with their healthcare and identifying the root cause of the poorer experiences with their coordination of care.

CSHCS

Performance Results

Table 3-22 presents **AET**’s 2023 and 2024 CSHCS CAHPS top-box scores. The following measures could not be displayed in the table because these measures had fewer than 11 responses in 2024 and were suppressed: *Customer Service, How Well Doctors Communicate, Access to Specialized Services, Transportation, Access to Prescription Medicines, Not Felt Treated Unfairly: Race and Ethnicity, Not Felt Treated Unfairly: Health Insurance Type*. Upward green or downward red arrows (↑ or ↓) indicate 2024 scores that were statistically significantly higher or lower than the 2023 NCQA child Medicaid national averages, respectively. Upward green or downward red triangles (▲ or ▼) indicate 2024 scores that were statistically significantly higher or lower than the 2023 scores, respectively.

Table 3-22—Summary of CSHCS CAHPS Survey Top-Box Scores for AET

	2023 Top-Box Score	2024 Top-Box Score
Global Ratings		
<i>Rating of Health Plan</i>	81.25% ⁺	58.33% ⁺
<i>Rating of Health Care</i>	88.89% ⁺	83.33% ⁺ NA
<i>Rating of Specialist Seen Most Often</i>	85.71% ⁺	81.82% ⁺

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating the results.

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.

▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.

No triangle (▲ or ▼) indicates the 2024 score was not statistically significantly higher or lower than the 2023 score.

↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.

↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.

No arrow (↑ or ↓) indicates the 2024 score was not statistically significantly higher or lower than the 2023 national average.

NA Indicates a national average is not available for the measure.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the CAHPS 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: AET’s 2024 top-box scores were not statistically significantly higher than the 2023 NCQA child Medicaid national averages or the 2023 top-box scores for any reportable measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: AET’s 2024 top-box scores were not statistically significantly lower than the 2023 NCQA child Medicaid national averages or the 2023 top-box scores for any reportable measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

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

Quality Rating

The 2024 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2024 Michigan Consumer Guide, which is inclusive of AET’s performance.

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

HSAG performed a comprehensive assessment of AET’s aggregated performance, and its overall strengths and weaknesses related to the provision of healthcare services that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how AET’s overall performance contributed to the CHCP’s progress in achieving the CQS goals and objectives. Table 3-23 displays each MDHHS CQS goal and the EQR activity results that indicate whether the MHP positively (✓), negatively (✗), or minimally (m) impacted the CHCP’s progress toward achieving the applicable goals and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to AET’s Medicaid members. Not applicable (NA) was used when EQR activities do not produce data to assess the impact of a quality measure(s) under an objective.

Table 3-23—Overall Performance Impact to CQS and Quality, Timeliness, and Access

Objective	Program	Quality Measure	Overall Performance Impact	Performance Domain
Goal #1: Ensure high quality and high levels of access to care				
1.1	CHCP	<i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	m	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	CHCP	<i>Prenatal and Postpartum Care—Postpartum Care</i>	m	

Objective	Program	Quality Measure	Overall Performance Impact	Performance Domain
	CHCP	Childhood Immunization Status—Combination 3	m	
	CSHCS	Global Rating of Health Plan	x	
	CSHCS	Global Rating of Specialist Seen Most Often	✓	
	CSHCS	Global Rating of Health Care	✓	
	CSHCS	Composite Measure for Access to Specialized Services	NA	
	CSHCS	Composite Measure for Transportation	NA	
1.2	CHCP	Asthma Medication Ratio—Total	x	
	CHCP	Controlling High Blood Pressure	m	
	CHCP	Comprehensive Diabetes Care (CDC)—Eye Exams ^l	✓	
	CSHCS	Composite Measure for How Well Doctors Communicate	NA	
	CSHCS	Composite Measure for Customer Service	NA	
1.3	CHCP	Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	NA	
	CHCP	Getting Care Quickly Composite (Adult CAHPS)	m	
	CSHCS	Global Rating of Health Care	✓	
	CSHCS	Composite Measure for Access to Specialized Services	NA	
	CSHCS	Access to Prescription Medicines	NA	
Goal #2: Strengthen person and family-centered approaches				
2.1	CHCP	Rating of Health Plan ²	m	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	CHCP	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years Old	✓	
	CHCP	Access to Dental Care	x	
	CHCP	Completion of Annual Health Risk Assessment	NA	
	CSHCS	Composite Measure for How Well Doctors Communicate	NA	
	CSHCS	Global Rating of Health Plan	x	
	CSHCS	Global Rating of Health Care	✓	
	CSHCS	Global Rating of Specialist Seen Most Often	✓	
2.2	CHCP	SDOH: Total Member Screening Rate	NA	
	CHCP	SDOH: Total Member Referral Rate	NA	
	CHCP	Social Need Screening and Intervention	NA	
	CSHCS	Composite Measure for Access to Specialized Services	NA	

Objective	Program	Quality Measure	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)				
3.1	CHCP	Follow-Up After Hospitalization for Mental Illness Within 30 Days (FUH) (Adults)	NA	☒ Quality ☒ Timeliness ☒ Access
	CSHCS	Coordination of Care	NA	
3.2	CHCP	Implementation of Joint Care Management Processes	NA	
	CSHCS	Global Rating of Health Plan	✖	
	CSHCS	Global Rating of Health Care	✓	
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes				
4.1	CHCP	Chlamydia Screening in Women—Total ³	NA	☒ Quality ☒ Timeliness ☒ Access
	CHCP	Prenatal and Postpartum Care—Postpartum Care ³	NA	
	CHCP	Children Immunization Combo 3 ³	NA	
	CHCP	Lead Screening in Children ³	NA	
	CHCP	Comprehensive Diabetes Care—Eye Exam ³	NA	
	CHCP	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years Old ³	NA	
	CSHCS	Not Felt Treated Unfairly: Race and Ethnicity	NA	
Goal #5: Improve quality outcomes through value-based initiatives and payment reform				
5.1	CHCP	Average Percentage of Plan Payments to Providers Who Are in APM Arrangements ("Big Numerator")	NA	☒ Quality ☐ Timeliness ☐ Access
	CHCP	Average Percentage of Plan Payments to Providers That Are Tied to Quality ("Small Numerator")	NA	

✓ = The MHP's rate met the 2026 statewide performance target; or the MHP's rate did not meet the 2026 statewide performance target but demonstrated a statistically significant increase in performance from the prior year.

m = The MHP's rate did not meet the 2026 statewide performance target and while the MHP's rate increased in performance from the prior year, the increase was not statistically significant.

✗ = The MHP's rate did not meet the 2026 statewide performance target and/or the MHP's rate decreased in performance from the prior year.

NA = EQR activities published in this report do not produce data to assess the impact of a quality measure(s) under an objective.

¹ NCQA replaced the *Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed* performance measure with the *Eye Exam for Patients With Diabetes (EED)* performance measure, the overall performance impact was based on the MHP's reported rate for *Eye Exam for Patients With Diabetes (EED)*.

² As the CQS did not identify whether this quality measure applies to the adult or child CAHPS, HSAG assessed performance using the adult rate.

³ While there are reported HEDIS rates that are stratified by race/ethnicity, the EQR deliverables did not include an analysis of these data.

Blue Cross Complete of Michigan

Validation of Performance Improvement Projects

Performance Results

HSAG’s validation evaluated the technical methods of **BCC**’s PIP (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-24 displays the overall validation rating, the baseline rate, Remeasurement 1, and Remeasurement 2 results for the performance indicators, and if a disparity existed within the most recent measurement period.

Table 3-24—Overall Validation Rating for BCC

PIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
Reducing Racial Disparities Within Timeliness of Prenatal Care	High Confidence	No Confidence	1. Black women residing in Region 10 (disparate group)	67.0%	67.1% ⇨	67.7% ⇨	Yes
			2. White women residing in Region 10 (comparison group)	76.6%	73.7% ⇨	76.7% ⇨	

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).

The goals of **BCC**’s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black women) will demonstrate a statistically significant increase over the baseline rate without a decline in performance for the comparison subgroup (White women). Table 3-25 displays the barriers identified through QI and causal/barrier analysis processes and the interventions initiated by the MHP to support achievement of the PIP goals and address the barriers.

Table 3-25—Remeasurement 2 Barriers and Interventions for BCC

Barriers	Interventions
Late Entry into Prenatal Care for Black women—many Black women receive prenatal care outside the HEDIS time frame of within the first trimester or within 42 days of enrolling into the health plan.	Stratify pregnant Black women in Wayne County/Region 10 as high risk for priority high touch early outreach by Bright Start and expedited referral to a home visiting Maternal Infant Health Program (MIHP).

Barriers	Interventions
	Pilot a \$50 incentive for Black women in Wayne County who keep timely prenatal care appointments.
Unable to Reach (UTR) women by phone—barrier for members for whom the plan has no active phone number or for whom there is no response to outreach.	Establish handoff process for UTR prioritized members from Bright Start to Community Outreach team for expedited door-to-door follow-up.
Structural Racism/Lack of safe spaces and ability to safely trust in the healthcare system—Black women do not feel they can safely receive information and care from the healthcare system.	Establish a safe space for pregnant Black women to get trusted peer-led education about prenatal care by developing Community Pregnancy Groups in Detroit.
Need for education about the importance of timely prenatal care—women are not aware of the importance of a prenatal care visit within the first trimester.	Launch Facebook/Instagram social media campaign with prenatal messaging for focus population of Black women of childbearing age in Detroit.
	A second social media campaign with broadened prenatal messaging was launched in January 2024, with an expanded focus population of Black women in Wayne County, including Detroit.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PIP 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: BCC initiated timely interventions that were reasonably linked to their corresponding barriers. The interventions were evaluated to determine the effectiveness of each effort, with decisions to continue, discontinue, or revise an effort being data driven. [Quality, Timeliness, and Access]

Weaknesses and Recommendations

Weakness #1: BCC did not achieve the state-defined goal of eliminating the existing disparity with the second remeasurement period. [Quality, Timeliness, and Access]

Why the weakness exists: While it is unclear why the goal was not achieved, BCC has made progress in improving performance for the disparate population, demonstrating improvement year-over-year.

Recommendation: HSAG recommends that BCC continue testing or implement intervention strategies that have demonstrated improvement on the performance indicator. The MHP should revisit its causal/barrier analysis to ensure appropriate identification of barriers or the need to develop new or modified intervention strategies.

Performance Measure Validation

Performance Results

BCC was evaluated against NCQA’s IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2023 Compliance Audit Report findings, **BCC** was fully compliant with all four IS standards.

According to the auditor’s review, **BCC** followed the NCQA HEDIS MY 2023 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-26 displays the MDHHS-selected performance measures, HEDIS MY 2022 and MY 2023 rates, MY 2022 and MY 2023 comparisons, and MY 2023 performance levels based on comparisons to national percentiles³⁰ for **BCC**. Additional performance measures and performance measure results for **BCC** can be referenced in Appendix B.

Table 3-26—HEDIS MY 2023 Performance Measure Results for BCC

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
Child & Adolescent Care				
<i>Childhood Immunization Status (CIS)</i>				
<i>Combination 3</i>	57.91%	60.34%	+2.43	★★
<i>Combination 7</i>	48.66%	51.09%	+2.43	★★
<i>Combination 10</i>	26.28%	23.60%	-2.68	★
<i>Well-Child Visits in the First 30 Months of Life (W30)</i>				
<i>Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	67.72%	67.71%	-0.01	★★★★
<i>Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i>	63.64%	67.86%	+4.22+	★★★★
<i>Lead Screening in Children (LSC)</i>				
<i>Lead Screening in Children</i>	53.28%	57.22%	+3.93	★★
<i>Child and Adolescent Well-Care Visits (WCV)</i>				
<i>Ages 3 to 11 Years</i>	59.79%	62.53%	+2.74+	★★★★
<i>Ages 12 to 17 Years</i>	48.29%	51.35%	+3.06+	★★★★

³⁰ HEDIS MY 2023 performance measure rates are compared to NCQA’s Quality Compass National Medicaid Health Maintenance Organization (HMO) percentiles for HEDIS MY 2022 (referred to as “percentiles” throughout this section of the report).

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
<i>Ages 18 to 21 Years</i>	29.30%	31.88%	+2.58+	★★★★
<i>Total</i>	50.85%	54.19%	+3.34+	★★★★
Immunizations for Adolescents (IMA)				
<i>Combination 1 (Meningococcal, Tdap)</i>	74.42%	78.59%	+4.17	★★
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	28.89%	33.82%	+4.93+	★★
Women—Adult Care				
<i>Chlamydia Screening in Women (CHL)</i>³				
<i>Ages 16 to 20 Years</i>	60.81%	61.32%	+0.51	★★★★
<i>Ages 21 to 24 Years</i>	65.78%	66.55%	+0.77	★★★★
<i>Total</i>	63.55%	64.05%	+0.49	★★★★
<i>Cervical Cancer Screening (CCS-E)</i>				
<i>Cervical Cancer Screening</i>	60.30%	55.35%	-4.95 ⁺⁺	★★
<i>Breast Cancer Screening (BCS-E)</i>				
<i>Breast Cancer Screening</i>	53.17%	54.29%	+1.12	★★★★
Access to Care				
<i>Adults’ Access to Preventive/Ambulatory Health Services (AAP)</i>				
<i>Ages 20 to 44 Years</i>	74.19%	74.46%	+0.27	★★★★
<i>Ages 45 to 64 Years</i>	81.71%	82.04%	+0.33	★★★★
<i>Ages 65 Years and Older</i>	76.10%	72.29%	-3.81 ⁺⁺	★
<i>Total</i>	76.71%	77.02%	+0.31+	★★★★
Pregnancy Care				
<i>Prenatal and Postpartum Care (PPC)</i>³				
<i>Timeliness of Prenatal Care</i>	86.86%	88.16%	+1.30	★★★★
<i>Postpartum Care</i>	76.40%	81.62%	+5.22	★★★★
Living With Illness				
<i>Hemoglobin A1c Control for Patients With Diabetes (HBD)</i>				
<i>HbA1c Control (<8.0%)</i>	59.61%	58.92%	-0.69	★★★★
<i>Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*</i>	34.06%	35.21%	+1.14	★★★★
<i>Blood Pressure Control for Patients With Diabetes (BPD)</i>				
<i>Blood Pressure Control for Patients With Diabetes</i>	70.07%	65.77%	-4.30	★★★★

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
Eye Exam for Patients With Diabetes (EED)³				
Eye Exam for Patients With Diabetes	54.01%	56.97%	+2.95	★★★★
Kidney Health Evaluation for Patients With Diabetes (KED)				
Ages 18 to 64 Years	34.76%	36.39%	+1.63+	★★★★
Ages 65 to 74 Years	40.39%	41.71%	+1.32	★★★★
Ages 75 to 85 Years	37.93%	35.62%	-2.31	★★
Total	34.85%	36.45%	+1.60+	★★★★
Asthma Medication Ratio (AMR)				
Total	49.04%	50.42%	+1.38	★
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	58.81%	64.34%	+5.53	★★★★
Diagnosed Mental Health Disorders (DMH)				
Ages 1 to 17 Years	21.43%	23.14%	+1.72+	★★★★
Ages 18 to 64 Years	31.35%	32.90%	+1.55+	★★★★
Ages 65 Years and Older	18.56%	18.17%	-0.39	★
Total	27.90%	29.39%	+1.49+	★★★★
Utilization				
Plan All-Cause Readmissions (PCR)				
Observed Readmissions—Total	10.65%	11.55%	+0.89	NC
Expected Readmissions—Total	10.25%	10.31%	+0.06	NC
O/E Ratio—Total	1.0390	1.1200	+0.08	★

¹ HEDIS MY 2022 to HEDIS MY 2023 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2022–MY 2023 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2022–MY 2023 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

² Performance Levels for MY 2023 were based on comparisons of the HEDIS MY 2023 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2022 benchmark.

³ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

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

Please note that for the *Diagnosed Mental Health Disorders (DMH)* measure, a higher or lower rate does not indicate better performance, as the measure provides information on the diagnosed prevalence of mental health disorders. Therefore, this measure is not included in the evaluation of strengths and weaknesses below.

Green Shading⁺ Indicates that the HEDIS MY 2023 rate demonstrated a significant improvement from the HEDIS MY 2022 rate.

Red Shading⁺⁺ Indicates that the HEDIS MY 2023 rate demonstrated a significant decline from the HEDIS MY 2022 rate.

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

HEDIS MY 2023 Performance Levels represent the following percentile comparisons:

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

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PMV 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: BCC's performance ranked between the 75th and 89th percentiles for the *Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator, indicating children who turned 15 months old during the measurement year were having at least six well-child visits with a PCP during their first 15 months of life most of the time. Research shows that early intervention treatment services can greatly improve a child's development. Early intervention services help children from birth through 3 years of age (36 months) learn important skills.³¹ [Quality, Timeliness, and Access]

Strength #2: BCC's performance ranked between the 75th and 89th percentiles for the *Child and Adolescent Well-Care Visits (WCV)—Ages 18 to 21 Years* measure indicator and demonstrated significant improvement from MY 2022 to MY 2023, indicating members between the ages of 18 and 21 years received one or more well-care visits with a PCP or OB/GYN practitioner during the measurement year most of the time. More frequent well-child visits in the first years of life and one or more well-child visits from ages 3–21 are recommended. Well-child visits should include, but are not limited to, an initial/interval medical history, physical exam, developmental assessment, immunization, and anticipatory guidance.³² [Quality, Timeliness, and Access]

Strength #3: BCC's performance ranked between the 75th and 89th percentiles for the *Chlamydia Screening in Women (CHL)—Ages 16 to 20 Years, Ages 21 to 24 Years, and Total* measure indicators, indicating women 16 to 24 years of age identified as sexually active had at least one test for chlamydia during the measurement year most of the time. Untreated chlamydia infections can lead to serious and irreversible complications. Screening is important, as approximately 75 percent

³¹ National Committee for Quality Assurance. Well-Child Visits in the First 30 Months of Life (W30). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/well-child-visits-in-the-first-30-months-of-life-w30/>. Accessed on: Apr 2, 2025.

³² National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (WCV). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/child-and-adolescent-well-care-visits-wcv/>. Accessed on: Apr 2, 2025.

of chlamydia infections in women are asymptomatic and 95 percent of infections in men are asymptomatic. This results in delayed medical care and treatment.³³ [Quality]

Strength #4: BCC's performance ranked between the 75th and 89th percentiles for the *Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Control (<8.0%)* measure indicator, indicating members with diabetes had controlled HbA1c levels most of the time during the measurement year. Glycemic control is management of blood sugar levels to reduce the risk of microvascular complications (eye, kidney, and nerve diseases). Many complications such as heart disease, stroke, blindness, kidney failure, and amputation can be prevented if diabetes is detected and addressed in the early stages.³⁴ [Quality and Access]

Strength #5: BCC demonstrated overall strength in its HEDIS data reporting, as BCC was fully compliant with all four IS standards and all performance measure rates were determined to be Reportable. [Quality]

Weaknesses and Recommendations

Weakness #1: BCC's performance for the *Childhood Immunization Status (CIS)—Combination 10* measure indicator ranked below the 25th percentile. In addition, the *Childhood Immunization Status (CIS)—Combination 3* and *Combination 7* measure indicators ranked between the 25th and 49th percentiles, indicating that children 2 years of age were not receiving some vaccinations by their second birthday. Childhood immunizations help prevent serious illnesses such as polio, tetanus, and hepatitis. Vaccines are a proven way to help a child stay healthy and avoid the potentially harmful effects of childhood diseases like mumps and measles.³⁵ [Quality and Timeliness]

Why the weakness exists: The rates for the *Childhood Immunization Status (CIS)—Combination 3*, *Combination 7*, and *Combination 10* measure indicators all ranked below the 50th percentile, with the *Combination 10* measure indicator ranking below the 25th percentile. Potential barriers to improved measure performance may include, but are not limited to, provider challenges with vaccination storage protocols, providers obtaining necessary vaccination certifications, provider cost deterrents related to the short shelf life of vaccines/maintaining inventory, and parental vaccination hesitancy.

Recommendation: HSAG recommends that BCC develop targeted interventions to improve performance for the *Childhood Immunization Status (CIS)* measure. Initiatives should be monitored and expanded upon as contributing factors to rate performance are identified. BCC could consider exploring avenues to increase awareness of vaccination importance among parents to reduce

³³ National Committee for Quality Assurance. Chlamydia Screening in Women (CHL). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/chlamydia-screening-chl/>. Accessed on: Apr 1, 2025.

³⁴ National Committee for Quality Assurance. Glycemic Status Assessment for Patients With Diabetes (GSD). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/glycemic-status-assessment-for-patients-with-diabetes-gsd/>. Accessed on: Apr 1, 2025.

³⁵ National Committee for Quality Assurance. Childhood Immunization Status (CIS-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/childhood-immunization-status-cis-e/>. Accessed on: Apr 2, 2025.

vaccination hesitancy such as a “speculation versus fact” pamphlet which includes a phone number for care management support. **BCC** could also consider issuing provider incentives for maintaining complete inventory of vaccinations.

Weakness #2: **BCC**’s performance for the *Adults’ Access to Preventive/Ambulatory Health Services (AAP)—Ages 65 Years and Older* measure indicator ranked below the 25th percentile and significantly declined from MY 2022 to MY 2023, indicating that some members ages 65 years and older were not having an ambulatory or preventive care visit during the measurement year. Healthcare visits are an opportunity for individuals to receive preventive services and counseling on topics such as diet and exercise.³⁶ [Quality and Access]

Why the weakness exists: The rate for the *Adults’ Access to Preventive/Ambulatory Health Services (AAP)—Ages 65 Years and Older* measure indicator ranked below the 25th percentile and demonstrated a significant decline. Potential barriers to improved rate performance may include but are not limited to socioeconomic disparities that impact access to preventive care and member non-compliance with scheduled preventive care visits.

Recommendation: HSAG recommends that **BCC** develop targeted interventions to improve performance for the *Adults’ Access to Preventive/Ambulatory Health Services (AAP)* measure. Possible initiatives to increase patient engagement, improve upon outreach efforts, or streamline appointment scheduling (e.g., expanding upon office hours) should be considered as contributing factors to rate performance.

Weakness #3: **BCC**’s performance for the *Asthma Medication Ratio (AMR)* measure ranked below the 25th percentile, indicating that some members 5–64 years of age, who were identified as having persistent asthma, did not have a ratio of controller medication to total asthma medication of 0.50 or greater during the measurement year. Appropriate medication management for patients with asthma could reduce the need for rescue medication, the costs associated with ED visits, inpatient admissions, and missed days of work or school.³⁷ [Quality]

Why the weakness exists: The rate for the *Asthma Medication Ratio (AMR)* measure ranked below the 25th percentile. Potential barriers to improved rate performance may include, but are not limited to, utilization of ED services for management of asthma symptoms, and underutilization of primary care services for treatment and management of asthma.

Recommendation: HSAG recommends that **BCC** develop targeted interventions to improve performance for the *Asthma Medication Ratio (AMR)* measure. Initiatives should be monitored and expanded upon as contributing factors to rate performance are identified. **BCC** could consider providing education to members on proper medication management in order to avoid ED visits.

³⁶ National Committee for Quality Assurance. Adults’ Access to Preventive/Ambulatory Health Services (AAP). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/adults-access-to-preventive-ambulatory-health-services-aap/>. Accessed on: Apr 1, 2025.

³⁷ National Committee for Quality Assurance. Asthma Medication Ratio (AMR). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/asthma-medication-ratio-amr/>. Accessed on: Apr 2, 2025.

Weakness #4: BCC’s performance for the *Plan All-Cause Readmissions—O/E Ratio—Total* measure indicator ranked below the 25th percentile, indicating that there were more unplanned acute readmissions within 30 days after discharge than expected for members 18 to 64 years of age. A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination. Unplanned readmissions are associated with increased mortality and higher healthcare costs. Unplanned readmissions can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management.³⁸ [Quality, Timeliness, and Access]

Why the weakness exists: The rate for the *Plan All-Cause Readmissions—O/E Ratio—Total* measure indicator ranked below the 25th percentile. Potential barriers may include but are not limited to unaddressed medical need during initial acute inpatient admission, limited informal support systems for members, SDOH factors not included in discharge planning, or member compliance challenges with follow-up appointments or discharge instructions.

Recommendation: HSAG recommends that BCC develop targeted interventions to help reduce unplanned acute readmissions for members. Any initiatives implemented should be monitored and expanded upon as contributing factors to rate performance are identified.

Compliance Review

Performance Results


Table 3-27 presents the total number of criteria for each standard that received a score of *Met*, *Satisfied*, or *Not Met*. Table 3-27 also presents BCC’s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. *NA* was used when MDHHS determined the review element was not applicable during the compliance review. For elements scored as *Not Met*, BCC was subject to a corrective action review process outlined in Appendix A.

Table 3-27—Compliance Review Results for BCC

Standard		Number of Scores				Compliance Scores	
		<i>Met</i>	<i>Satisfied</i> ¹	<i>Not Met</i>	<i>NA</i>	BCC ²	Statewide ³
1	Administrative	5	0	0	0	100%	100%
2	Providers	23	0	1	0	96%	95.4%
3	Members	29	0	0	1	100%	98.9%
4	Quality	24	0	0	0	100%	100%
5	MIS/Financial	49	2	0	0	96%	94.6%

³⁸ National Committee for Quality Assurance. Plan All-Cause Readmissions (PCR). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/plan-all-cause-readmissions-pcr/>. Accessed on: Apr 2, 2025.

Standard		Number of Scores				Compliance Scores	
		Met	Satisfied ¹	Not Met	NA	BCC ²	Statewide ³
6	OIG/Program Integrity	9	0	1	0	90%	85.6%
Overall		139	2	2	1	97%	96.0%

 Indicates the standard scored below the statewide rate.

 Indicates the standard had a score of 100 percent.

¹ A score of *Satisfied* was only allowable for select elements under the MIS/Financial standard.

² MDHHS calculated the total compliance score for each standard by totaling the number of *Met* (i.e., 1 point) elements and the number of *Not Met* and *Satisfied* (i.e., 0 points) elements, then dividing the summed score by the total number of elements for that standard.

³ MDHHS calculated the statewide performance scores to the tenth decimal place; however, MHP performance scores were calculated using whole number percentages.

Additionally, to supplement the compliance review activity, MDHHS conducted staff interviews, referred to as focus studies, in the following three areas: CSHCS, Operations, and Quality. While the results of the focus studies are not incorporated into the scoring of the compliance review, **BCC** met MDHHS' expectations for participation in the studies.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the compliance review 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: BCC achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. **[Quality]**

Strength #2: BCC achieved full compliance in the Members standard, demonstrating the MHP maintained sufficient policies and procedures to support its membership, which included, but was not limited to, access to service authorization processes; care coordination procedures; fair grievance and appeal systems; member information materials such as the handbook, newsletters, and website; and choice of PCPs. **[Quality, Timeliness, and Access]**

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

Weaknesses and Recommendations

Weakness #1: HSAG did not find any substantial weaknesses for **BCC** through the compliance review activity.

Why the weakness exists: NA

Recommendation: NA

Network Adequacy Validation

Performance Results

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MHP's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each MHP according to Table 3-28.

Table 3-28—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	<i>High Confidence</i>
50.0% to 89.9%	<i>Moderate Confidence</i>
10.0% to 49.9%	<i>Low Confidence</i>
Less than 10% and/or any <i>Not Met</i> element has significant bias on the results	<i>No Confidence</i>

No indicators were identified as *Low Confidence* or *No Confidence* designations.

HSAG determined that **BCC** met both the time and distance standards and the ratio standard requirements for 100 percent of its members across all indicators or submitted an exception to MDHHS. The exceptions indicated that **BCC** was aware of a gap and, while corrective steps were underway, the issue had not been fully resolved at the time of reporting. Adequacy was determined based on the MHP's compliance with MDHHS' time and distance and ratio standards, with an assessment conducted for each provider type according to county. Table 3-30 outlines the counties and provider specialties for which exceptions were submitted. Results are presented by provider specialty in Table 3-29.

Table 3-29—BCC Submitted Exceptions

County Exception Submitted	Specialty Exception Submitted
Allegan	Prosthodontist
Allegan	Endodontist
Barry	Periodontist

County Exception Submitted	Specialty Exception Submitted
Barry	Prosthodontist
Barry	Endodontist
Clinton	Prosthodontist
Clinton	Endodontist
Eaton	Prosthodontist
Eaton	Endodontist
Jackson	Prosthodontist
Kent	Prosthodontist
Lake	Prosthodontist
Lake	Endodontist
Mason	General Dentistry
Mason	Prosthodontist
Mason	Endodontist
Montcalm	Prosthodontist
Montcalm	Periodontist
Montcalm	Endodontist
Muskegon	Prosthodontist
Muskegon	Endodontist
Newaygo	Prosthodontist
Newaygo	Endodontist
Oceana	Endodontist
Oceana	Prosthodontist
Osceola	Endodontist
Osceola	Prosthodontist
Ottawa	Prosthodontist
Ottawa	Endodontist
St. Clair	Periodontist
St. Clair	Endodontist

Table 3-30—BCC Network Adequacy Compliance

Provider Specialty	Non-Rural Time and Distance	Rural Time and Distance	Non-Rural Ratio	Rural Ratio
PCPs (Adult)	Compliant	Compliant	Compliant	Compliant
PCPs (Pediatric)	Compliant	Compliant	Compliant	Compliant
OB/GYN	Compliant	Compliant	NA	NA
Cardiology	Compliant	Compliant	NA	NA
Outpatient Behavioral Health	Compliant	Compliant	NA	NA
Hospital	Compliant	Compliant	NA	NA
Pharmacy	Compliant	Compliant	NA	NA
General Dentistry	Compliant	Compliant	Compliant	Compliant
Endodontist	Compliant	Compliant	NA	NA
Oral Surgeon	Compliant	Compliant	NA	NA
Periodontist	Compliant	Compliant	NA	NA
Prosthodontist	Compliant	Compliant	NA	NA

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: BCC demonstrated its capability of maintaining an adequate provider network to service its members that included comprehensive contracting, provider data maintenance, and reporting methods. BCC addressed any gaps in its network by submitting exception requests to MDHHS and increasing contracting efforts to fill network gaps. [Access]

Weaknesses and Recommendations

Weakness #1: No specific opportunities were identified related to the systems, management processes, or data integration BCC had in place to inform network adequacy standard and indicator calculation and reporting.

Why the weakness exists: NA

Recommendation: NA

Network Validation Survey

Performance Results

HSAG’s reviewers evaluated 388 randomly sampled cases by comparing provider data submitted to HSAG by BCC against BCC’s online provider directory. The sample included 192 PCPs, 192 pediatric providers, and only 4 OB/GYN providers.³⁹ Overall, 90.2 percent of the sampled providers were located in the online directory at the sampled location, while 6.2 percent of the sampled providers located in the online directory were not at the sampled location. Additionally, 3.6 percent of the overall sampled providers could not be located in the online directory. Notably, none of the OB/GYN providers were found in the directory at the sampled location.

Table 3-31 summarizes the findings regarding the number of sampled providers and provider locations (i.e., “cases”) that HSAG’s reviewers located in the MHP’s online directory.

Table 3-31—Summary of Providers Present in Online Directory by Provider Category

Provider Category	Number of Sampled Providers	Providers Not Found in Directory		Providers Found in Directory—Not at Sampled Location		Providers Found in Directory—At Sampled Location	
		Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
PCPs	192	7	3.6%	8	4.2%	177	92.2%
Pediatric Providers	192	5	2.6%	14	7.3%	173	90.1%
OB/GYN Providers	4	2	50.0%	2	50.0%	0	0.0%
BCC Total	388	14	3.6%	24	6.2%	350	90.2%

¹ The denominator includes the number of sampled providers.

Table 3-32 displays the total number and percentage of cases with matched data values for indicators that were reviewed between data values shown in BCC’s provider data submission to HSAG and BCC’s online provider directory. Cases with unmatched results may include incorrect information or information not listed in the directory (e.g., the provider data included a data value for a study indicator, but the online provider directory did not include a data value for the study indicator).

³⁹ A low number of OB/GYN providers was sampled due to the eligible population criteria (i.e., providers with the PCP indicator) which reduced the number of eligible OB/GYN providers. Caution should be exercised when interpreting OB/GYN results for BCC.

Table 3-32—Provider Demographic Indicators Matching Online Directory

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		Overall	
	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
Provider Name	185	100%	187	100%	2	100%	374	100%
Provider Street Address	177	95.7%	173	92.5%	0	0.0%	350	93.6%
Provider Suite Number	183	98.9%	181	96.8%	2	100%	366	97.9%
Provider City	182	98.4%	182	97.3%	2	100%	366	97.9%
Provider State	185	100%	187	100%	2	100%	374	100%
Provider ZIP Code	181	97.8%	177	94.7%	1	50.0%	359	96.0%
Provider Telephone Number	180	97.3%	176	94.1%	1	50.0%	357	95.5%
Provider Type/Specialty	185	100%	187	100%	2	100%	374	100%
Provider Accepting New Patients	185	100%	187	100%	2	100%	374	100%
Provider Gender	184	99.5%	187	100%	2	100%	373	99.7%
Provider Primary Language ²	185	100%	187	100%	2	100%	374	100%
Non-English Language Speaking Provider (including American Sign Language) ²	185	100%	187	100%	2	100%	374	100%

¹ The denominator for each study indicator includes the number of cases in which the provider was found in the directory.

² The PDV review evaluated whether the indicator was present in the directory, but specific values were not validated.

For the secret shopper telephone survey, HSAG attempted to contact 344 sampled provider locations for **BCC**, with an overall response rate of 84.6 percent. Table 3-33 summarizes the survey response rates for all MHPs and for **BCC**, by provider category.

Table 3-33—Response Rates

Provider Category	Number of Total Cases ¹	Cases Reached	Response Rate
PCPs	177	134	75.7%
Pediatric Providers	167	157	94.0%
BCC Total	344	291	84.6%
All MHPs Total	2,633	1,775	67.4%

¹ Total number of cases includes cases that were found in the online directory and matched on eight key indicators (i.e., name, address, city, state, ZIP Code, telephone number, provider type/specialty, and new patient acceptance).

Table 3-34 summarizes the provider data validation and accuracy results for all MHPs and **BCC**, by provider category.

Table 3-34—Provider Data Validation and Accuracy Results

Provider Category	Denom ¹	Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance		Accepting New Patients	
		Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
PCPs	134	125	93.3%	116	86.6%	101	75.4%	71	53.0%	61	45.5%
Pediatric Providers	157	130	82.8%	126	80.3%	126	80.3%	113	72.0%	108	68.8%
BCC Total	291	255	87.6%	242	83.2%	227	78.0%	184	63.2%	169	58.1%
All MHPs Total	1,775	1,280	72.1%	1,215	68.5%	1,082	61.0%	822	46.3%	731	41.2%

¹ The denominator includes cases reached.

Table 3-35 displays the number of survey respondents who offered appointments to new patients for routine PCP and prenatal care visits for all MHPs and **BCC**, by provider category.

Table 3-35—Appointment Availability for Routine PCP and Prenatal Care Visits¹

Provider Category	Cases Reached	Cases Offered an Appointment	
		Count	Rate ²
PCPs	134	43	32.1%
Pediatric Providers	157	69	43.9%
BCC Total	291	112	38.5%
All MHPs Total	1,775	424	23.9%

¹ Appointment availability rates were calculated using cases accepting new patients and total survey cases as the denominator in the 2022 and 2023 reports. However, the denominator used in the 2024 report was cases reached. Caution should be exercised when comparing 2024 appointment availability rates with the rates in the 2022 and 2023 reports.

² The denominator includes cases reached.

Table 3-36 displays the new patient wait time results for all MHPs and **BCC**, by provider category.

Table 3-36—Appointment Wait Time Results

Provider Category	Appointment Wait Time (Business Days)				Rate of Cases Within Standard ^{1,2}
	Min	Max	Average	Median	
PCPs	0	165	21	10	86.0%
Pediatric Providers	0	84	7	3	95.7%
BCC Total	0	165	12	5	92.0%
All MHPs Total	0	261	18	8	80.9%

¹ The denominator includes cases offered an appointment.

² Rate of cases within standard represents the percentage of cases that were offered an appointment that was compliant with the 30-business-day standard for routine appointments and seven-business-day standard for prenatal care appointments.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NVS 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: Reviewers located 96.4 percent of the sampled providers in BCC’s online provider directory. [Access]

Strength #2: Of the providers located in the online directory, all indicators had a match rate above 90.0 percent. [Access]

Strength #3: Of the cases that offered an appointment, 92.0 percent were compliant with the appointment wait time standard. [Timeliness]

Weaknesses and Recommendations

Weakness #1: Overall, 84.6 percent of the sampled provider locations were reached. [Access]

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

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

Weakness #2: Of the locations reached, 87.6 percent confirmed affiliation with the sampled provider. Additionally, 83.2 percent confirmed accuracy of the sampled address, 78.0 percent confirmed the services were offered, 63.2 percent confirmed the requested insurance, and 58.1 percent confirmed new patient acceptance. [Quality and Access]

Why the weakness exists: BCC's provider data included invalid provider, address, specialty, new patient acceptance, and insurance information.

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

Weakness #3: Of the cases reached, only 38.5 percent of locations offered an appointment date. However, pediatric providers had an appointment availability rate of 43.9 percent, while PCPs had an appointment availability rate of 32.1 percent. [Access]

Why the weakness exists: For new BCC members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included pre-registration as well as requiring additional personal information, a Medicaid ID, or an MRR.

Recommendation: HSAG recommends that BCC work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that BCC 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 BCC procured medical records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*, to identify discrepancies and ensure alignment between the medical records and the encounter data submitted to MDHHS.

Table 3-37 outlines the key findings for BCC based on the assessment of encounter data completeness and accuracy conducted through a review of members' medical records for services rendered from October 1, 2022, through September 30, 2023.

Table 3-37—Key Findings for BCC

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	<ul style="list-style-type: none"> The medical procurement rate was 99.5 percent, indicating that nearly all requested records were successfully procured and submitted.
Second Date of Service Submission Rate	<ul style="list-style-type: none"> Among the procured medical records, 42.1 percent included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	<ul style="list-style-type: none"> The <i>Procedure Code</i> and <i>Procedure Code Modifier</i> data elements had relatively high medical record omission rates at 10.7 percent and 14.3 percent, respectively. This indicates that the procedure codes and the modifiers in the encounter data were not adequately supported by the members' medical records.
Encounter Data Omission Rate	<ul style="list-style-type: none"> All key data elements exhibited relatively low encounter data omission rates, with <i>Date of Service</i> having the highest encounter data omission rate at 6.2 percent.
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Diagnosis Code</i> data element was accurate in 99.7 percent of instances where codes were present in both the medical records and encounter data, with most errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code</i> data element was accurate in 97.8 percent of instances where codes were present in both the medical records and encounter data; most errors were related to inaccurate coding, while some were attributed to providers submitting higher-level service codes than those supported in the medical records.
Procedure Code Modifier Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code Modifier</i> data element was accurate in 100 percent of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	<ul style="list-style-type: none"> Dates of service with accurate values for all key data elements (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, and <i>Procedure Code Modifier</i>) were observed in 73.1 percent of the dates of service present in both data sources (i.e., encounter data and medical records).

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: A high percentage of *Date of Service* and *Diagnosis Code* data element values in the encounter data were supported by the members' medical records, as evidenced by the low medical record omission rates of 0.7 percent and 5.9 percent, respectively. [Quality]

Strength #2: The *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data element values identified in the medical records were generally present in the encounter data, as evidenced by the low encounter data omission rates of 6.2 percent, 3.5 percent, 5.8 percent, and 1.3 percent, respectively. [Quality]

Strength #3: When key data elements were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate with rates of at least 97.8 percent each. [Quality]

Weaknesses and Recommendations

Weakness #1: More than 10.0 percent of *Procedure Code* and more than 14.0 percent of *Procedure Code Modifier* data element values identified in the encounter data were not supported by the members' medical records. [Quality]

Why the weakness exists: The findings where encounter data are not supported by the medical records can stem from several potential reasons, which can involve provider documentation practices (e.g., incomplete or inaccurate documentation, coding errors, lack of detail), data submission (e.g., incorrect coding during data submission or data entry errors), or processing issues (e.g., data mapping or translation issues, errors in data transmission).

Recommendation: BCC should investigate the root cause(s) for these omissions, with a focus on both provider documentation practices and data handling processes. Periodic MRRs of submitted claims should be conducted to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should be used to develop and provide ongoing education and training for providers. Topics should include encounter data submissions, medical record documentation requirements, and coding practices to reduce future omissions and improve data accuracy.

Consumer Assessment of Healthcare Providers and Systems Analysis

Adult and Child Medicaid

Performance Results

Table 3-38 presents BCC’s 2023 and 2024 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2024 scores were statistically significantly higher or lower than the 2023 national average. Triangles (▲ or ▼) indicate 2024 scores were statistically significantly higher or lower than the 2023 scores.

Table 3-38—Summary of Adult and Child Medicaid CAHPS Top-Box Scores for BCC

	2023 Adult Medicaid	2024 Adult Medicaid	2023 Child Medicaid	2024 Child Medicaid
Global Ratings				
<i>Rating of Health Plan</i>	63.23%	63.67%	72.76%	69.68%
<i>Rating of All Health Care</i>	58.74%	57.84%	68.79%	66.67%
<i>Rating of Personal Doctor</i>	62.14%	65.78%	72.97%	80.73%
<i>Rating of Specialist Seen Most Often</i>	63.36%	68.75%	71.67% ⁺	76.79% ⁺
Composite Measures				
<i>Getting Needed Care</i>	84.50%	83.36%	83.22%	83.48%
<i>Getting Care Quickly</i>	82.90%	83.76%	89.54%	88.34% ⁺
<i>How Well Doctors Communicate</i>	92.10%	93.83%	96.83%	96.33% ↑
<i>Customer Service</i>	91.65%	89.10%	88.04% ⁺	90.50% ⁺
Individual Item Measure				
<i>Coordination of Care</i>	85.22%	87.37% ⁺	82.76% ⁺	90.77% ⁺
Medical Assistance With Smoking and Tobacco Use Cessation Items*				
<i>Advising Smokers and Tobacco Users to Quit</i>	75.48%	76.65%	—	—
<i>Discussing Cessation Medications</i>	54.49%	52.98%	—	—
<i>Discussing Cessation Strategies</i>	47.40%	45.83%	—	—

⁺ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

* These rates follow NCQA’s methodology of calculating a rolling two-year average.

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.

▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.

No triangles (▲ or ▼) indicate the 2024 score was not statistically significantly higher or lower than the 2023 score.

↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.

↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.
 No arrows (↑ or ↓) indicate the 2024 score was not statistically significantly higher or lower than the 2023 national average.
 — Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the CAHPS 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: BCC's 2024 top-box score was statistically significantly higher than the 2023 NCQA child Medicaid national average for one measure, *How Well Doctors Communicate*. [Quality]

Weaknesses and Recommendations

Weakness #1: BCC's 2024 top-box scores were not statistically significantly lower than the 2023 NCQA adult and child Medicaid national averages or 2023 top-box scores for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

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

CSHCS

Performance Results

Table 3-39 presents BCC's 2023 and 2024 CSHCS CAHPS top-box scores. Upward green or downward red arrows (↑ or ↓) indicate 2024 scores were statistically significantly higher or lower than the 2023 national average. Upward green or downward red triangles (▲ or ▼) indicate 2024 scores were statistically significantly higher or lower than the 2023 scores.

Table 3-39—Summary of CSHCS CAHPS Survey Top-Box Scores for BCC

	2023 Top-Box Score	2024 Top-Box Score
Global Ratings		
<i>Rating of Health Plan</i>	65.49%	66.79%
<i>Rating of Health Care</i>	68.30%	64.79% NA
<i>Rating of Specialist Seen Most Often</i>	70.48%	67.88%
Composite Measures		
<i>Customer Service</i>	82.35% ⁺	87.12% ⁺

	2023 Top-Box Score	2024 Top-Box Score
<i>How Well Doctors Communicate</i>	92.52%	93.72% NA
<i>Access to Specialized Services</i>	67.06% ⁺	78.90% ⁺ ▲ NA
<i>Transportation</i>	—	90.00% ⁺ NT NA
Individual Item Measures		
<i>Access to Prescription Medicines</i>	85.80%	88.38%
<i>Not Felt Treated Unfairly: Race and Ethnicity</i>	97.55%	95.50% NA
<i>Not Felt Treated Unfairly: Health Insurance Type</i>	95.73%	93.53% NA

⁺ Indicates fewer than 100 respondents. Caution should be exercised when evaluating the results.

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.

▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.

No triangle (▲ or ▼) indicates the 2024 score was not statistically significantly higher or lower than the 2023 score.

↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.

↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.

No arrow (↑ or ↓) indicates the 2024 score was not statistically significantly higher or lower than the 2023 national average.

NA Indicates a national average is not available for the measure.

NT Indicates that results for this measure could not be trended.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the CAHPS 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: BCC's 2024 top-box score was statistically significantly higher than the 2023 top-box score for one measure, *Access to Specialized Services*. [Access]

Weaknesses and Recommendations

Weakness #1: BCC's 2024 top-box scores were not statistically significantly lower than the 2023 NCQA child Medicaid national averages or the 2023 top-box scores for any reportable measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

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

Quality Rating

The 2024 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2024 Michigan Consumer Guide, which is inclusive of **BCC**'s performance.

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

HSAG performed a comprehensive assessment of **BCC**'s aggregated performance, and its overall strengths and weaknesses related to the provision of healthcare services that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **BCC**'s overall performance contributed to the CHCP's progress in achieving the CQS goals and objectives. Table 3-40 displays each MDHHS CQS goal and the EQR activity results that indicate whether the MHP positively (✓), negatively (✗), or minimally (m) impacted the CHCP's progress toward achieving the applicable goals and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to **BCC**'s Medicaid members. Not applicable (NA) was used when EQR activities do not produce data to assess the impact of a quality measure(s) under an objective.

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

Objective	Program	Quality Measure	Overall Performance Impact	Performance Domain
Goal #1: Ensure high quality and high levels of access to care				
1.1	CHCP	<i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	✓	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	CHCP	<i>Prenatal and Postpartum Care—Postpartum Care</i>	✓	
	CHCP	<i>Childhood Immunization Status—Combination 3</i>	m	
	CSHCS	<i>Global Rating of Health Plan</i>	m	
	CSHCS	<i>Global Rating of Specialist Seen Most Often</i>	✗	
	CSHCS	<i>Global Rating of Health Care</i>	✗	
	CSHCS	<i>Composite Measure for Access to Specialized Services</i>	✓	
	CSHCS	<i>Composite Measure for Transportation</i>	✓	
1.2	CHCP	<i>Asthma Medication Ratio—Total</i>	m	
	CHCP	<i>Controlling High Blood Pressure</i>	m	
	CHCP	<i>Comprehensive Diabetes Care (CDC)—Eye Exams¹</i>	m	
	CSHCS	<i>Composite Measure for How Well Doctors Communicate</i>	m	
	CSHCS	<i>Composite Measure for Customer Service</i>	m	

Objective	Program	Quality Measure	Overall Performance Impact	Performance Domain
1.3	CHCP	Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	NA	
	CHCP	Getting Care Quickly Composite (Adult CAHPS)	m	
	CSHCS	Global Rating of Health Care	x	
	CSHCS	Composite Measure for Access to Specialized Services	✓	
	CSHCS	Access to Prescription Medicines	m	
Goal #2: Strengthen person and family-centered approaches				
2.1	CHCP	Rating of Health Plan ²	m	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	CHCP	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years Old	m	
	CHCP	Access to Dental Care	x	
	CHCP	Completion of Annual Health Risk Assessment	NA	
	CSHCS	Composite Measure for How Well Doctors Communicate	m	
	CSHCS	Global Rating of Health Plan	m	
	CSHCS	Global Rating of Health Care	x	
	CSHCS	Global Rating of Specialist Seen Most Often	x	
2.2	CHCP	SDOH: Total Member Screening Rate	NA	
	CHCP	SDOH: Total Member Referral Rate	NA	
	CHCP	Social Need Screening and Intervention	NA	
	CSHCS	Composite Measure for Access to Specialized Services	✓	
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)				
3.1	CHCP	Follow-Up After Hospitalization for Mental Illness Within 30 Days (FUH) (Adults)	NA	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	CSHCS	Coordination of Care	NA	
3.2	CHCP	Implementation of Joint Care Management Processes	NA	
	CSHCS	Global Rating of Health Plan	m	
	CSHCS	Global Rating of Health Care	x	
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes				
4.1	CHCP	Chlamydia Screening in Women—Total ³	NA	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	CHCP	Prenatal and Postpartum Care—Postpartum Care ³	NA	
	CHCP	Children Immunization Combo 3 ³	NA	
	CHCP	Lead Screening in Children ³	NA	

Objective	Program	Quality Measure	Overall Performance Impact	Performance Domain
	CHCP	Comprehensive Diabetes Care—Eye Exam ³	NA	
	CHCP	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years Old ³	NA	
	CSHCS	Not Felt Treated Unfairly: Race and Ethnicity	✖	
Goal #5: Improve quality outcomes through value-based initiatives and payment reform				
5.1	CHCP	Average Percentage of Plan Payments to Providers who are in APM arrangements ("Big Numerator")	NA	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access
	CHCP	Average Percentage of Plan Payments to Providers That Are Tied to Quality ("Small Numerator")	NA	

✓ = The MHP's rate met the 2026 statewide performance target; or the MHP's rate did not meet the 2026 statewide performance target but demonstrated a statistically significant increase in performance from the prior year.

m = The MHP's rate did not meet the 2026 statewide performance target and while the MHP's rate increased in performance from the prior year, the increase was not statistically significant.

✖ = The MHP's rate did not meet the 2026 statewide performance target and/or the MHP's rate decreased in performance from the prior year.

NA = EQR activities published in this report do not produce data to assess the impact of a quality measure(s) under an objective.

¹ NCQA replaced the *Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed* performance measure with the *Eye Exam for Patients With Diabetes (EED)* performance measure, the overall performance impact was based on the MHP's reported rate for *Eye Exam for Patients With Diabetes (EED)*.

² As the CQS did not identify whether this quality measure applies to the adult or child CAHPS, HSAG assessed performance using the adult rate.

³ While there are reported HEDIS rates that are stratified by race/ethnicity, the EQR deliverables did not include an analysis of these data.

HAP CareSource

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **HCS'** PIP (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-41 displays the overall validation rating, the baseline rate, Remeasurement 1, and Remeasurement 2 results for the performance indicators, and if a disparity existed within the most recent measurement period.

Table 3-41—Overall Validation Rating for HCS

PIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
<i>Improving the Timeliness of Prenatal Care</i>	<i>High Confidence</i>	<i>No Confidence</i>	Measuring the percentage of Black/African-American pregnant women who have a prenatal visit within 42 days of enrollment or within the first trimester	72.4%	75.1% ⇄	70.5% ⇄	NA

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).

NA = The MHP did not identify a disparity within its population; therefore, an assessment of an existing disparity during R2 is not applicable.

Due to its small population size and lack of an identified disparity, **HCS** determined through data analysis that the focus for the PIP should be improving timeliness of prenatal care for Black/African-American pregnant women as this population was the lowest-performing subgroup. The goal for **HCS'** PIP is to demonstrate statistically significant improvement over the baseline for the remeasurement periods. Table 3-42 displays the barriers identified through QI and causal/barrier analysis processes and the interventions initiated by the MHP to support achievement of the PIP goals and address the barriers.

Table 3-42—Remeasurement 2 Barriers and Interventions for HCS

Barriers	Interventions
Lack of member outreach/engagement.	Outreached to engage members in the internal case management program for maternity utilizing monthly pregnancy reports.
Member education/outreach and SDOH needs.	Implemented a maternity-focused care management program powered by ProgenyHealth. The program assesses member SDOH needs and refers to resources as needed.
Member education/outreach.	Progeny outreaches to engage members and refer to Maternal Infant Health Program (MIHP), an evidence-based home visitation program for Medicaid eligible pregnant members.
Medicaid members may have financial gaps that prevent attending appointments for prenatal visits.	Continued strategies to engage members and educate on incentive program. Reward flyer sent to members in welcome packet.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PIP 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: HCS used appropriate QI tools to conduct its causal/barrier analysis and interventions were initiated in a timely manner and reasonably linked to the identified barriers. [Quality, Timeliness, and Access]

Weaknesses and Recommendations

Weakness #1: HCS demonstrated a decrease in performance for the second remeasurement period as compared to the baseline performance. [Quality, Timeliness, and Access]

Why the weakness exists: While it is unclear why the performance indicator demonstrated a decrease in performance, the data suggest that barriers exist for the targeted population in the receipt of timely prenatal care.

Recommendation: HSAG recommends that **HCS** consider evidence-based intervention efforts and risk factors in quality and timeliness of care for the targeted population. **HCS** should also closely evaluate the success of each intervention strategy to determine any needs for modifications in order to achieve the desired improvement.

Performance Measure Validation

Performance Results

HCS was evaluated against NCQA’s IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2023 Compliance Audit Report findings, **HCS** was fully compliant with all four IS standards.

According to the auditor’s review, **HCS** followed the NCQA HEDIS MY 2023 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-43 displays the MDHHS-selected performance measures, HEDIS MY 2022 and MY 2023 rates, MY 2022 and MY 2023 comparisons, and MY 2023 performance levels based on comparisons to national percentiles⁴⁰ for **HCS**. Additional performance measures and performance measure results for **HCS** can be referenced in Appendix B.

Table 3-43—HEDIS MY 2023 Performance Measure Results for HCS

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
Child & Adolescent Care				
<i>Childhood Immunization Status (CIS)</i>				
<i>Combination 3</i>	46.22%	50.46%	+4.24	★
<i>Combination 7</i>	39.33%	41.31%	+1.98	★
<i>Combination 10</i>	19.83%	17.39%	-2.45	★
<i>Well-Child Visits in the First 30 Months of Life (W30)</i>				
<i>Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	52.44%	54.92%	+2.48	★★
<i>Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i>	47.35%	59.13%	+11.79+	★
<i>Lead Screening in Children (LSC)</i>				
<i>Lead Screening in Children</i>	48.74%	55.97%	+7.23+	★★
<i>Child and Adolescent Well-Care Visits (WCV)</i>				
<i>Ages 3 to 11 Years</i>	47.26%	51.14%	+3.88+	★★
<i>Ages 12 to 17 Years</i>	36.91%	37.01%	+0.10	★

⁴⁰ HEDIS MY 2023 performance measure rates are compared to NCQA’s Quality Compass National Medicaid Health Maintenance Organization (HMO) percentiles for HEDIS MY 2022 (referred to as “percentiles” throughout this section of the report).

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
<i>Ages 18 to 21 Years</i>	22.12%	20.81%	-1.31	★★
<i>Total</i>	38.98%	41.56%	+2.58+	★
Immunizations for Adolescents (IMA)				
<i>Combination 1 (Meningococcal, Tdap)</i>	65.23%	69.28%	+4.05	★
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	17.19%	22.87%	+5.68	★
Women—Adult Care				
Chlamydia Screening in Women (CHL)³				
<i>Ages 16 to 20 Years</i>	64.90%	62.96%	-1.94	★★★★
<i>Ages 21 to 24 Years</i>	66.17%	65.08%	-1.09	★★★★
<i>Total</i>	65.78%	64.29%	-1.50	★★★★
Cervical Cancer Screening (CCS-E)				
<i>Cervical Cancer Screening</i>	56.45%	45.23%	-11.22 ⁺⁺	★
Breast Cancer Screening (BCS-E)				
<i>Breast Cancer Screening</i>	54.60%	55.11%	+0.51	★★★★
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
<i>Ages 20 to 44 Years</i>	61.17%	62.38%	+1.21+	★
<i>Ages 45 to 64 Years</i>	74.93%	75.57%	+0.64	★★
<i>Ages 65 Years and Older</i>	90.91%	90.08%	-0.83	★★★★
<i>Total</i>	68.50%	69.16%	+0.66	★★
Pregnancy Care				
Prenatal and Postpartum Care (PPC)³				
<i>Timeliness of Prenatal Care</i>	79.21%	76.11%	-3.10	★
<i>Postpartum Care</i>	68.68%	65.00%	-3.68	★
Living With Illness				
Hemoglobin A1c Control for Patients With Diabetes (HBD)				
<i>HbA1c Control (<8.0%)</i>	56.20%	60.25%	+4.04	★★★★
<i>Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*</i>	35.77%	32.35%	-3.42	★★★★
Blood Pressure Control for Patients With Diabetes (BPD)				
<i>Blood Pressure Control for Patients With Diabetes</i>	61.07%	66.17%	+5.10	★★★★

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
Eye Exam for Patients With Diabetes (EED)³				
Eye Exam for Patients With Diabetes	58.88%	53.33%	-5.55	★★★
Kidney Health Evaluation for Patients With Diabetes (KED)				
Ages 18 to 64 Years	37.86%	38.72%	+0.86	★★★
Ages 65 to 74 Years	44.93%	42.58%	-2.36	★★★
Ages 75 to 85 Years	43.10%	38.50%	-4.60	★★★
Total	39.52%	39.37%	-0.16	★★★
Asthma Medication Ratio (AMR)				
Total	52.03%	55.56%	+3.52	★
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	62.53%	65.72%	+3.19	★★★
Diagnosed Mental Health Disorders (DMH)				
Ages 1 to 17 Years	12.95%	16.99%	+4.03+	★★
Ages 18 to 64 Years	23.73%	26.61%	+2.89+	★★
Ages 65 Years and Older	34.25%	36.20%	+1.95	★★★
Total	22.40%	25.18%	+2.78+	★★
Utilization				
Plan All-Cause Readmissions (PCR)				
Observed Readmissions—Total	8.83%	9.60%	+0.77	NC
Expected Readmissions—Total	10.44%	10.19%	-0.24	NC
O/E Ratio—Total	0.8463	0.9415	+0.10	★★★

¹ HEDIS MY 2022 to HEDIS MY 2023 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2022–MY 2023 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2022–MY 2023 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

² Performance Levels for MY 2023 were based on comparisons of the HEDIS MY 2023 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2022 benchmark.

³ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

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

Please note that for the *Diagnosed Mental Health Disorders (DMH)* measure, a higher or lower rate does not indicate better performance, as the measure provides information on the diagnosed prevalence of mental health disorders. Therefore, this measure is not included in the evaluation of strengths and weaknesses below.

Green Shading⁺ Indicates that the HEDIS MY 2023 rate demonstrated a significant improvement from the HEDIS MY 2022 rate.

Red Shading⁺⁺ Indicates that the HEDIS MY 2023 rate demonstrated a significant decline from the HEDIS MY 2022 rate.

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

HEDIS MY 2023 Performance Levels represent the following percentile comparisons:

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

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PMV 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: HCS' performance ranked between the 75th and 89th percentiles for the *Chlamydia Screening in Women (CHL)—Ages 16 to 20 Years* and *Total* measure indicators, indicating women 16 to 24 years of age identified as sexually active had at least one test for chlamydia during the measurement year most of the time. Untreated chlamydia infections can lead to serious and irreversible complications. Screening is important, as approximately 75 percent of chlamydia infections in women are asymptomatic and 95 percent of infections in men are asymptomatic. This results in delayed medical care and treatment.⁴¹ [Quality]

Strength #2: HCS' performance ranked between the 75th and 89th percentiles for the *Adults' Access to Preventive/Ambulatory Health Services (AAP)—Ages 65 Years and Older* measure indicator, indicating that members 65 years of age and older had an ambulatory or preventive care visit most of the time. Healthcare visits are an opportunity for individuals to receive preventive services and counseling on topics such as diet and exercise. These visits also can help them to address acute issues or manage chronic conditions.⁴² [Quality and Access]

Strength #3: HCS' performance ranked between the 75th and 89th percentiles for the *Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Control (<8.0%)* and *Hemoglobin A1c (HbA1c) Poor Control (>9.0%)* measure indicators, indicating members with diabetes had controlled HbA1c levels most of the time during the measurement year. Glycemic control is management of blood sugar levels to reduce the risk of microvascular complications (eye, kidney, and nerve diseases). Many complications such as heart disease, stroke, blindness, kidney failure, and

⁴¹ National Committee for Quality Assurance. Chlamydia Screening in Women (CHL). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/chlamydia-screening-chl/>. Accessed on: Apr 1, 2025.

⁴² National Committee for Quality Assurance. Adults' Access to Preventive/Ambulatory Health Services (AAP). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/adults-access-to-preventive-ambulatory-health-services-aap/>. Accessed on: Apr 1, 2025.

amputation can be prevented if diabetes is detected and addressed in the early stages.⁴³ [Quality and Access]

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

Weaknesses and Recommendations

Weakness #1: HCS' performance for the *Childhood Immunization Status (CIS)—Combination 3, Combination 7, and Combination 10* measure indicators ranked below the 25th percentile, indicating that children 2 years of age were not receiving some vaccinations by their second birthday. Childhood immunizations help prevent serious illnesses such as polio, tetanus, and hepatitis. Vaccines are a proven way to help a child stay healthy and avoid the potentially harmful effects of childhood diseases like mumps and measles.⁴⁴ [Quality and Timeliness]

Why the weakness exists: The rates for the *Childhood Immunization Status (CIS)—Combination 3, Combination 7, and Combination 10* measure indicators ranked below the 25th percentile, suggesting barriers exist for children 2 years of age to receive some vaccinations by their second birthday. Potential barriers to improved measure performance may include, but are not limited to, provider challenges with vaccination storage protocols, providers obtaining necessary vaccination certifications, provider cost deterrents related to the short shelf life for vaccines/maintaining inventory, and parental vaccination hesitancy.

Recommendation: HSAG recommends that HCS develop targeted interventions to improve performance for the *Childhood Immunization Status (CIS)* measure. Initiatives should be monitored and expanded upon as contributing factors to rate performance are identified. HCS could consider exploring avenues to increase awareness of vaccination importance among parents to reduce vaccination hesitancy such as a “speculation versus fact” pamphlet which includes a phone number for care management support. HCS could also consider issuing provider incentives for maintaining a complete inventory of vaccinations.

Weakness #2: HCS' performance for the *Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicators ranked between the 25th and 49th percentiles, and below the 25th percentile, respectively, indicating children who turned 15 months old during the measurement year were not having at least six well-child visits with a PCP during their first 15 months of life and that children who turned 30 months old during the measurement year were not having at least two well-child visits with a PCP in the last 15 months.

⁴³ National Committee for Quality Assurance. Glycemic Status Assessment for Patients With Diabetes (GSD). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/glycemic-status-assessment-for-patients-with-diabetes-gsd/>. Accessed on: Apr 1, 2025.

⁴⁴ National Committee for Quality Assurance. Childhood Immunization Status (CIS-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/childhood-immunization-status-cis-e/>. Accessed on: Apr 2, 2025.

Research shows that early intervention treatment services can greatly improve a child's development. Early intervention services help children from birth through 3 years of age (36 months) learn important skills.⁴⁵ [Quality, Timeliness, and Access]

Why the weakness exists: While the rate for the *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator demonstrated significant improvement from MY 2022 to MY 2023, both *Well-Child Visits in the First 30 Months of Life (W30)* measure indicator rates fell below the 50th percentile, suggesting some barriers exist for children to have well-care visits. Potential barriers noted by HCS include incorrect member contact information for outreach and members ages 18–21 years being less likely to obtain their annual well-child visits, as the contact information for these members continues to be that of their parent/guardian, thus preventing HCS from conversing with and coordinating services for these members.

Recommendation: While HCS demonstrated a significant improvement for the *Child Visits for Age 15 Months to 30 Months (W30)—Two or More Well-Child Visits* measure indicator, and noted several interventions currently in place to target improvement, such as hiring health outreach specialists to focus on scheduling well-child visits/gap closure outreach, contacting the provider if unable to reach members, and restructuring the member rewards program to include incentives for the *Well-Child Visits for Age 15 Months to 30 Months (W30)* measure indicators, performance remains low. Therefore, HSAG recommends that HCS continue its efforts to improve performance for the *Well-Child Visits in the First 30 Months of Life (W30)* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified. Increased provider and member incentives for well-child visits may be an option to consider.

Weakness #3: HCS' performance for the *Child and Adolescent Well-Care Visits (WCV)—Ages 3 to 11 Years* and *Ages 18 to 21 Years* measure indicators ranked between the 25th and 49th percentiles and ranked below the 25th percentile for the *Child and Adolescent Well-Care Visits (WCV)—Ages 12 to 17 Years* and *Total* measure indicators, indicating that members 3–21 years of age were not always receiving one or more well-care visits with a PCP or an OB/GYN practitioner during the measurement year. More frequent well-child visits in the first years of life and one or more well-child visits from ages 3–21 are recommended. Well-child visits should include, but are not limited to, an initial/interval medical history, physical exam, developmental assessment, immunization, and anticipatory guidance.⁴⁶ [Quality, Timeliness, and Access]

Why the weakness exists: While the rates for the *Ages 3 to 11 Years* and *Total* measure indicators demonstrated significant improvement from MY 2022 to MY 2023, the rates for the *Child and Adolescent Well-Care Visits (WCV)—Ages 3 to 11 Years* and *Ages 18 to 21 Years* measure indicators ranked between the 25th and 49th percentiles and ranked below the 25th percentile for the *Child and Adolescent Well-Care Visits (WCV)—Ages 12 to 17 Years* and *Total* measure indicators. Potential

⁴⁵ National Committee for Quality Assurance. Well-Child Visits in the First 30 Months of Life (W30). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/well-child-visits-in-the-first-30-months-of-life-w30/>. Accessed on: Apr 2, 2025.

⁴⁶ National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (WCV). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/child-and-adolescent-well-care-visits-wcv/>. Accessed on: Apr 2, 2025.

barriers noted by **HCS** include incorrect member contact information for outreach and members ages 18–21 years being less likely to obtain their annual well-child visits, as the contact information for these members continues to be that of their parent/guardian, thus preventing **HCS** from conversing with and coordinating services for these members.

Recommendation: While **HCS** demonstrated a significant improvement for the *Ages 3 to 11 Years* and *Total* measure indicators and noted several interventions currently in place to target improvement, such as hiring health outreach specialists to focus on scheduling well-child visits/gap closure outreach, contacting the provider if unable to reach members, and restructuring the member rewards program to include incentives for the measure indicators, performance remains low. Therefore, HSAG recommends that **HCS** continue its efforts to improve performance for the *Child and Adolescent Well-Care Visits (WCV)* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified. Increased provider and member incentives for well-child visits may be an option to consider.

Weakness #4: **HCS'** performance for the *Immunizations for Adolescents (IMA)—Combination 1* and *Combination 2* measure indicators ranked below the 25th percentile, indicating that members 13 years of age were not always receiving one dose of the meningococcal vaccine, one Tdap vaccine, and the complete human papillomavirus vaccine series by their 13th birthday during the measurement year. These vaccines are available for adolescents to prevent them from acquiring serious diseases and help protect against disease in populations that lack immunity, such as infants, the elderly, and individuals with chronic conditions.⁴⁷ [Quality, Timeliness, and Access]

Why the weakness exists: The rates for the *Immunizations for Adolescents (IMA)—Combination 1* and *Combination 2*) measure indicators ranked below the 25th percentile. Potential barriers may include, but are not limited to, provider challenges with vaccination storage protocols, providers obtaining necessary vaccination certifications, provider cost deterrents related to the short shelf life for vaccines/maintaining inventory, and parental vaccination hesitancy.

Recommendation: HSAG recommends that **HCS** develop targeted interventions to improve performance for the *Immunizations for Adolescents (IMA)* measure. Initiatives should be monitored and expanded upon as contributing factors to rate performance are identified. **HCS** could consider exploring avenues to increase awareness of vaccination importance among parents to reduce vaccination hesitancy such as a “speculation versus fact” pamphlet which includes a phone number for care management support. **HCS** could also consider issuing provider incentives for maintaining a complete inventory of vaccinations.

Weakness #5: **HCS'** performance for the *Cervical Cancer Screening (CCS-E)* measure ranked below the 25th percentile, indicating women were not always being screened for cervical cancer during the specified time frame. Cervical cancer can be detected in its early stages by regular

⁴⁷ National Committee for Quality Assurance. Immunizations for Adolescents (IMA-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/immunizations-for-adolescents-ima-e/>. Accessed on: Apr 2, 2025.

screening. Due to the success of cervical cancer screening in the U.S., dramatic decreases have been observed in both mortality and incidence of invasive cervical cancer.⁴⁸ [Quality and Access]

Why the weakness exists: The rate for the *Cervical Cancer Screening (CCS-E)* measure ranked below the 25th percentile. Some barriers noted by HCS include inaccurate contact information for members, preventive screenings not being completed during doctor visits, provider confusion on what age the screening should be completed and whether the screening should be completed with an HPV test, and members not being aware screening is needed if they are exhibiting any signs or symptoms.

Recommendation: While HCS noted several interventions currently in place to target improvement, such as providing some provider groups with monthly HEDIS reporting packages, implementing events for women focused on providing needed screenings while also growing partnerships with providers, and evaluating each intervention by reviewing HEDIS results and comparing baseline to remeasurement periods, performance remains low for the *Cervical Cancer Screening (CCS-E)* measure. Therefore, HSAG recommends that HCS continue its efforts to improve performance for the *Cervical Cancer Screening (CCS-E)* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified. HCS could consider the development and deployment of a digital notification system for members needing cervical cancer screening and incorporating screening reminders into current care coordination member touchpoints.

Weakness #6: HCS' performance for the *Adults' Access to Preventive/Ambulatory Health Services (AAP)—Ages 45 to 64 Years* and *Total* measure indicators ranked between the 25th and 49th percentiles, and the *Ages 20 to 44 Years* measure indicator ranked below the 25th percentile, indicating that some members ages 20 years and older were not having an ambulatory or preventive care visit during the measurement year. Healthcare visits are an opportunity for individuals to receive preventive services and counseling on topics such as diet and exercise.⁴⁹ [Quality and Access]

Why the weakness exists: The rates for the *Adults' Access to Preventive/Ambulatory Health Services (AAP)—Ages 45 to 64 Years* and *Total* measure indicators ranked between the 25th and 49th percentiles, and the *Ages 20 to 44 Years* measure indicator ranked below the 25th percentile. Potential barriers to improved rate performance may include but are not limited to socioeconomic disparities that impact access to preventive care and member non-compliance with scheduled preventive care visits.

Recommendation: HSAG recommends that HCS develop targeted interventions to improve performance for the *Adults' Access to Preventive/Ambulatory Health Services (AAP)—Ages 45 to 64 Years* measure. Possible initiatives to increase patient engagement, improve upon outreach efforts, or

⁴⁸ National Committee for Quality Assurance. Cervical Cancer Screening (CCS-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/cervical-cancer-screening-ccs-e/>. Accessed on: Apr 2, 2025.

⁴⁹ National Committee for Quality Assurance. Adults' Access to Preventive/Ambulatory Health Services (AAP). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/adults-access-to-preventive-ambulatory-health-services-aap/>. Accessed on: Apr 1, 2025.

streamline appointment scheduling (e.g., expanding upon office hours) should be considered as contributing factors to rate performance.

Weakness #7: HCS' performance for both of the *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators ranked below the 25th percentile, indicating that pregnant women were not always having a prenatal visit in the first trimester and not always having a postpartum visit on or between 7 and 84 days after delivery during the measurement year. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.⁵⁰ [Quality, Timeliness, and Access]

Why the weakness exists: The rates for the *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators ranked below the 25th percentile, suggesting that barriers exist for some pregnant women to have timely prenatal and postpartum visits.

Recommendation: HSAG recommends that HCS continue developing targeted interventions to improve the performance of the *Prenatal and Postpartum Care (PPC)* measure indicators. Initiatives should be monitored and expanded upon as additional contributing factors are identified. HCS could consider creating member incentives to promote increased prenatal and postpartum engagement, such a baby registry for pre-approved baby items and supplies.

Weakness #8: HCS' performance for the *Asthma Medication Ratio (AMR)* measure ranked below the 25th percentile, indicating that some members 5–64 years of age, who were identified as having persistent asthma, did not have a ratio of controller medication to total asthma medication of 0.50 or greater during the measurement year. Appropriate medication management for patients with asthma could reduce the need for rescue medication, the costs associated with ED visits, inpatient admissions, and missed days of work or school.⁵¹ [Quality]

Why the weakness exists: The rate for the *Asthma Medication Ratio (AMR)* measure ranked below the 25th percentile. Potential barriers to improved rate performance may include, but are not limited to, utilization of ED services for management of asthma symptoms, and underutilization of primary care services for treatment and management of asthma.

Recommendation: HSAG recommends that HCS develop targeted interventions to improve performance for the *Asthma Medication Ratio (AMR)* measure. Initiatives should be monitored and expanded upon as contributing factors to rate performance are identified. HCS could consider providing education to members on proper medication management in order to avoid ED visits.

⁵⁰ National Committee for Quality Assurance. Prenatal and Postpartum Care (PPC). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/prenatal-and-postpartum-care-ppc/>. Accessed on: Apr 2, 2025.

⁵¹ National Committee for Quality Assurance. Asthma Medication Ratio (AMR). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/asthma-medication-ratio-amr/>. Accessed on: Apr 2, 2025.

Compliance Review

Performance Results

Table 3-44 presents the total number of criteria for each standard that received a score of *Met*, *Satisfied*, or *Not Met*. Table 3-44 also presents **HCS**' overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. *NA* was used when MDHHS determined the review element was not applicable during the compliance review. For elements scored as *Not Met*, **HCS** was subject to a corrective action review process outlined in Appendix A.

Table 3-44—Compliance Review Results for HCS

Standard		Number of Scores				Compliance Scores	
		<i>Met</i>	<i>Satisfied</i> ¹	<i>Not Met</i>	<i>NA</i>	HCS ²	Statewide ³
1	Administrative	5	0	0	0	100%	100%
2	Providers	22	0	2	0	92%	95.4%
3	Members	29	0	0	1	100%	98.9%
4	Quality	24	0	0	0	100%	100%
5	MIS/Financial	46	4	1	0	90%	94.6%
6	OIG/Program Integrity	8	0	2	0	80%	85.6%
Overall		134	4	5	1	94%	96.0%

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

¹ A score of *Satisfied* was only allowable for select elements under the MIS/Financial standard.

² MDHHS calculated the total compliance score for each standard by totaling the number of *Met* (i.e., 1 point) elements and the number of *Not Met* and *Satisfied* (i.e., 0 points) elements, then dividing the summed score by the total number of elements for that standard.

³ MDHHS calculated the statewide performance scores to the tenth decimal place; however, MHP performance scores were calculated using whole number percentages.

Additionally, to supplement the compliance review activity, MDHHS conducted staff interviews, referred to as focus studies, in the following three areas: CSHCS, Operations, and Quality. While the results of the focus studies are not incorporated into the scoring of the compliance review, **HCS** met MDHHS' expectations for participation in the studies.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the compliance review 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: HCS achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. [Quality]

Strength #2: HCS achieved full compliance in the Members standard, demonstrating that the MHP maintained sufficient policies and procedures to support its membership, which included, but was not limited to, access to service authorization processes; care coordination procedures; fair grievance and appeal systems; member information materials, such as the handbook, newsletters, and website; and choice of PCPs. [Quality, Timeliness, and Access]

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

Weaknesses and Recommendations

Weakness #1: While **HCS** demonstrated high performance overall (i.e., 90 percent or higher but less than 100 percent) in the Providers standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for elements *August 2.21–Secret Shopper Calls–PCP Secret Shopper Calls* and *June 2.22–Non-Emergency Medical Transportation (NEMT)*. [Timeliness and Access]

Why the weakness exists: Regarding element *August 2.21* findings, discrepancies in provider data for general PCPs and pediatric PCPs were identified through the secret shopper activity. Specifically, the MHP did not achieve the 75 percent threshold in areas assessed for accuracy of PCPs listed as “accepting new patients,” having correct location and contact information, and being accurately listed for “accepting of Medicaid.” Regarding *June 2.22* findings, MDHHS determined that **HCS’** NEMT policy did not sufficiently address the prevention of excessive multi-loading of vehicles, ensuring that members are not unduly burdened or forced to travel for significantly longer periods of time than necessary.

Recommendation: **HCS** was required to submit a CAP to address element *June 2.22*, which was approved by MDHHS. MDHHS did not require **HCS** to submit a CAP for element *August 2.21* as MDHHS was analyzing findings for possible enforcement action. As such, HSAG recommends that **HCS** continue to implement action plans and monitoring processes to improve the accuracy of provider data and ensure members do not have excessively long transportation rides to appointments.

Weakness #2: While **HCS** demonstrated high performance overall (i.e., 90 percent or higher but less than 100 percent) in the MIS/Financial standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for element *February 5.11–Claims Processing (Non-Pharmacy)*, and a *Satisfied* score for elements *May 5.11–Claims Processing (Non-Pharmacy)*, *February 5.14–Monthly Pharmacy Encounter Timeliness*, *December 5.15–Monthly Encounter Record Acceptance Rate in CHAMPS*, and *January 5.15–Monthly Encounter Record Acceptance Rate in CHAMPS*. [Quality and Timeliness]

Why the weakness exists: Regarding element *February 5.11* findings, MDHHS noted inaccuracies in some line values/calculations presented by **HCS** in its monthly claims processing report. **HCS** reported it was required to include delegated vendor claims, which were not previously reported, and that data received from its vendor were submitted prematurely and did not include all claim transactions for the month. Similar findings were identified during the review of element *May 5.11*. Regarding element *February 5.14* findings, **HCS** did not meet timeliness requirements for pharmacy encounters paid during October 2023. **HCS** noted that its pharmacy benefit manager (PBM) underwent a configuration change when transitioning from HAP to the HAP CareSource contract effective October 1, 2023, and during the transition, the PBM modified the prompt pay timeline, which caused a delay in reporting encounters paid during October 2023. Regarding element *December 5.15* findings, **HCS** did not meet the minimum encounter acceptance rate for dental invoice types for the submission month of October 2023. **HCS** indicated that the encounter acceptance rate was missed because of an issue with the encounter file generation process; therefore, two weeks of encounter data were duplicated in **HCS** submissions. Similar findings were identified during the review of element *January 5.15*.

Recommendation: **HCS** was required to submit a CAP to address element *February 5.11*, which was approved by MDHHS. MDHHS did not require a CAP to address elements *May 5.11*, *February 5.14*, *December 5.15*, or *January 5.15* as an existing CAP was already open, the issue was already resolved, or MDHHS was satisfied with the information provided by **HCS**. As such, HSAG recommends that **HCS** continue to implement action plans and monitoring processes to improve the accuracy of claims data reported to MDHHS, improve timeliness of pharmacy encounter submissions, and improve the encounter acceptance date for dental invoice types.

Weakness #3: **HCS** demonstrated moderate performance overall (i.e., 80 percent or higher but less than 90 percent) in the OIG/Program Integrity standard and scored below the statewide average. The MHP received a *Not Met* score for elements *November 6.1-6.7–Quarterly Program Integrity Report* and *August 6.1-6.7–Quarterly PI Report*. [Quality]

Why the weakness exists: Several data errors were reporting on the quarterly program integrity reports and **HCS** did not adhere to certain technical specifications. **HCS** reported the findings were attributed to needing clarification on the pharmacy-related lines and that additional oversight was needed on the categorization and date fields, and there was a missed oversight opportunity.

Recommendation: **HCS** was required to submit a CAP to address elements *November 6.1-6.7* and *August 6.1-6.7*, which were approved by MDHHS. As such, HSAG recommends that **HCS** continue to implement action plans and monitoring processes to improve the accuracy of claims data reported to MDHHS, improve timeliness of pharmacy encounters submissions, and improve the encounter acceptance date for dental invoice types.

Network Adequacy Validation

Performance Results

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MHP's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each MHP according to Table 3-45.

Table 3-45—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	<i>High Confidence</i>
50.0% to 89.9%	<i>Moderate Confidence</i>
10.0% to 49.9%	<i>Low Confidence</i>
Less than 10% and/or any <i>Not Met</i> element has significant bias on the results	<i>No Confidence</i>

No indicators were identified as *Low Confidence* or *No Confidence* designations.

HSAG determined that **HCS** met both the time and distance standards and the ratio standard requirements for 100 percent of its members across all indicators or submitted an exception to MDHHS. The exceptions indicated that **HCS** was aware of a gap and while corrective steps were underway, the issue had not been fully resolved at the time of reporting. Adequacy was determined based on the MHP's compliance with MDHHS' time and distance and ratio standards, with an assessment conducted for each provider type according to county. Table 3-46 outlines the counties and provider specialties for which exceptions were submitted. Results are presented by provider specialty in Table 3-47.

Table 3-46—HCS Submitted Exceptions

County Exception Submitted	Specialty Exception Submitted
Sanilac	PCPs (Pediatric)

Table 3-47—HCS Network Adequacy Compliance

Provider Specialty	Non-Rural Time and Distance	Rural Time and Distance	Non-Rural Ratio	Rural Ratio
PCPs (Adult)	Compliant	Compliant	Compliant	Compliant
PCPs (Pediatric)	Compliant	Compliant	Compliant	Compliant
OB/GYN	Compliant	Compliant	NA	NA

Provider Specialty	Non-Rural Time and Distance	Rural Time and Distance	Non-Rural Ratio	Rural Ratio
Cardiology	Compliant	Compliant	NA	NA
Outpatient Behavioral Health	Compliant	Compliant	NA	NA
Hospital	Compliant	Compliant	NA	NA
Pharmacy	Compliant	Compliant	NA	NA
General Dentistry	Compliant	Compliant	Compliant	Compliant
Endodontist	Compliant	Compliant	NA	NA
Oral Surgeon	Compliant	Compliant	NA	NA
Periodontist	Compliant	Compliant	NA	NA
Prosthodontist	Compliant	Compliant	NA	NA

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: HCS had multilayered processes in place for ensuring member and provider addresses were geocoded correctly such as using Melissa Data reports, source of truth data, and manual overview. [Access]

Weaknesses and Recommendations

Weakness #1: HCS had challenges gathering timely information from providers. [Access]

Why the weakness exists: HCS did not have sufficient measures in place with providers to mandate and facilitate the timely submission of provider data.

Recommendation: HSAG recommends that **HCS** implement additional strategies to help improve communication and overall provider engagement.

Network Validation Survey

Performance Results

HSAG’s reviewers evaluated 404 randomly sampled cases by comparing provider data submitted to HSAG by **HCS** against **HCS**’ online provider directory. The sample included 202 PCPs and 202 pediatric providers. There were no OB/GYN providers sampled due to the eligible population criteria (i.e., limiting to providers with the PCP indicator reduced the number of eligible OB/GYN providers). Overall, 98.8 percent of the sampled providers were located in the online directory at the sampled location, while 0.5 percent of the sampled providers located in the online directory were not at the sampled location. Additionally, 0.7 percent of the overall sampled providers could not be located in the online directory.

Table 3-48 summarizes the findings regarding the number of sampled providers and provider locations (i.e., “cases”) that HSAG’s reviewers located in the MHP’s online directory.

Table 3-48—Summary of Providers Present in Online Directory by Provider Category

Provider Category	Number of Sampled Providers	Providers Not Found in Directory		Providers Found in Directory—Not at Sampled Location		Providers Found in Directory—At Sampled Location	
		Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
PCPs	202	1	0.5%	2	1.0%	199	98.5%
Pediatric Providers	202	2	1.0%	0	0.0%	200	99.0%
HCS Total	404	3	0.7%	2	0.5%	399	98.8%

¹ The denominator includes the number of sampled providers.

Table 3-49 displays the total number and percentage of cases with matched data values for indicators that were reviewed between data values shown in **HCS**’ provider data submission to HSAG and **HCS**’ online provider directory. Cases with unmatched results may include incorrect information or information not listed in the directory (e.g., the provider data included a data value for a study indicator, but the online provider directory did not include a data value for the study indicator).

Table 3-49—Provider Demographic Indicators Matching Online Directory

Indicator	PCPs		Pediatric Providers		Overall	
	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
Provider Name	201	100%	200	100%	401	100%
Provider Street Address	199	99.0%	200	100%	399	99.5%
Provider Suite Number	200	99.5%	199	99.5%	399	99.5%

Indicator	PCPs		Pediatric Providers		Overall	
	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
Provider City	200	99.5%	200	100%	400	99.8%
Provider State	201	100%	200	100%	401	100%
Provider ZIP Code	200	99.5%	200	100%	400	99.8%
Provider Telephone Number	200	99.5%	200	100%	400	99.8%
Provider Type/Specialty	200	99.5%	192	96.0%	392	97.8%
Provider Accepting New Patients	201	100%	200	100%	401	100%
Provider Gender	200	99.5%	200	100%	400	99.8%
Provider Primary Language ²	201	100%	200	100%	401	100%
Non-English Language Speaking Provider (including American Sign Language) ²	201	100%	200	100%	401	100%

¹ The denominator for each study indicator includes the number of cases in which the provider was found in the directory.

² The PDV review evaluated whether the indicator was present in the directory, but specific values were not validated.

For the secret shopper telephone survey, HSAG attempted to contact 388 sampled provider locations for **HCS**, with an overall response rate of 65.7 percent. Table 3-50 summarizes the survey response rates (i.e., cases reached) for all MHPs and for **HCS**, by provider category.

Table 3-50—Response Rates

Provider Category	Total Number of Cases ¹	Cases Reached	Response Rate
PCPs	196	121	61.7%
Pediatric Providers	192	134	69.8%
HCS Total	388	255	65.7%
All MHPs Total	2,633	1,775	67.4%

¹ Total number of cases includes cases that were found in the online directory and matched on eight key indicators (i.e., name, address, city, state, ZIP Code, telephone number, provider type/specialty, and new patient acceptance).

Table 3-51 summarizes the provider data validation and accuracy results for all MHPs and **HCS**, by provider category.

Table 3-51—Provider Data Validation and Accuracy Results

Provider Category	Denom ¹	Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance		Accepting New Patients	
		Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
PCPs	121	90	74.4%	87	71.9%	74	61.2%	46	38.0%	39	32.2%
Pediatric Providers	134	106	79.1%	99	73.9%	85	63.4%	59	44.0%	56	41.8%
HCS Total	255	196	76.9%	186	72.9%	159	62.4%	105	41.2%	95	37.3%
All MHPs Total	1,775	1,280	72.1%	1,215	68.5%	1,082	61.0%	822	46.3%	731	41.2%

¹ The denominator includes cases reached.

Table 3-52 displays the number of survey respondents who offered appointments to new patients for routine PCP and prenatal care visits for all MHPs and **HCS**, by provider category.

Table 3-52—Appointment Availability for Routine PCP and Prenatal Care Visits¹

Provider Category	Cases Reached	Cases Offered an Appointment	
		Count	Rate ²
PCPs	121	22	18.2%
Pediatric Providers	134	35	26.1%
HCS Total	255	57	22.4%
All MHPs Total	1,775	424	23.9%

¹ Appointment availability rates were calculated using cases accepting new patients and total survey cases as the denominator in the 2022 and 2023 reports. However, the denominator used in the 2024 report was cases reached. Caution should be exercised when comparing 2024 appointment availability rates with the rates in the 2022 and 2023 reports.

² The denominator includes cases reached.

Table 3-53 displays the new patient wait time results for all MHPs and **HCS**, by provider category.

Table 3-53—Appointment Wait Time Results

Provider Category	Appointment Wait Time (Business Days)				Rate of Cases Within Standard ^{1,2}
	Min	Max	Average	Median	
PCPs	2	88	16	12	86.4%
Pediatric Providers	0	55	8	5	97.1%

Provider Category	Appointment Wait Time (Business Days)				Rate of Cases Within Standard ^{1,2}
	Min	Max	Average	Median	
HCS Total	0	88	11	6	93.0%
All MHPs Total	0	261	18	8	80.9%

¹ The denominator includes cases offered an appointment.

² Rate of cases within standard represents the percentage of cases that were offered an appointment that was compliant with the 30-business-day standard for routine appointments and seven-business-day standard for prenatal care appointments.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NVS 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: Reviewers located 99.3 percent of the sampled providers in **HCS**' online provider directory.

Strength #2: Of the providers located in the online directory, all indicators had a match rate above 95.0 percent. [**Access**]

Strength #3: Of the cases that offered an appointment, 93.0 percent were compliant with the appointment wait time standard. [**Timeliness**]

Weaknesses and Recommendations

Weakness #1: Only 65.7 percent of the sampled provider locations could be reached. [**Access**]

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

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

Weakness #2: Of the locations reached, only 76.9 percent confirmed affiliation with the sampled provider. Additionally, 72.9 percent confirmed accuracy of the sampled address, 62.4 percent confirmed the services were offered, 41.2 percent confirmed the requested insurance, and 37.3 percent confirmed new patient acceptance. [**Quality and Access**]

Why the weakness exists: **HCS**'s provider data included invalid provider, address, specialty, new patient acceptance, and insurance information.

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

Weakness #3: Among the responsive cases, only 22.4 percent of locations offered an appointment date. While PCP locations had an appointment availability rate of 18.2 percent, pediatric providers had an appointment availability rate of 26.1 percent. [Access]

Why the weakness exists: For new **HCS** members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included pre-registration as well as requiring additional personal information, a Medicaid ID, or an MRR.

Recommendation: HSAG recommends that **HCS** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **HCS** 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 **HCS** procured medical records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*, to identify discrepancies and ensure alignment between the medical records and the encounter data submitted to MDHHS.

Table 3-54 outlines the key findings for **HCS** based on the assessment of encounter data completeness and accuracy conducted through a review of members' medical records for services rendered from October 1, 2022, through September 30, 2023.

Table 3-54—Key Findings for HCS

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	<ul style="list-style-type: none"> The medical procurement rate was 82.0 percent, indicating that nearly 20.0 percent of the requested records were not successfully procured and submitted. Of the medical records not submitted, nearly 84 percent were not submitted due to non-responsive providers or provider did not respond in a timely manner.

Analysis	Key Findings
Second Date of Service Submission Rate	<ul style="list-style-type: none"> Among the procured medical records, 50.4 percent included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	<ul style="list-style-type: none"> All key data elements (i.e., <i>Date of Service</i>, <i>Diagnosis Code</i>, <i>Procedure Code</i>, and <i>Procedure Code Modifier</i>) had relatively high medical record omission rates, ranging from 13.6 percent (<i>Date of Service</i>) to 30.8 percent (<i>Procedure Code Modifier</i>). This suggests that the data elements in the encounter data were not adequately supported by the members' medical records. The high medical record omission rates for all key data elements were partially influenced by medical record non-submission. In cases where no medical records were submitted for a requested case, all associated data elements were categorized as medical record omissions.
Encounter Data Omission Rate	<ul style="list-style-type: none"> All key data elements exhibited relatively low encounter data omission rates, with <i>Date of Service</i> having the highest omission rate at 4.4 percent.
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Diagnosis Code</i> data element was accurate in 99.8 percent of instances where codes were present in both the medical records and encounter data, with all errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code</i> data element was accurate in 96.9 percent of instances where codes were present in both the medical records and encounter data; most errors were related to inaccurate coding, while some were attributed to providers submitting higher-level service codes than those supported in the medical records.
Procedure Code Modifier Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code Modifier</i> data element was accurate in 100 percent of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	<ul style="list-style-type: none"> Dates of service with accurate values for all key data elements (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, and <i>Procedure Code Modifier</i>) were observed in 71.3 percent of the dates of service present in both data sources (i.e., encounter data and medical records).

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the EDV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one

or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: The *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data element values identified in the medical records were generally present in the encounter data, as evidenced by the low encounter data omission rates of 4.4 percent, 3.2 percent, 3.1 percent, and 0.9 percent, respectively. [Quality]

Strength #2: When key data elements were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate with rates of at least 96.9 percent each. [Quality]

Weaknesses and Recommendations

Weakness #1: HCS was unable to procure all the requested medical records from its contracted providers mostly due to providers being non-responsive or providers not responding in a timely manner. [Quality and Timeliness]

Why the weakness exists: The non-submission reason for non-responsive providers or providers who did not respond in a timely manner may indicate that the contracted providers were unaware of the submission requirements or the deadline.

Recommendation: HCS should ensure its contracted providers' accountability in responding to medical record requests for the purposes of auditing, inspection, and oversight. HSAG recommends HCS consider strengthening and/or enforcing its contract requirements with its providers in providing the requested documentation.

Weakness #2: All data elements had more than 13.0 percent identified in the encounter data that were not supported by the members' medical records. [Quality]

Why the weakness exists: Non-submitted medical records contribute to medical record omissions, as the expected information in the medical records cannot be compared to the encounter data. Additional contributing factors include provider documentation practices (e.g., incomplete or inaccurate documentation, coding errors, lack of detail), data submission (e.g., incorrect coding during data submission or data entry errors), or processing issues (e.g., data mapping or translation issues, or errors in data transmission).

Recommendation: HCS should investigate the root cause(s) for these omissions, with a focus on both provider documentation practices and data handling processes. Periodic MRRs of submitted claims should be conducted to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should be used to develop and provide ongoing education and training for providers. Topics should include encounter data submissions, medical record documentation requirements, and coding practices to reduce future omissions and improve data accuracy.

Consumer Assessment of Healthcare Providers and Systems Analysis

Adult and Child Medicaid

Performance Results

Table 3-55 presents HCS' 2023 and 2024 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2024 scores were statistically significantly higher or lower than the 2023 national average. Triangles (▲ or ▼) indicate 2024 scores were statistically significantly higher or lower than the 2023 scores.

Table 3-55—Summary of Adult and Child Medicaid CAHPS Top-Box Scores for HCS

	2023 Adult Medicaid	2024 Adult Medicaid	2023 Child Medicaid	2024 Child Medicaid
Global Ratings				
<i>Rating of Health Plan</i>	63.89%	59.84%	69.14%	64.38%
<i>Rating of All Health Care</i>	57.14%	64.60% ↑	69.70% ⁺	61.76%
<i>Rating of Personal Doctor</i>	71.03%	72.14%	72.46%	75.71%
<i>Rating of Specialist Seen Most Often</i>	63.10% ⁺	70.00%	84.85% ⁺	65.79% ⁺
Composite Measures				
<i>Getting Needed Care</i>	80.54%	83.64%	79.24% ⁺	79.18% ⁺
<i>Getting Care Quickly</i>	78.70% ⁺	82.98%	87.50% ⁺	81.80% ⁺
<i>How Well Doctors Communicate</i>	93.32%	92.05%	93.96%	95.60%
<i>Customer Service</i>	90.26% ⁺	92.07%	86.79% ⁺	87.00% ⁺
Individual Item Measure				
<i>Coordination of Care</i>	86.67% ⁺	79.17% ⁺	82.35% ⁺	79.17% ⁺
Medical Assistance With Smoking and Tobacco Use Cessation Items*				
<i>Advising Smokers and Tobacco Users to Quit</i>	65.69%	63.81%	—	—
<i>Discussing Cessation Medications</i>	46.08%	47.52%	—	—
<i>Discussing Cessation Strategies</i>	38.83%	45.10%	—	—

⁺ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

* These rates follow NCQA's methodology of calculating a rolling two-year average.

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.

▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.

No triangles (▲ or ▼) indicate the 2024 score was not statistically significantly higher or lower than the 2023 score.

↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.

↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.
 No arrows (↑ or ↓) indicate the 2024 score was not statistically significantly higher or lower than the 2023 national average.
 — Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the CAHPS 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: HCS' 2024 top-box score was statistically significantly higher than the 2023 NCQA adult Medicaid national average for one measure, *Rating of All Health Care*. [Quality]

Weaknesses and Recommendations

Weakness #1: HCS' 2024 top-box scores were not statistically significantly lower than the 2023 NCQA adult and child Medicaid national averages or 2023 top-box scores for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

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

CSHCS

Performance Results

Table 3-56 presents HCS' 2023 and 2024 CSHCS CAHPS top-box scores. The following measures could not be displayed in the table because these measures had fewer than 11 responses in 2024 and were suppressed: *Rating of Specialist Seen Most Often*, *Customer Service*, *Access to Specialized Services*, and *Transportation*. Upward green or downward red arrows (↑ or ↓) indicate 2024 scores were statistically significantly higher or lower than the 2023 national average. Upward green or downward red triangles (▲ or ▼) indicate 2024 scores were statistically significantly higher or lower than the 2023 scores.

Table 3-56—Summary of CSHCS CAHPS Survey Top-Box Scores for HCS

	2023 Top-Box Score	2024 Top-Box Score
Global Ratings		
<i>Rating of Health Plan</i>	76.92% ⁺	60.00% ⁺
<i>Rating of Health Care</i>	76.92% ⁺	73.33% ⁺ NA

	2023 Top-Box Score	2024 Top-Box Score
Composite Measures		
<i>How Well Doctors Communicate</i>	100.00% ⁺	89.58% ⁺ NA
Individual Item Measures		
<i>Access to Prescription Medicines</i>	—	91.67% ⁺ NT
<i>Not Felt Treated Unfairly: Race and Ethnicity</i>	100.00% ⁺	91.67% ⁺ NA
<i>Not Felt Treated Unfairly: Health Insurance Type</i>	100.00% ⁺	91.67% ⁺ NA

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating the results.

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.

▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.

No triangle (▲ or ▼) indicates the 2024 score was not statistically significantly higher or lower than the 2023 score.

↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.

↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.

No arrow (↑ or ↓) indicates the 2024 score was not statistically significantly higher or lower than the 2023 national average.

NA Indicates a national average is not available for the measure.

NT Indicates that results for this measure could not be trended.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the CAHPS 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: HCS' 2024 top-box scores were not statistically significantly higher than the 2023 NCQA child Medicaid national averages or the 2023 top-box scores for any reportable measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: HCS' 2024 top-box scores were not statistically significantly lower than the 2023 NCQA child Medicaid national averages or the 2023 top-box scores for any reportable measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

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

Quality Rating

The 2024 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2024 Michigan Consumer Guide, which is inclusive of **HCS**’ performance.

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

HSAG performed a comprehensive assessment of **HCS**’ aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **HCS** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **HCS**’ overall performance contributed to the CHCP’s progress in achieving the CQS goals and objectives. Table 3-57 displays each MDHHS CQS goal and the EQR activity results that indicate whether the MHP positively (✓), negatively (✗), or minimally (m) impacted the CHCP’s progress toward achieving the applicable goals and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to **HCS**’ Medicaid members. Not applicable (NA) was used when EQR activities do not produce data to assess the impact of a quality measure(s) under an objective.

Table 3-57—Overall Performance Impact to CQS and Quality, Timeliness, and Access

Objective	Program	Quality Measure	Overall Performance Impact	Performance Domain
Goal #1: Ensure high quality and high levels of access to care				
1.1	CHCP	<i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	m	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	CHCP	<i>Prenatal and Postpartum Care—Postpartum Care</i>	✗	
	CHCP	<i>Childhood Immunization Status—Combination 3</i>	m	
	CSHCS	<i>Global Rating of Health Plan</i>	✗	
	CSHCS	<i>Global Rating of Specialist Seen Most Often</i>	NA	
	CSHCS	<i>Global Rating of Health Care</i>	✓	
	CSHCS	<i>Composite Measure for Access to Specialized Services</i>	NA	
	CSHCS	<i>Composite Measure for Transportation</i>	NA	
1.2	CHCP	<i>Asthma Medication Ratio—Total</i>	m	
	CHCP	<i>Controlling High Blood Pressure</i>	m	
	CHCP	<i>Comprehensive Diabetes Care (CDC)—Eye Exams¹</i>	✗	
	CSHCS	<i>Composite Measure for How Well Doctors Communicate</i>	✗	
	CSHCS	<i>Composite Measure for Customer Service</i>	NA	

Objective	Program	Quality Measure	Overall Performance Impact	Performance Domain	
1.3	CHCP	Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	NA		
	CHCP	Getting Care Quickly Composite (Adult CAHPS)	m		
	CSHCS	Global Rating of Health Care	✓		
	CSHCS	Composite Measure for Access to Specialized Services	NA		
	CSHCS	Access to Prescription Medicines	✓		
Goal #2: Strengthen person and family-centered approaches					
2.1	CHCP	Rating of Health Plan ²	✗	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access	
	CHCP	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years Old	✓		
	CHCP	Access to Dental Care	✓		
	CHCP	Completion of Annual Health Risk Assessment	NA		
	CSHCS	Composite Measure for How Well Doctors Communicate	✗		
	CSHCS	Global Rating of Health Plan	✗		
	CSHCS	Global Rating of Health Care	✓		
	CSHCS	Global Rating of Specialist Seen Most Often	NA		
2.2	CHCP	SDOH: Total Member Screening Rate	NA		
	CHCP	SDOH: Total Member Referral Rate	NA		
	CHCP	Social Need Screening and Intervention	NA		
	CSHCS	Composite Measure for Access to Specialized Services	NA		
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)					
3.1	CHCP	Follow-Up After Hospitalization for Mental Illness Within 30 Days (FUH) (Adults)	NA	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access	
	CSHCS	Coordination of Care	NA		
3.2	CHCP	Implementation of Joint Care Management Processes	NA		
	CSHCS	Global Rating of Health Plan	✗		
	CSHCS	Global Rating of Health Care	✓		
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes					
4.1	CHCP	Chlamydia Screening in Women—Total ³	NA	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access	
	CHCP	Prenatal and Postpartum Care—Postpartum Care ³	NA		
	CHCP	Children Immunization Combo 3 ³	NA		
	CHCP	Lead Screening in Children ³	NA		

Objective	Program	Quality Measure	Overall Performance Impact	Performance Domain
	CHCP	Comprehensive Diabetes Care—Eye Exam ³	NA	
	CHCP	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years Old ³	NA	
	CSHCS	Not Felt Treated Unfairly: Race and Ethnicity	✖	
Goal #5: Improve quality outcomes through value-based initiatives and payment reform				
5.1	CHCP	Average Percentage of Plan Payments to Providers who are in APM arrangements ("Big Numerator")	NA	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access
	CHCP	Average Percentage of Plan Payments to Providers That Are Tied to Quality ("Small Numerator")	NA	

✓ = The MHP's rate met the 2026 statewide performance target; or the MHP's rate did not meet the 2026 statewide performance target but demonstrated a statistically significant increase in performance from the prior year.

m = The MHP's rate did not meet the 2026 statewide performance target and while the MHP's rate increased in performance from the prior year, the increase was not statistically significant.

✖ = The MHP's rate did not meet the 2026 statewide performance target and/or the MHP's rate decreased in performance from the prior year.

NA = EQR activities published in this report do not produce data to assess the impact of a quality measure(s) under an objective.

¹ NCQA replaced the *Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed* performance measure with the *Eye Exam for Patients With Diabetes (EED)* performance measure, the overall performance impact was based on the MHP's reported rate for *Eye Exam for Patients With Diabetes (EED)*.

² As the CQS did not identify whether this quality measure applies to the adult or child CAHPS, HSAG assessed performance using the adult rate.

³ While there are reported HEDIS rates that are stratified by race/ethnicity, the EQR deliverables did not include an analysis of these data.

McLaren Health Plan

Validation of Performance Improvement Projects

Performance Results

HSAG’s validation evaluated the technical methods of **MCL**’s PIP (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-58 displays the overall validation rating, the baseline rate, Remeasurement 1, and Remeasurement 2 results for the performance indicators, and if a disparity existed within the most recent measurement period.

Table 3-58—Overall Validation Rating for MCL

PIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
Addressing Disparities in Timeliness of Prenatal Care	High Confidence	No Confidence	1. The percentage of deliveries that received a prenatal care visit as a member of an organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization for Black members.	60.8%	62.1% ⇨	64.5% ⇨	Yes
			2. The percentage of deliveries that received a prenatal care visit as a member of an organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization for White members.	71.7%	71.9% ⇨	72.7% ⇨	

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).

The goals for **MCL**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black women) will demonstrate a significant increase over the baseline rate without a decline in performance for the comparison subgroup (White women). Table 3-59 displays the barriers identified through QI and causal/barrier analysis processes and the interventions initiated by the MHP to support achievement of the PIP goals and address the barriers.

Table 3-59—Remeasurement 2 Barriers and Interventions for MCL

Barriers	Interventions
Members are not obtaining prenatal care in a timely manner.	Targeted outreach to members in regions 6 and 7 (highest population and disparate areas) upon notification of pregnancy to facilitate timeliness of prenatal care and outreach via text campaigns for timely prenatal care.
Obstetrician (OB) providers not getting members into prenatal visits in a timely manner.	Providers received a \$100 incentive for completing timely prenatal and postpartum care.
	Providers received monthly gaps-in-care reports with disparity information for this measure.
Members are not being identified early in their pregnancy.	Members received a \$10 gift card incentive upon notification of pregnancy to the MHP.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PIP 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: **MCL** initiated timely interventions that were reasonably linked to their corresponding barriers. The interventions were evaluated to determine the effectiveness of each effort, with decisions to continue, discontinue, or revise an effort being data driven. [**Quality, Timeliness, and Access**]

Weaknesses and Recommendations

Weakness #1: **MCL** did not achieve the state-defined goal of eliminating the existing disparity with the second remeasurement period [**Quality, Timeliness, and Access**]

Why the weakness exists: While it is unclear why the goal was not achieved, **MCL** has made progress in improving performance for the disparate population, demonstrating improvement year-over-year.

Recommendation: HSAG recommends that **MCL** continue testing or implement intervention strategies that have demonstrated improvement on the performance indicator. The MHP should revisit its causal/barrier analysis to ensure appropriate identification of barriers or the need to develop new or modified intervention strategies.

Performance Measure Validation

Performance Results

MCL was evaluated against NCQA’s IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2023 Compliance Audit Report findings, **MCL** was fully compliant with all four IS standards.

According to the auditor’s review, **MCL** followed the NCQA HEDIS MY 2023 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-60 displays the MDHHS-selected performance measures, HEDIS MY 2022 and MY 2023 rates, MY 2022 and MY 2023 comparisons, and MY 2023 performance levels based on comparisons to national percentiles⁵² for **MCL**. Additional performance measures and performance measure results for **MCL** can be referenced in Appendix B.

Table 3-60—HEDIS MY 2023 Performance Measure Results for MCL

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
Child & Adolescent Care				
<i>Childhood Immunization Status (CIS)</i>				
<i>Combination 3</i>	54.99%	58.88%	+3.89	★★
<i>Combination 7</i>	47.20%	49.79%	+2.58	★
<i>Combination 10</i>	23.36%	21.87%	-1.49	★
<i>Well-Child Visits in the First 30 Months of Life (W30)</i>				
<i>Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	65.02%	65.75%	+0.73	★★★★
<i>Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i>	62.08%	66.45%	+4.37+	★★
<i>Lead Screening in Children (LSC)</i>				
<i>Lead Screening in Children</i>	43.33%	51.89%	+8.55+	★★
<i>Child and Adolescent Well-Care Visits (WCV)</i>				
<i>Ages 3 to 11 Years</i>	58.39%	59.38%	+0.99+	★★★★
<i>Ages 12 to 17 Years</i>	47.20%	47.44%	+0.24	★★

⁵² HEDIS MY 2023 performance measure rates are compared to NCQA’s Quality Compass National Medicaid Health Maintenance Organization (HMO) percentiles for HEDIS MY 2022 (referred to as “percentiles” throughout this section of the report).

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
<i>Ages 18 to 21 Years</i>	23.31%	24.42%	+1.11+	★★★★
<i>Total</i>	48.46%	49.89%	+1.43+	★★★★
Immunizations for Adolescents (IMA)				
<i>Combination 1 (Meningococcal, Tdap)</i>	75.91%	79.32%	+3.41	★★
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	28.47%	29.68%	+1.22	★★
Women—Adult Care				
<i>Chlamydia Screening in Women (CHL)</i>³				
<i>Ages 16 to 20 Years</i>	52.46%	52.75%	+0.29	★★★★
<i>Ages 21 to 24 Years</i>	62.53%	62.65%	+0.12	★★★★
<i>Total</i>	57.54%	57.67%	+0.14	★★★★
<i>Cervical Cancer Screening (CCS-E)</i>				
<i>Cervical Cancer Screening</i>	55.06%	53.26%	-1.81	★★
<i>Breast Cancer Screening (BCS-E)</i>				
<i>Breast Cancer Screening</i>	54.57%	54.76%	+0.19	★★★★
Access to Care				
<i>Adults’ Access to Preventive/Ambulatory Health Services (AAP)</i>				
<i>Ages 20 to 44 Years</i>	70.38%	70.70%	+0.32	★★★★
<i>Ages 45 to 64 Years</i>	80.64%	80.87%	+0.23	★★★★
<i>Ages 65 Years and Older</i>	72.24%	67.30%	-4.93	★
<i>Total</i>	73.68%	74.00%	+0.32	★★★★
Pregnancy Care				
<i>Prenatal and Postpartum Care (PPC)</i>³				
<i>Timeliness of Prenatal Care</i>	71.86%	78.36%	+6.50+	★
<i>Postpartum Care</i>	75.96%	77.78%	+1.82	★★
Living With Illness				
<i>Hemoglobin A1c Control for Patients With Diabetes (HBD)</i>				
<i>HbA1c Control (<8.0%)</i>	34.79%	49.39%	+14.60+	★★
<i>Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*</i>	58.64%	42.58%	-16.06+	★★
<i>Blood Pressure Control for Patients With Diabetes (BPD)</i>				
<i>Blood Pressure Control for Patients With Diabetes</i>	47.69%	62.53%	+14.84+	★★

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
Eye Exam for Patients With Diabetes (EED)³				
Eye Exam for Patients With Diabetes	52.55%	56.93%	+4.38	★★★
Kidney Health Evaluation for Patients With Diabetes (KED)				
Ages 18 to 64 Years	30.99%	35.76%	+4.77+	★★★
Ages 65 to 74 Years	20.63%	43.55%	+22.91+	★★★
Ages 75 to 85 Years	NA	NA	NC	NC
Total	30.94%	35.81%	+4.86+	★★★
Asthma Medication Ratio (AMR)				
Total	54.48%	49.55%	-4.93 ⁺⁺	★
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	46.47%	52.80%	+6.33	★
Diagnosed Mental Health Disorders (DMH)				
Ages 1 to 17 Years	26.67%	28.43%	+1.76+	★★★★★
Ages 18 to 64 Years	36.86%	38.45%	+1.59+	★★★★★
Ages 65 Years and Older	23.95%	26.17%	+2.22	★★
Total	33.10%	34.68%	+1.58+	★★★★★
Utilization				
Plan All-Cause Readmissions (PCR)				
Observed Readmissions—Total	9.56%	8.52%	-1.04+	NC
Expected Readmissions—Total	9.63%	9.38%	-0.25	NC
O/E Ratio—Total	0.9936	0.9089	-0.08	★★★

¹ HEDIS MY 2022 to HEDIS MY 2023 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2022–MY 2023 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2022–MY 2023 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

² Performance Levels for MY 2023 were based on comparisons of the HEDIS MY 2023 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2022 benchmark

³ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

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

Please note that for the *Diagnosed Mental Health Disorders (DMH)* measure, a higher or lower rate does not indicate better performance, as the measure provides information on the diagnosed prevalence of mental health disorders. Therefore, this measure is not included in the evaluation of strengths and weaknesses below.

Green Shading⁺ Indicates that the HEDIS MY 2023 rate demonstrated a significant improvement from the HEDIS MY 2022 rate.

Red Shading⁺⁺ Indicates that the HEDIS MY 2023 rate demonstrated a significant decline from the HEDIS MY 2022 rate.

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

HEDIS MY 2023 Performance Levels represent the following percentile comparisons:

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

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PMV 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: MCL's performance ranked between the 75th and 89th percentiles for the *Well-Child Visits in the First 30 Months of Life (W30)*—*Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator, indicating children who turned 15 months old during the measurement year were having at least six well-child visits with a PCP during their first 15 months of life most of the time. Research shows that early intervention treatment services can greatly improve a child's development. Early intervention services help children from birth through 3 years of age (36 months) learn important skills.⁵³ [Quality, Timeliness, and Access]

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

Weaknesses and Recommendations

Weakness #1: MCL's performance for *Childhood Immunization Status (CIS)*—*Combination 7* and *Combination 10* measure indicators ranked below the 25th percentile. In addition, the *Childhood Immunization Status (CIS)*—*Combination 3* measure indicator ranked between the 25th and 49th percentiles, indicating that children 2 years of age were not receiving some vaccinations by their second birthday. Childhood immunizations help prevent serious illnesses such as polio, tetanus, and hepatitis. Vaccines are a proven way to help a child stay healthy and avoid the potentially harmful effects of childhood diseases like mumps and measles.⁵⁴ [Quality and Timeliness]

Why the weakness exists: The rates for the *Childhood Immunization Status (CIS)*—*Combination 7* and *Combination 10* measure indicators ranked below the 25th percentile. In addition, the *Childhood*

⁵³ National Committee for Quality Assurance. Well-Child Visits in the First 30 Months of Life (W30). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/well-child-visits-in-the-first-30-months-of-life-w30/>. Accessed on: Apr 2, 2025.

⁵⁴ National Committee for Quality Assurance. Childhood Immunization Status (CIS-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/childhood-immunization-status-cis-e/>. Accessed on: Apr 2, 2025.

Immunization Status (CIS)—Combination 3 measure indicator ranked between the 25th and 49th percentiles. Potential barriers to improved measure performance may include, but are not limited to, provider challenges with vaccination storage protocols, providers obtaining necessary vaccination certifications, provider cost deterrents related to the short shelf life of vaccines/maintaining inventory, and parental vaccination hesitancy.

Recommendation: HSAG recommends that **MCL** develop targeted interventions to improve performance for the *Childhood Immunization Status (CIS)* measure. Initiatives should be monitored and expanded upon as contributing factors to rate performance are identified. **MCL** could consider exploring avenues to increase awareness of vaccination importance among parents to reduce vaccination hesitancy such as a “speculation versus fact” pamphlet which includes a phone number for care management support. **MCL** could also consider issuing provider incentives for maintaining a complete inventory of vaccinations.

Weakness #2: **MCL**’s performance for the *Adults’ Access to Preventive/Ambulatory Health Services (AAP)—Ages 65 Years and Older* measure indicator ranked below the 25th percentile, indicating that some members ages 65 years and older were not having an ambulatory or preventive care visit during the measurement year. Healthcare visits are an opportunity for individuals to receive preventive services and counseling on topics such as diet and exercise.⁵⁵ [**Quality and Access**]

Why the weakness exists: The rate for the *Adults’ Access to Preventive/Ambulatory Health Services (AAP)—Ages 65 Years and Older* measure indicator ranked below the 25th percentile. Potential barriers to improved rate performance may include but are not limited to socioeconomic disparities that impact access to preventive care and member non-compliance with scheduled preventive care visits.

Recommendation: HSAG recommends that **MCL** develop targeted interventions to improve performance for the *Adults’ Access to Preventive/Ambulatory Health Services (AAP)—Ages 65 Years and Older* measure. Possible initiatives to increase patient engagement, improve upon outreach efforts, or streamline appointment scheduling (e.g., expanding upon office hours) should be considered as contributing factors to rate performance.

Weakness #3: **MCL**’s performance for the *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators ranked below the 25th percentile and between the 25th and 49th percentile, respectively, indicating that pregnant women were not always having a prenatal visit in the first trimester and not always having a postpartum visit on or between 7 and 84 days after delivery during the measurement year. Timely and adequate prenatal and

⁵⁵ National Committee for Quality Assurance. Adults’ Access to Preventive/Ambulatory Health Services (AAP). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/adults-access-to-preventive-ambulatory-health-services-aap/>. Accessed on: Apr 1, 2025.

postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.⁵⁶ [Quality, Timeliness, and Access]

Why the weakness exists: While the rate for the *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care* measure indicator demonstrated significant improvement from MY 2022 to MY 2023, both rates for *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care* and *Postpartum Care* ranked below the 25th percentile and between the 25th and 49th percentile, respectively, suggesting that barriers exist for some pregnant women to have timely prenatal and postpartum visits.

Recommendation: HSAG recommends that **MCL** continue developing targeted interventions to improve the performance of the *Prenatal and Postpartum Care (PPC)* measure indicators. Initiatives should be monitored and expanded upon as additional contributing factors are identified. **MCL** could consider creating member incentives to promote increased prenatal and postpartum engagement, such a baby registry for pre-approved baby items and supplies.

Weakness #4: **MCL**'s performance for the *Asthma Medication Ratio (AMR)* measure ranked below the 25th percentile, indicating that some members 5–64 years of age, who were identified as having persistent asthma, did not have a ratio of controller medication to total asthma medication of 0.50 or greater during the measurement year. Appropriate medication management for patients with asthma could reduce the need for rescue medication, the costs associated with ED visits, inpatient admissions, and missed days of work or school.⁵⁷ [Quality]

Why the weakness exists: The rate for the *Asthma Medication Ratio (AMR)* measure ranked below the 25th percentile. Potential barriers to improved rate performance may include, but are not limited to, utilization of ED services for management of asthma symptoms, and underutilization of primary care services for treatment and management of asthma.

Recommendation: HSAG recommends that **MCL** develop targeted interventions to improve performance for the *Asthma Medication Ratio (AMR)* measure. Initiatives should be monitored and expanded upon as contributing factors to rate performance are identified. **MCL** could consider providing education to members on proper medication management in order to avoid ED visits.

Weakness #5: **MCL**'s performance for the *Controlling High Blood Pressure (CBP)* measure ranked below the 25th percentile, indicating that some members ages 18–85 years of age, with a diagnosis of hypertension, did not have blood pressure adequately controlled. Controlling high blood pressure

⁵⁶ National Committee for Quality Assurance. Prenatal and Postpartum Care (PPC). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/prenatal-and-postpartum-care-ppc/>. Accessed on: Apr 2, 2025.

⁵⁷ National Committee for Quality Assurance. Asthma Medication Ratio (AMR). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/asthma-medication-ratio-amr/>. Accessed on: Apr 2, 2025.

is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.⁵⁸ [Quality]

Why the weakness exists: The rate for the *Controlling High Blood Pressure (CBP)* measure ranked below the 25th percentile. Some barriers noted by MCL included the transition to a new healthcare analytic vendor, the loss of a data repository which left plan without the ability to utilize or distribute gap reports for a significant portion of the measurement year, and limited member reports leading to a decrease in outreach activities and opportunity to close gaps in care.

Recommendation: While MCL noted several interventions currently in place to target improvement, such as faxing quality quick tips to providers on the importance of blood pressure management, conducting monthly monitoring of rates and gap reporting, and exploring further collaboration with physician partners, measure performance for *Controlling High Blood Pressure (CBP)* remained low. Therefore, HSAG recommends that MCL continue its efforts to improve performance for the *Controlling High Blood Pressure (CBP)* measure. Initiatives should continue to be monitored and expanded upon as additional contributing factors are identified. MCL could consider providing education to members on the importance of controlled blood pressure and monitoring. MCL could also consider encouraging members to monitor their blood pressure levels at home.

Compliance Review

Performance Results


Table 3-61 presents the total number of criteria for each standard that received a score of *Met*, *Satisfied*, or *Not Met*. Table 3-61 also presents MCL’s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. *NA* was used when MDHHS determined the review element was not applicable during the compliance review. For elements scored as *Not Met*, MCL was subject to a corrective action review process outlined in Appendix A.


Table 3-61—Compliance Review Results for MCL

Standard		Number of Scores				Compliance Scores	
		<i>Met</i>	<i>Satisfied</i> ¹	<i>Not Met</i>	<i>NA</i>	MCL ²	Statewide ³
1	Administrative	5	0	0	0	100%	100%
2	Providers	23	0	1	0	96%	95.4%
3	Members	29	0	0	1	100%	98.9%
4	Quality	24	0	0	0	100%	100%
5	MIS/Financial	49	1	1	0	96%	94.6%

⁵⁸ National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/controlling-high-blood-pressure-cbp/>. Accessed on: Apr 2, 2025.

Standard		Number of Scores				Compliance Scores	
		Met	Satisfied ¹	Not Met	NA	MCL ²	Statewide ³
6	OIG/Program Integrity	9	0	1	0	90%	85.6%
Overall		139	1	3	1	97%	96.0%

 Indicates the standard scored below the statewide rate.

 Indicates the standard had a score of 100 percent.

¹ A score of *Satisfied* was only allowable for select elements under the MIS/Financial standard.

² MDHHS calculated the total compliance score for each standard by totaling the number of *Met* (i.e., 1 point) elements and the number of *Not Met* and *Satisfied* (i.e., 0 points) elements, then dividing the summed score by the total number of elements for that standard.

³ MDHHS calculated the statewide performance scores to the tenth decimal place; however, MHP performance scores were calculated using whole number percentages.

Additionally, to supplement the compliance review activity, MDHHS conducted staff interviews, referred to as focus studies, in the following three areas: CSHCS, Operations, and Quality. While the results of the focus studies are not incorporated into the scoring of the compliance review, **MCL** met MDHHS' expectations for participation in the studies.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the compliance review 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: MCL achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. **[Quality]**

Strength #2: MCL achieved full compliance in the Members standard, demonstrating the MHP maintained sufficient policies and procedures to support its membership, which included, but was not limited to, access to service authorization processes; care coordination procedures; fair grievance and appeal systems; member information materials such as the handbook, newsletters, and website; and choice of PCPs. **[Quality, Timeliness, and Access]**

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

Weaknesses and Recommendations

Weakness #1: HSAG did not find any substantial weaknesses for **MCL** through the compliance review activity.

Why the weakness exists: NA

Recommendation: NA

Network Adequacy Validation

Performance Results

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MHP's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each MHP according to Table 3-62.

Table 3-62—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	<i>High Confidence</i>
50.0% to 89.9%	<i>Moderate Confidence</i>
10.0% to 49.9%	<i>Low Confidence</i>
Less than 10% and/or any <i>Not Met</i> element has significant bias on the results	<i>No Confidence</i>

No indicators were identified as *Low Confidence* or *No Confidence* designations.

HSAG determined that **MCL** met both the time and distance standards and the ratio standard requirements for 100 percent of its members across all indicators or submitted an exception to MDHHS. The exceptions indicated that **MCL** was aware of a gap and while corrective steps were underway, the issue had not been fully resolved at the time of reporting. Adequacy was determined based on the MHP's compliance with MDHHS' time and distance and ratio standards, with an assessment conducted for each provider type according to county. Table 3-63 outlines the counties and provider specialties for which exceptions were submitted. Results are presented by provider specialty in Table 3-64.

Table 3-63—MCL Submitted Exceptions

County Exception Submitted	Specialty Exception Submitted
Oscoda	Cardiology
Alpena (Rural)	Endodontist
Antrim (Rural)	Endodontist
Benzie (Rural)	Endodontist

County Exception Submitted	Specialty Exception Submitted
Berrien (Non-Rural)	Endodontist
Cass (Non-Rural)	Endodontist
Charlevoix (Rural)	Endodontist
Cheboygan (Rural)	Endodontist
Emmet (Rural)	Endodontist
Leelanau (Rural)	Endodontist
Montmorency (Rural)	Endodontist
Muskegon (Non-Rural)	Endodontist
Otsego (Rural)	Endodontist
Presque Isle (Rural)	Endodontist
Berrien	General Dentistry
Gratiot	General Dentistry
Berrien	Hospital
Cheboygan	OB/GYN
Bay (Non-Rural)	Periodontist
Berrien (Non-Rural)	Periodontist
Cass (Non-Rural)	Periodontist
Kalamazoo (Non-Rural)	Periodontist
Midland (Non-Rural)	Periodontist
Saginaw (Non-Rural)	Periodontist
St. Clair (Non-Rural)	Periodontist
Alpena (Rural)	Prosthodontist
Antrim (Rural)	Prosthodontist
Benzie (Rural)	Prosthodontist
Calhoun (Non-Rural)	Prosthodontist
Charlevoix (Rural)	Prosthodontist
Cheboygan (Rural)	Prosthodontist
Clinton (Non-Rural)	Prosthodontist
Eaton (Non-Rural)	Prosthodontist
Emmet (Rural)	Prosthodontist

Table 3-64—MCL Network Adequacy Compliance

Provider Specialty	Non-Rural Time and Distance	Rural Time and Distance	Non-Rural Ratio	Rural Ratio
PCPs (Adult)	Compliant	Compliant	Compliant	Compliant
PCPs (Pediatric)	Compliant	Compliant	Compliant	Compliant
OB/GYN	Compliant	Compliant	NA	NA
Cardiology	Compliant	Compliant	NA	NA
Outpatient Behavioral Health	Compliant	Compliant	NA	NA
Hospital	Compliant	Compliant	NA	NA
Pharmacy	Compliant	Compliant	NA	NA
General Dentistry	Compliant	Compliant	Compliant	Compliant
Endodontist	Compliant	Compliant	NA	NA
Oral Surgeon	Compliant	Compliant	NA	NA
Periodontist	Compliant	Compliant	NA	NA
Prosthodontist	Compliant	Compliant	NA	NA

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: MCL demonstrated its capability of maintaining an adequate provider network to service its members that included comprehensive contracting, provider data maintenance, and reporting methods. MCL addressed any gaps in its network by submitting exception requests to MDHHS and increasing contracting efforts to fill network gaps, and created a Gap Analysis Workgroup to monitor its contracted provider network quarterly to monitor and/or act on any changes or gaps occurring in its network. [Access]

Weaknesses and Recommendations

Weakness #1: No specific opportunities were identified related to the systems, management processes, or data integration MCL had in place to inform network adequacy standard and indicator calculation and reporting.

Why the weakness exists: NA

Recommendation: NA

Network Validation Survey

Performance Results

HSAG’s reviewers evaluated 437 randomly sampled cases by comparing provider data submitted to HSAG by **MCL** against **MCL**’s online directory. The sample included 216 PCPs, 216 pediatric providers, and only five OB/GYN providers.⁵⁹ Overall, 89.2 percent of the sampled providers were located in the online directory at the sampled location, while 2.3 percent of the sampled providers located in the online directory were not at the sampled location. Additionally, 8.5 percent of all sampled providers were not found in the online directory. Notably, only three out of the five OB/GYN providers were found in the directory at the sampled location.

Table 3-65 summarizes the findings regarding the number of sampled providers and provider locations (i.e., “cases”) that HSAG’s reviewers located in the MHP’s online directory.

Table 3-65—Summary of Providers Present in Online Directory, by Provider Category

Provider Category	Number of Sampled Providers	Providers Not Found in Directory		Providers Found in Directory—Not at Sampled Location		Providers Found in Directory—At Sampled Location	
		Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
PCPs	216	14	6.5%	8	3.7%	194	89.8%
Pediatric Providers	216	21	9.7%	2	0.9%	193	89.4%
OB/GYN Providers	5	2	40.0%	0	0.0%	3	60.0%
MCL Total	437	37	8.5%	10	2.3%	390	89.2%

¹ The denominator includes the number of sampled providers.

Table 3-66 displays the total number and percentage of cases with matched data values for indicators that were reviewed between data values shown in **MCL**’s provider data submission to HSAG and **MCL**’s online directory. Cases with unmatched results may include incorrect information or information not listed in the directory (e.g., the provider data included a data value for a study indicator, but the online directory did not include a data value for the study indicator).

⁵⁹ A low number of OB/GYN providers was sampled due to the eligible population criteria (i.e., providers with the PCP indicator) which reduced the number of eligible OB/GYN providers. Caution should be exercised when interpreting OB/GYN results for **MCL**.

Table 3-66—Provider Demographic Indicators Matching Online Directory

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		Overall	
	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
Provider Name	202	100%	195	100%	3	100%	400	100%
Provider Street Address	194	96.0%	193	99.0%	3	100%	390	97.5%
Provider Suite Number	199	98.5%	195	100%	3	100%	397	99.3%
Provider City	195	96.5%	191	97.9%	3	100%	389	97.3%
Provider State	202	100%	195	100%	3	100%	400	100%
Provider ZIP Code	196	97.0%	194	99.5%	3	100%	393	98.3%
Provider Telephone Number	195	96.5%	192	98.5%	3	100%	390	97.5%
Provider Type/Specialty	199	98.5%	186	95.4%	3	100%	388	97.0%
Provider Accepting New Patients	200	99.0%	194	99.5%	3	100%	397	99.3%
Provider Gender	202	100%	195	100%	3	100%	400	100%
Provider Primary Language ²	201	99.5%	192	98.5%	3	100%	396	99.0%
Non-English Language Speaking Provider (including American Sign Language) ²	202	100%	195	100%	3	100%	400	100%

¹ The denominator for each study indicator includes the number of cases in which the provider was found in the directory.

² The PDV review evaluated whether the indicator was present in the directory, but specific values were not validated.

For the secret shopper telephone survey, HSAG attempted to contact 373 sampled provider locations for **MCL**, with an overall response rate of 68.9 percent. Table 3-67 summarizes the survey response rates (i.e., cases reached) for all MHPs and for **MCL**, by provider category.

Table 3-67—Response Rates

Provider Category	Number of Total Cases ¹	Cases Reached	Response Rate
PCPs	191	124	64.9%
Pediatric Providers	179	130	72.6%
OB/GYN Providers	3	3	100%
MCL Total	373	257	68.9%
All MHPs Total	2,633	1,775	67.4%

¹ Total number of cases includes cases that were found in the online directory and matched on eight key provider indicators (i.e., name, address, city, state, ZIP Code, telephone number, provider type/specialty, and new patient acceptance).

Table 3-68 summarizes the provider data validation and accuracy results for all MHPs and **MCL**, by provider category.

Table 3-68—Provider Data Validation and Accuracy Results

Provider Category	Denom ¹	Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance		Accepting New Patients	
		Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
PCPs	124	78	62.9%	73	58.9%	60	48.4%	38	30.6%	29	23.4%
Pediatric Providers	130	78	60.0%	72	55.4%	59	45.4%	47	36.2%	34	26.2%
OB/GYN Providers	3	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
MCL Total	257	156	60.7%	145	56.4%	119	46.3%	85	33.1%	63	24.5%
All MHPs Total	1,775	1,280	72.1%	1,215	68.5%	1,082	61.0%	822	46.3%	731	41.2%

¹ The denominator includes cases reached.

Table 3-69 displays the number of survey respondents who offered appointments to new patients for routine PCP and prenatal care visits for all MHPs and **MCL**, by provider category.

Table 3-69—Appointment Availability for Routine PCP and Prenatal Care Visits¹

Provider Category	Cases Reached	Cases Offered an Appointment	
		Count	Rate ²
PCPs	124	19	15.3%
Pediatric Providers	130	24	18.5%
OB/GYN Providers	3	0	0.0%
MCL Total	257	43	16.7%
All MHPs Total	1,775	424	23.9%

¹ Appointment availability rates were calculated using cases accepting new patients and total survey cases as the denominator in the 2022 and 2023 reports. However, the denominator used in the 2024 report was cases reached. Caution should be exercised when comparing 2024 appointment availability rates with the rates in the 2022 and 2023 reports.

² The denominator includes cases reached.

Table 3-70 displays the new patient wait time results for all MHPs and **MCL**, by provider category.

Table 3-70—Appointment Wait Time Results

Provider Category	Appointment Wait Time (Business Days)				Rate of Cases Within Standard ^{1,2}
	Min	Max	Average	Median	
PCPs	1	109	28	20	68.4%
Pediatric Providers	1	120	27	12	70.8%
OB/GYN Providers	NA	NA	NA	NA	NA
MCL Total	1	120	27	19	69.8%
All MHPs Total	0	261	18	8	80.9%

¹ The denominator includes cases offered an appointment.

² Rate of cases within standard represents the percentage of cases that were offered an appointment that was compliant with the 30-business-day standard for routine appointments and seven-business-day standard for prenatal care appointments.

NA indicates “not applicable” since no appointments were offered.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NVS 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: Reviewers located 91.5 percent of the sampled providers in **MCL**’s online provider directory. [Access]

Strength #2: Of the providers located in the online directory, all indicators had a match rate above 95.0 percent. [Access]

Weaknesses and Recommendations

Weakness #1: Overall, only 68.9 percent of the sampled provider locations were reached. [Access]

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

Recommendation: HSAG recommends that **MCL** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information or reviewers encountering voicemail messages, disconnected numbers, or extended hold times) to address the provider data deficiencies.

Weakness #2: Of the cases reached, 60.7 percent confirmed affiliation with the sampled provider. Additionally, 56.4 percent confirmed accuracy of the sampled address, 46.3 percent confirmed the services were offered, 33.1 percent confirmed the requested insurance, and 24.5 percent confirmed new patient acceptance. [Quality and Access]

Why the weakness exists: MCL's provider data included invalid provider, address, specialty, new patient acceptance, and insurance information.

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

Weakness #3: Among the cases reached, only 16.7 percent of locations offered an appointment date, including 15.3 percent of PCPs, 18.5 percent of pediatric providers, and 0.0 percent of OB/GYN providers. Of the cases that offered an appointment, 69.8 percent were compliant with the appointment wait time standard. [Timeliness and Access]

Why the weakness exists: For new MCL members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included pre-registration as well as requiring additional personal information, a Medicaid ID, or an MRR.

Recommendation: HSAG recommends that MCL work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that MCL 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 MCL procured medical records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*, to identify discrepancies and ensure alignment between the medical records and the encounter data submitted to MDHHS.

Table 3-71 outlines the key findings for MCL based on the assessment of encounter data completeness and accuracy conducted through a review of members' medical records for services rendered from October 1, 2022, through September 30, 2023.

Table 3-71—Key Findings for MCL

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	<ul style="list-style-type: none"> The medical record rate was 94.4 percent, indicating that most of the requested records were procured and submitted. Of the medical records not submitted, all were not submitted due to non-responsive provider or provider did not respond in a timely manner.
Second Date of Service Submission Rate	<ul style="list-style-type: none"> Among the procured medical records, 59.8 percent included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	<ul style="list-style-type: none"> The <i>Procedure Code</i> and <i>Procedure Code Modifier</i> data elements had relatively high medical record omission rates at 14.7 percent and 22.0 percent, respectively. This indicates that the procedure codes and the modifiers in the encounter data were not adequately supported by the members' medical records.
Encounter Data Omission Rate	<ul style="list-style-type: none"> All key data elements exhibited relatively low encounter data omission rates, with <i>Date of Service</i> having the highest encounter data omission rate at 5.1 percent.
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Diagnosis Code</i> data element was accurate in 99.7 percent of instances where codes were present in both the medical records and encounter data, with all errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code</i> data element was accurate in 98.1 percent of instances where codes were present in both the medical records and encounter data; most errors were related to inaccurate coding, while some were attributed to providers submitting higher-level service codes than those supported in medical records.
Procedure Code Modifier Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code Modifier</i> data element was accurate in 100 percent of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	<ul style="list-style-type: none"> Dates of service with accurate values for all key data elements (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, and <i>Procedure Code Modifier</i>) were observed in 75.9 percent of the dates of service present in both data sources (i.e., encounter data and medical records).

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: A high percentage of *Date of Service* and *Diagnosis Code* data element values in the encounter data were supported by the members' medical records, as evidenced by the low medical record omission rates of 4.1 percent and 8.5 percent, respectively. [Quality]

Strength #2: The *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data element values identified in the medical records were generally present in the encounter data, as evidenced by the low encounter data omission rates of 5.1 percent, 2.3 percent, 4.5 percent, and 1.7 percent, respectively. [Quality]

Strength #3: When key data elements were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate with rates of at least 98.1 percent each. [Quality]

Weaknesses and Recommendations

Weakness #1: MCL was unable to procure all the requested medical records from its contracted providers mostly due to providers being non-responsive or providers not responding in a timely manner. [Quality and Timeliness]

Why the weakness exists: The non-submission reason for non-responsive providers or providers who did not respond in a timely manner may indicate that the contracted providers were unaware of the submission requirements or the deadline.

Recommendation: MCL should ensure its contracted providers' accountability in responding to medical record requests for the purposes of auditing, inspection, and oversight. HSAG recommends MCL consider strengthening and/or enforcing its contract requirements with its providers in providing the requested documentation.

Weakness #2: More than 14.0 percent of the *Procedure Code* and 22.0 percent of the *Procedure Code Modifier* data element values identified in the encounter data were not supported by the members' medical records. [Quality]

Why the weakness exists: Non-submitted medical records contribute to medical record omissions, as the expected information in the medical records cannot be compared to the encounter data. Additional contributing factors include provider documentation practices (e.g., incomplete or inaccurate documentation, coding errors, lack of detail), data submission (e.g., incorrect coding during data submission or data entry errors), or processing issues (e.g., data mapping or translation issues, or errors in data transmission).

Recommendation: **MCL** should investigate the root cause(s) for these omissions, with a focus on both provider documentation practices and data handling processes. Periodic MRRs of submitted claims should be conducted to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should be used to develop and provide ongoing education and training for providers. Topics should include encounter data submissions, medical record documentation requirements, and coding practices to reduce future omissions and improve data accuracy.

Consumer Assessment of Healthcare Providers and Systems Analysis

Adult and Child Medicaid

Performance Results

Table 3-72 presents **MCL**'s 2023 and 2024 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2024 scores were statistically significantly higher or lower than the 2023 national average. Triangles (▲ or ▼) indicate 2024 scores were statistically significantly higher or lower than the 2023 scores.

Table 3-72—Summary of Adult and Child Medicaid CAHPS Top-Box Scores for MCL

	2023 Adult Medicaid	2024 Adult Medicaid	2023 Child Medicaid	2024 Child Medicaid
Global Ratings				
<i>Rating of Health Plan</i>	63.35%	61.45%	71.43%	72.36%
<i>Rating of All Health Care</i>	57.14%	54.78%	59.44%	70.77% ▲
<i>Rating of Personal Doctor</i>	65.41%	60.87%	74.78%	75.14%
<i>Rating of Specialist Seen Most Often</i>	56.04% ⁺	74.70% ⁺ ▲	74.70% ⁺	73.33% ⁺
Composite Measures				
<i>Getting Needed Care</i>	87.78%	81.04%	88.13%	87.14% ⁺
<i>Getting Care Quickly</i>	87.87%	81.87% ⁺	89.75%	87.42% ⁺
<i>How Well Doctors Communicate</i>	92.11%	92.22%	94.20%	94.90%
<i>Customer Service</i>	88.34% ⁺	88.87% ⁺	90.38% ⁺	91.00% ⁺
Individual Item Measure				
<i>Coordination of Care</i>	83.95% ⁺	84.48% ⁺	83.72% ⁺	77.61% ⁺
Medical Assistance With Smoking and Tobacco Use Cessation Items*				
<i>Advising Smokers and Tobacco Users to Quit</i>	72.05%	71.43%	—	—

	2023 Adult Medicaid	2024 Adult Medicaid	2023 Child Medicaid	2024 Child Medicaid
<i>Discussing Cessation Medications</i>	50.31%	48.65%	—	—
<i>Discussing Cessation Strategies</i>	46.54%	43.12%	—	—

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

* These rates follow NCQA's methodology of calculating a rolling two-year average.

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.

▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.

No triangles (▲ or ▼) indicate the 2024 score was not statistically significantly higher or lower than the 2023 score.

↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.

↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.

No arrows (↑ or ↓) indicate the 2024 score was not statistically significantly higher or lower than the 2023 national average.

— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the CAHPS 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: MCL's 2024 top-box score was statistically significantly higher than the 2023 adult Medicaid top-box score for one measure, *Rating of Specialist Seen Most Often*. [Quality]

Strength #2: MCL's 2024 top-box score was statistically significantly higher than the 2023 child Medicaid top-box score for one measure, *Rating of All Health Care*. [Quality]

Weaknesses and Recommendations

Weakness #1: MCL's 2024 top-box scores were not statistically significantly lower than the 2023 NCQA adult and child Medicaid national averages or 2023 top-box scores for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

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

CSHCS

Performance Results

Table 3-73 presents MCL’s 2023 and 2024 CSHCS CAHPS top-box scores. Upward green or downward red arrows (↑ or ↓) indicate 2024 scores were statistically significantly higher or lower than the 2023 national average. Upward green or downward red triangles (▲ or ▼) indicate 2024 scores were statistically significantly higher or lower than the 2023 scores.

Table 3-73—Summary of CSHCS CAHPS Survey Top-Box Scores for MCL

	2023 Top-Box Score	2024 Top-Box Score
Global Ratings		
<i>Rating of Health Plan</i>	68.64%	73.63%↑
<i>Rating of Health Care</i>	72.02%	73.72% NA
<i>Rating of Specialist Seen Most Often</i>	78.65%	74.89%
Composite Measures		
<i>Customer Service</i>	95.95% ⁺	88.33% ⁺
<i>How Well Doctors Communicate</i>	95.44%	95.16% NA
<i>Access to Specialized Services</i>	72.03% ⁺	73.17% ⁺ NA
<i>Transportation</i>	82.05% ⁺	71.19% ⁺ NA
Individual Item Measures		
<i>Access to Prescription Medicines</i>	89.39%	89.52%
<i>Not Felt Treated Unfairly: Race and Ethnicity</i>	99.49%	97.36% NA
<i>Not Felt Treated Unfairly: Health Insurance Type</i>	95.41%	94.71% NA

⁺ Indicates fewer than 100 respondents. Caution should be exercised when evaluating the results.

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.

▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.

No triangle (▲ or ▼) indicates the 2024 score was not statistically significantly higher or lower than the 2023 score.

↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.

↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.

No arrow (↑ or ↓) indicates the 2024 score was not statistically significantly higher or lower than the 2023 national average.

NA Indicates a national average is not available for the measure.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the CAHPS 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: **MCL**'s 2024 top-box score was statistically significantly higher than the 2023 NCQA child Medicaid national average for one measure, *Rating of Health Plan*. [Quality]

Weaknesses and Recommendations

Weakness #1: **MCL**'s 2024 top-box scores were not statistically significantly lower than the 2023 NCQA child Medicaid national averages or 2023 top-box scores for any reportable measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

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

Quality Rating

The 2024 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2024 Michigan Consumer Guide, which is inclusive of **MCL**'s performance.

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

HSAG performed a comprehensive assessment of **MCL**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **MCL** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **MCL**'s overall performance contributed to the CHCP's progress in achieving the CQS goals and objectives. Table 3-74 displays each MDHHS CQS goal and the EQR activity results that indicate whether the MHP positively (✓), negatively (✗), or minimally (m) impacted the CHCP's progress toward achieving the applicable goals and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to **MCL**'s Medicaid members. Not applicable (NA) was used when EQR activities do not produce data to assess the impact of a quality measure(s) under an objective.

Table 3-74—Overall Performance Impact to CQS and Quality, Timeliness, and Access

Objective	Program	Quality Measure	Overall Performance Impact	Performance Domain
Goal #1: Ensure high quality and high levels of access to care				
1.1	CHCP	<i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	✓	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	CHCP	<i>Prenatal and Postpartum Care—Postpartum Care</i>	m	

Objective	Program	Quality Measure	Overall Performance Impact	Performance Domain
	CHCP	Childhood Immunization Status—Combination 3	m	
	CSHCS	Global Rating of Health Plan	✓	
	CSHCS	Global Rating of Specialist Seen Most Often	✓	
	CSHCS	Global Rating of Health Care	✓	
	CSHCS	Composite Measure for Access to Specialized Services	✓	
	CSHCS	Composite Measure for Transportation	✗	
1.2	CHCP	Asthma Medication Ratio—Total	✗	
	CHCP	Controlling High Blood Pressure	m	
	CHCP	Comprehensive Diabetes Care (CDC)—Eye Exams ^l	m	
	CSHCS	Composite Measure for How Well Doctors Communicate	✓	
	CSHCS	Composite Measure for Customer Service	✗	
1.3	CHCP	Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	NA	
	CHCP	Getting Care Quickly Composite (Adult CAHPS)	✗	
	CSHCS	Global Rating of Health Care	✓	
	CSHCS	Composite Measure for Access to Specialized Services	✓	
	CSHCS	Access to Prescription Medicines	m	
Goal #2: Strengthen person and family-centered approaches				
2.1	CHCP	Rating of Health Plan ²	✗	☒ Quality ☐ Timeliness ☒ Access
	CHCP	Adults' Access to Preventive/Ambulatory Health Service—20–44 Years Old	m	
	CHCP	Access to Dental Care	m	
	CHCP	Completion of Annual Health Risk Assessment	NA	
	CSHCS	Composite Measure for How Well Doctors Communicate	✓	
	CSHCS	Global Rating of Health Plan	✓	
	CSHCS	Global Rating of Health Care	✓	
	CSHCS	Global Rating of Specialist Seen Most Often	✓	
2.2	CHCP	SDOH: Total Member Screening Rate	NA	
	CHCP	SDOH: Total Member Referral Rate	NA	
	CHCP	Social Need Screening and Intervention	NA	
	CSHCS	Composite Measure for Access to Specialized Services	✓	

Objective	Program	Quality Measure	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)				
3.1	CHCP	Follow-Up After Hospitalization for Mental Illness Within 30 Days (FUH) (Adults)	NA	☒ Quality ☒ Timeliness ☒ Access
	CSHCS	Coordination of Care	NA	
3.2	CHCP	Implementation of Joint Care Management Processes	NA	
	CSHCS	Global Rating of Health Plan	✓	
	CSHCS	Global Rating of Health Care	✓	
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes				
4.1	CHCP	Chlamydia Screening in Women—Total ³	NA	☒ Quality ☒ Timeliness ☒ Access
	CHCP	Prenatal and Postpartum Care—Postpartum Care ³	NA	
	CHCP	Children Immunization Combo 3 ³	NA	
	CHCP	Lead Screening in Children ³	NA	
	CHCP	Comprehensive Diabetes Care—Eye Exam ³	NA	
	CHCP	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years Old ³	NA	
	CSHCS	Not Felt Treated Unfairly: Race and Ethnicity	✗	
Goal #5: Improve quality outcomes through value-based initiatives and payment reform				
5.1	CHCP	Average Percentage of Plan Payments to Providers Who Are in APM Arrangements ("Big Numerator")	NA	☒ Quality ☐ Timeliness ☐ Access
	CHCP	Average Percentage of Plan Payments to Providers That Are Tied to Quality ("Small Numerator")	NA	

✓ = The MHP's rate met the 2026 statewide performance target; or the MHP's rate did not meet the 2026 statewide performance target but demonstrated a statistically significant increase in performance from the prior year.

m = The MHP's rate did not meet the 2026 statewide performance target and while the MHP's rate increased in performance from the prior year, the increase was not statistically significant.

✗ = The MHP's rate did not meet the 2026 statewide performance target and/or the MHP's rate decreased in performance from the prior year.

NA = EQR activities published in this report do not produce data to assess the impact of a quality measure(s) under an objective.

¹ NCQA replaced the *Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed* performance measure with the *Eye Exam for Patients With Diabetes (EED)* performance measure, the overall performance impact was based on the MHP's reported rate for *Eye Exam for Patients With Diabetes (EED)*.

² As the CQS did not identify whether this quality measure applies to the adult or child CAHPS, HSAG assessed performance using the adult rate.

³ While there are reported HEDIS rates that are stratified by race/ethnicity, the EQR deliverables did not include an analysis of these data.

Meridian Health Plan of Michigan

Validation of Performance Improvement Projects

Performance Results

HSAG’s validation evaluated the technical methods of **MER**’s PIP (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-75 displays the overall validation rating, the baseline rate, Remeasurement 1, and Remeasurement 2 results for the performance indicators, and if a disparity existed within the most recent measurement period.

Table 3-75—Overall Validation Rating for MER

PIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
Addressing Disparities for Timeliness of Prenatal Care: Addressing Racial Health Disparities	High Confidence	No Confidence	1. Improve the <i>PPC-Timeliness of Prenatal Care</i> rate for the Black (non-Hispanic) population residing in Region 6 in order to reduce the disparity to the comparison subgroup.	61.9%	53.1% ↔	61.5% ↔	No
			2. Maintain the performance of the HEDIS <i>PPC-Timeliness of Prenatal Care</i> performance result for eligible White (non-Hispanic) members residing in Region 6.	70.1%	62.8% ↓	57.5% ↓	

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).

The goals for **MER**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black women) will demonstrate a significant increase over the baseline rate without a decline in performance for the comparison subgroup (White women). Table 3-76 displays the barriers identified through QI and causal/barrier analysis processes and the interventions initiated by the MHP to support achievement of the PIP goals and address the barriers.

Table 3-76—Remeasurement 2 Barriers and Interventions for MER

Barriers	Interventions
Members lack awareness of the importance of early and adequate prenatal care and associated resources to attain prenatal care.	Meridian's Member Services department outreaches to members due for HEDIS <i>PPC-Timeliness of Prenatal Care</i> services telephonically to provide education and awareness, and to offer care coordination assistance. The Member Services department ensures members connect to care by helping members locate providers, schedule appointments, and [arrange for] transportation when needed or requested by members.
	Meridian to offer a member gift card incentive to members due for prenatal care visits after the member satisfactorily meets measure compliance.
	Meridian to incentivize members for self-reporting pregnancies to plan for care coordination and SDOH needs assessment.
Providers miss initiating timely prenatal care per the <i>PPC HEDIS</i> measure specifications. Providers may not be aware of members' pregnancy. Providers may have limited availability to accommodate timely prenatal care visits.	Providers are incentivized for successful completion of <i>HEDIS PPC Timeliness of Prenatal Care</i> measure. Meridian publishes PPC HEDIS care gap reports and education to the providers for any members due for measure completion.
	Care gap reports and education are published for providers for any members due for measure completion.
Coronavirus disease 2019 (COVID-19): Members experience vaccine hesitancy, misinformation, and virus contraction concerns. Meridian Medicaid members have proven to be difficult to reach and transient at times. Members lack awareness of the importance of early and adequate prenatal care and access to attain prenatal care.	Meridian to refer Region 6 pregnant members due for prenatal care visits to community health workers (CHWs) for intensive outreach and engagement. Members will receive a CHW referral for a home visit or telephonic engagement to provide education on the importance of seeking prenatal care and to ensure successful connection to care. CHWs will assist members with finding providers, appointment scheduling, and scheduling transportation if needed or requested by the member. CHWs will assess and address identified SDOH needs of each referred member. Upon immediate receipt of CHW referral, a case investigation of updated member demographics is conducted via intense review of claims, pharmacy, and enrollment data prior to implementation of telephonic or home outreach. CHW will utilize updated demographic information from the investigation to perform care coordination duties.

Barriers	Interventions
Structural and Social Determinants of Health impede care.	Meridian to refer pregnant members to a group-based care program. Group prenatal care aims to educate women about pregnancy and childbirth in a group setting, with the goal of empowering patients to take control of their own health.
	Start Smart for Baby maternity case management program (SSFB). SSFB is an evidenced-based program that leverages advanced analytics to identify and engage members to improve obstetrical and pediatric care services, reduce pregnancy-related complications, premature deliveries, low birth weight deliveries, and infant disease.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PIP 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: MER used appropriate QI tools to conduct its causal/barrier analysis and interventions were initiated in a timely manner and reasonably linked to the identified barriers. [Quality, Timeliness, and Access]

Weaknesses and Recommendations

Weakness #1: MER did not achieve the state-defined goal of eliminating the existing disparity without a decline in performance for the comparison group for the second remeasurement period, with both performance indicators demonstrating a decrease in performance as compared to the baseline. [Quality, Timeliness, and Access]

Why the weakness exists: The MHP reported a decrease in prenatal care providers in areas where a high percentage of White members reside, including the closure of a birthing hospital.

Recommendation: HSAG recommends **MER** continue to assist members with locating providers and coordinating transportation to appointments, while building new relationships with non-contracted providers within areas with limited in-network prenatal care providers. The MHP should also consider evidence-based intervention efforts and risk factors in quality of care for both subgroups.

Performance Measure Validation

Performance Results

MER was evaluated against NCQA’s IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2023 Compliance Audit Report findings, **MER** was fully compliant with all four IS standards.

According to the auditor’s review, **MER** followed the NCQA HEDIS MY 2023 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-77 displays the MDHHS-selected performance measures, HEDIS MY 2022 and MY 2023 rates, MY 2022 and MY 2023 comparisons, and MY 2023 performance levels based on comparisons to national percentiles⁶⁰ for **MER**. Additional performance measures and performance measure results for **MER** can be referenced in Appendix B.

Table 3-77—HEDIS MY 2023 Performance Measure Results for MER

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
Child & Adolescent Care				
<i>Childhood Immunization Status (CIS)</i>				
<i>Combination 3</i>	58.88%	55.47%	-3.41	★
<i>Combination 7</i>	52.31%	49.39%	-2.92	★
<i>Combination 10</i>	25.30%	23.60%	-1.70	★
<i>Well-Child Visits in the First 30 Months of Life (W30)</i>				
<i>Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	55.37%	63.67%	+8.30+	★★★★★
<i>Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i>	59.29%	66.37%	+7.08+	★★
<i>Lead Screening in Children (LSC)</i>				
<i>Lead Screening in Children</i>	55.72%	58.30%	+2.58	★★
<i>Child and Adolescent Well-Care Visits (WCV)</i>				
<i>Ages 3 to 11 Years</i>	59.96%	62.34%	+2.37+	★★★★
<i>Ages 12 to 17 Years</i>	51.05%	53.53%	+2.48+	★★★★

⁶⁰ HEDIS MY 2023 performance measure rates are compared to NCQA’s Quality Compass National Medicaid Health Maintenance Organization (HMO) percentiles for HEDIS MY 2022 (referred to as “percentiles” throughout this section of the report).

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
<i>Ages 18 to 21 Years</i>	27.32%	30.08%	+2.76+	★★★★
<i>Total</i>	51.78%	54.49%	+2.71+	★★★
Immunizations for Adolescents (IMA)				
<i>Combination 1 (Meningococcal, Tdap)</i>	78.59%	80.05%	+1.46	★★
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	27.49%	32.12%	+4.62	★★
Women—Adult Care				
Chlamydia Screening in Women (CHL)³				
<i>Ages 16 to 20 Years</i>	61.07%	55.38%	-5.68 ⁺⁺	★★★
<i>Ages 21 to 24 Years</i>	70.85%	64.49%	-6.36 ⁺⁺	★★★
<i>Total</i>	65.64%	59.62%	-6.02 ⁺⁺	★★★
Cervical Cancer Screening (CCS-E)				
<i>Cervical Cancer Screening</i>	60.34%	57.00%	-3.34	★★
Breast Cancer Screening (BCS-E)				
<i>Breast Cancer Screening</i>	NA	55.06%	NC	★★★
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
<i>Ages 20 to 44 Years</i>	74.69%	74.64%	-0.05	★★★
<i>Ages 45 to 64 Years</i>	83.70%	83.55%	-0.14	★★★
<i>Ages 65 Years and Older</i>	88.39%	87.59%	-0.80	★★★
<i>Total</i>	77.94%	77.86%	-0.09	★★★
Pregnancy Care				
Prenatal and Postpartum Care (PPC)³				
<i>Timeliness of Prenatal Care</i>	74.45%	83.21%	+8.76+	★★
<i>Postpartum Care</i>	75.91%	76.16%	+0.24	★★
Living With Illness				
Hemoglobin A1c Control for Patients With Diabetes (HBD)				
<i>HbA1c Control (<8.0%)</i>	54.99%	60.34%	+5.35	★★★★★
<i>Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*</i>	38.93%	30.17%	-8.76+	★★★★★
Blood Pressure Control for Patients With Diabetes (BPD)				
<i>Blood Pressure Control for Patients With Diabetes</i>	67.88%	73.24%	+5.35	★★★★★

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
Eye Exam for Patients With Diabetes (EED)³				
Eye Exam for Patients With Diabetes	55.23%	61.31%	+6.08	★★★★
Kidney Health Evaluation for Patients With Diabetes (KED)				
Ages 18 to 64 Years	39.26%	40.25%	+0.99+	★★★★
Ages 65 to 74 Years	34.38%	37.58%	+3.21+	★★★★
Ages 75 to 85 Years	29.30%	34.79%	+5.50	★★
Total	38.78%	39.99%	+1.21+	★★★★
Asthma Medication Ratio (AMR)				
Total	61.16%	61.18%	+0.03	★★
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	62.77%	62.04%	-0.73	★★★★
Diagnosed Mental Health Disorders (DMH)				
Ages 1 to 17 Years	NA	27.02%	NC	★★★★
Ages 18 to 64 Years	NA	37.98%	NC	★★★★
Ages 65 Years and Older	NA	35.91%	NC	★★★★
Total	NA	33.47%	NC	★★★★
Utilization				
Plan All-Cause Readmissions (PCR)				
Observed Readmissions—Total	10.85%	11.29%	+0.44	NC
Expected Readmissions—Total	10.47%	10.40%	-0.07	NC
O/E Ratio—Total	1.0361	1.0855	+0.05	★

¹ HEDIS MY 2022 to HEDIS MY 2023 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2022–MY 2023 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2022–MY 2023 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

² Performance Levels for MY 2023 were based on comparisons of the HEDIS MY 2023 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2022 benchmark.

³ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

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

Please note that for the *Diagnosed Mental Health Disorders (DMH)* measure, a higher or lower rate does not indicate better performance, as the measure provides information on the diagnosed prevalence of mental health disorders. Therefore, this measure is not included in the evaluation of strengths and weaknesses below.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Green Shading⁺ Indicates that the HEDIS MY 2023 rate demonstrated a significant improvement from the HEDIS MY 2022 rate.

Red Shading⁺⁺ Indicates that the HEDIS MY 2023 rate demonstrated a significant decline from the HEDIS MY 2022 rate.

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

HEDIS MY 2023 Performance Levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PMV 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: MER's performance ranked between the 75th and 89th percentiles for the *Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator and demonstrated significant improvement from MY 2022 to MY 2023, indicating children who turned 15 months old during the measurement year were having at least six well-child visits with a PCP during their first 15 months of life most of the time. Research shows that early intervention treatment services can greatly improve a child's development. Early intervention services help children from birth through 3 years of age (36 months) learn important skills.⁶¹ [Quality, Timeliness, and Access]

Strength #2: MER's performance ranked between the 75th and 89th percentiles for the *Child and Adolescent Well-Care Visits (WCV)—Ages 18 to 21 Years* measure indicator and demonstrated significant improvement from MY 2022 to MY 2023, indicating members between the ages of 18 and 21 years received one or more well-care visits with a PCP or OB/GYN practitioner during the measurement year most of the time. More frequent well-child visits in the first years of life and one or more well-child visits from ages 3–21 are recommended. Well-child visits should include, but are not limited to, an initial/interval medical history, physical exam, developmental assessment, immunization, and anticipatory guidance.⁶² [Quality, Timeliness, and Access]

Strength #3: MER's performance ranked above the 90th percentile for the *Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Control (<8.0%)* measure indicator and ranked between the 75th and 89th percentiles for the *Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Poor Control (>9.0%)* measure indicator. In addition, the *Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Poor Control (>9.0%)* measure indicator rate demonstrated

⁶¹ National Committee for Quality Assurance. Well-Child Visits in the First 30 Months of Life (W30). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/well-child-visits-in-the-first-30-months-of-life-w30/>. Accessed on: Apr 2, 2025.

⁶² National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (WCV). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/child-and-adolescent-well-care-visits-wcv/>. Accessed on: Apr 2, 2025.

significant improvement from MY 2022 to MY 2023, indicating members with diabetes had controlled HbA1c levels most of the time during the measurement year. Glycemic control is management of blood sugar levels to reduce the risk of microvascular complications (eye, kidney, and nerve diseases). Many complications such as heart disease, stroke, blindness, kidney failure, and amputation can be prevented if diabetes is detected and addressed in the early stages.⁶³ [Quality and Access]

Strength #4: MER's performance ranked between the 75th and 89th percentiles for the *Blood Pressure Control for Patients With Diabetes (BPD)* measure indicator, indicating members 18–75 years of age, with a diagnosis of diabetes, had controlled blood pressure levels most of the time. Diabetes is a chronic condition marked by high blood sugar due to the body's inability to make or use insulin. Left unmanaged, diabetes can lead to more serious health conditions, including high blood pressure. Proper blood pressure management is essential to avoid further complications, including heart attack, stroke, kidney disease, and blindness. With support from healthcare providers, patients can manage their blood pressure to maintain a healthy and productive life.⁶⁴ [Quality]

Strength #5: MER's performance ranked between the 75th and 89th percentiles for the *Eye Exam for Patients With Diabetes (EED)* measure indicator, indicating members with diabetes had an eye exam to screen or monitor for diabetic retinal disease most of the time. Adults with diabetes should receive regular eye exams to help detect and manage visual complications. Regular eye exams are the best way to reduce the risk of blindness and maintain a healthy and productive life.⁶⁵ [Quality and Access]

Strength #6: MER demonstrated overall strength in its HEDIS data reporting, as **MER** was fully compliant with all four IS standards and all performance measure rates were determined to be *Reportable*. [Quality]

Weaknesses and Recommendations

Weakness #1: MER's performance for the *Childhood Immunization Status (CIS)—Combination 3, Combination 7, and Combination 10* measure indicators ranked below the 25th percentile, indicating that children 2 years of age were not receiving some vaccinations by their second birthday. Childhood immunizations help prevent serious illnesses such as polio, tetanus, and hepatitis.

⁶³ National Committee for Quality Assurance. Glycemic Status Assessment for Patients With Diabetes (GSD). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/glycemic-status-assessment-for-patients-with-diabetes-gsd/>. Accessed on: Apr 1, 2025.

⁶⁴ National Committee for Quality Assurance. Blood Pressure Control for Patients With Diabetes (BPD). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/blood-pressure-control-for-patients-with-diabetes-bpd/>. Accessed on: Apr 2, 2025.

⁶⁵ National Committee for Quality Assurance. Eye Exam for Patients With Diabetes (EED). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/eye-exam-for-patients-with-diabetes-eed/>. Accessed on: Apr 2, 2025.

Vaccines are a proven way to help a child stay healthy and avoid the potentially harmful effects of childhood diseases like mumps and measles.⁶⁶ [Quality and Timeliness]

Why the weakness exists: The rates for the *Childhood Immunization Status (CIS)*—Combination 3, Combination 7, and Combination 10 measure indicators ranked below the 25th percentile, suggesting barriers exist for children 2 years of age to receive some vaccinations by their second birthday. Potential barriers to improved measure performance may include, but are not limited to, provider challenges with vaccination storage protocols, providers obtaining necessary vaccination certifications, provider cost deterrents related to the short shelf life for vaccines/maintaining inventory, and parental vaccination hesitancy.

Recommendation: HSAG recommends that MER develop targeted interventions to improve performance for the *Childhood Immunization Status (CIS)* measure. Initiatives should be monitored and expanded upon as contributing factors to rate performance are identified. MER could consider exploring avenues to increase awareness of vaccination importance among parents to reduce vaccination hesitancy such as a “speculation versus fact” pamphlet which includes a phone number for care management support. MER could also consider issuing provider incentives for maintaining a complete inventory of vaccinations.

Weakness #2: MER’s performance for the *Plan All-Cause Readmissions—O/E Ratio—Total* measure indicator ranked below the 25th percentile, indicating that there were more unplanned acute readmissions within 30 days after discharge than expected for members 18 to 64 years of age. A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination. Unplanned readmissions are associated with increased mortality and higher healthcare costs. Unplanned readmissions can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management.⁶⁷ [Quality, Timeliness, and Access]

Why the weakness exists: The rate for the *Plan All-Cause Readmissions—O/E Ratio—Total* measure indicator ranked below the 25th percentile. Potential barriers may include but are not limited to unaddressed medical need during initial acute inpatient admission, limited informal support systems for members, SDOH factors not included in discharge planning, or member compliance challenges with follow-up appointments or discharge instructions.

Recommendation: HSAG recommends that MER develop targeted interventions to help reduce unplanned acute readmissions for members. Any initiatives implemented should be monitored and expanded upon as contributing factors to rate performance are identified.

⁶⁶ National Committee for Quality Assurance. Childhood Immunization Status (CIS-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/childhood-immunization-status-cis-e/>. Accessed on: Apr 2, 2025.

⁶⁷ National Committee for Quality Assurance. Plan All-Cause Readmissions (PCR). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/plan-all-cause-readmissions-pcr/>. Accessed on: Apr 2, 2025.

Compliance Review

Performance Results

Table 3-78 presents the total number of criteria for each standard that received a score of *Met*, *Satisfied*, or *Not Met*. Table 3-78 also presents **MER**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. *NA* was used when MDHHS determined the review element was not applicable during the compliance review. For elements scored as *Not Met*, **MER** was subject to a corrective action review process outlined in Appendix A.

Table 3-78—Compliance Review Results for MER

Standard		Number of Scores				Compliance Scores	
		<i>Met</i>	<i>Satisfied</i> ¹	<i>Not Met</i>	<i>NA</i>	MER ²	Statewide ³
1	Administrative	5	0	0	0	100%	100%
2	Providers	23	0	1	0	96%	95.4%
3	Members	29	0	0	1	100%	98.9%
4	Quality	24	0	0	0	100%	100%
5	MIS/Financial	45	5	1	0	88%	94.6%
6	OIG/Program Integrity	7	0	3	0	70%	85.6%
Overall		133	5	5	1	93%	96.0%

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

¹ A score of *Satisfied* was only allowable for select elements under the MIS/Financial standard.

² MDHHS calculated the total compliance score for each standard by totaling the number of *Met* (i.e., 1 point) elements and the number of *Not Met* and *Satisfied* (i.e., 0 points) elements, then dividing the summed score by the total number of elements for that standard.

³ MDHHS calculated the statewide performance scores to the tenth decimal place; however, MHP performance scores were calculated using whole number percentages.

Additionally, to supplement the compliance review activity, MDHHS conducted staff interviews, referred to as focus studies, in the following three areas: CSHCS, Operations, and Quality. While the results of the focus studies are not incorporated into the scoring of the compliance review, **MER** met MDHHS' expectations for participation in the studies.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the compliance review 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: MER achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. [Quality]

Strength #2: MER achieved full compliance in the Members standard, demonstrating the MHP maintained sufficient policies and procedures to support its membership, which included, but was not limited to, access to service authorization processes; care coordination procedures; fair grievance and appeal systems; member information materials such as the handbook, newsletters, and website; and choice of PCPs. [Quality, Timeliness, and Access]

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

Weaknesses and Recommendations

Weakness #1: MER demonstrated moderate performance overall (i.e., 80 percent or higher but less than 90 percent) in the MIS/Financial standard and the MHP scored below the statewide average. The MHP received a *Not Met* score for element *November 5.14–Monthly Pharmacy Encounter Timeliness*, and a *Satisfied* score for elements *December 5.15–Monthly Encounter Record Acceptance Rate in CHAMPS*, *January 5.15–Monthly Encounter Record Acceptance Rate in CHAMPS*, *March 5.15–Quarterly Encounter Record Acceptance Rate in CHAMPS*, *April 5.15–Quarterly Encounter Record Acceptance Rate in CHAMPS*, and *July 5.15–Monthly Encounter Record Acceptance Rate in CHAMPS*. [Quality and Timeliness]

Why the weakness exists: Regarding element *November 5.14* findings, **MER** did not meet timeliness for pharmacy encounter reporting for the encounters paid in September 2023 and submitted in October 2023. Further, **MER** failed to acknowledge this in its compliance review documentation and failed to provide an explanation for missing the metric. Regarding element *December 5.15* findings, **MER** did not meet the minimum encounter acceptance rate on professional encounter invoice types for the month of October 2023. **MER** identified the edits that caused the encounters to reject, and additional corrections were put into place. Regarding element *January 5.15* findings, **MER** did not meet the minimum encounter acceptance rate on dental encounter invoice types for the month of November 2023. **MER** indicated that during November 2023, some older encounters were submitted that had not been submitted previously and many of these encounters were rejected. **MER** further indicated these encounters were corrected at the end of November 2023. Regarding element *March 5.15* findings, **MER** did not meet the minimum encounter acceptance rate on professional encounter invoice types for the month of January 2024. **MER** reported that duplicate encounter files were unintentionally submitted, causing the rejections. Regarding element *April 5.15* findings, MDHHS noted that its data warehouse did not properly load encounters from CHAMPS in February 2024, which affected **MER**'s dental acceptance rate. However, the vendor was working to correct the issue and **MER**'s acceptance rate would be recalculated when the data were restored.

Lastly, regarding element *July 5.15* findings, **MER** did not meet the minimum acceptance rate for dental encounters submitted in May 2024 due to inadvertently submitted test files, which caused an increase in rejections.

Recommendation: **MER** was required to submit a CAP to address element *November 5.14*, which was approved by MDHHS. **MER** was not required to submit a CAP for elements *December 5.15*, *January 5.15*, *March 5.15*, *April 5.15*, and *July 5.15* as MDHHS indicated **MER** identified the issues and provided acceptable responses/action plans as a result of the compliance review findings. As such, HSAG recommends that **MER** continue to implement action plans and monitoring processes to improve the accuracy of encounter data submissions and acceptance rates.

Weakness #2: **MER** demonstrated low performance overall (i.e., below 80 percent) in the OIG/Program Integrity standard and the MHP scored below the statewide average. The MHP received a *Not Met* score for elements *January 6.8–Encounter Adjustment*, *May 6.1–6.7–Quarterly PI Reports*, and *July 6.8–Encounter Adjustments*. [Quality]

Why the weakness exists: Regarding element *January 6.8* findings, **MER** did not meet the minimum match requirements for encounters. **MER** reported that eight medical encounters were inaccurately reported to MDHHS and transaction control number (TCN) inaccuracies were identified in six pharmacy encounters. **MER** also did not meet the minimum match requirements for encounters during the review of element *July 6.8* which was the result of internal data quality issues. Regarding element *May 6.1–6.7–Quarterly PI Reports* findings, multiple errors were identified in the reports, which were the result of human error; formatting errors; misclassification of fraud, waste, and abuse (FWA) referral source; and an overlap between the handoff from the **MER**'s special investigations unit (SIU) and dental vendor when referring the case, resulting in missing dates.

Recommendation: **MER** was required to submit a CAP to address elements *January 6.8*, *May 6.1–6.7*, and *July 6.8*, which was approved by MDHHS. As such, HSAG recommends that **MER** continue to implement action plans and monitoring processes to improve the accuracy of encounter data submissions and program integrity reports.

Network Adequacy Validation

Network Adequacy Analysis

Performance Results

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MHP’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each MHP according to Table 3-79.

Table 3-79—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	<i>High Confidence</i>
50.0% to 89.9%	<i>Moderate Confidence</i>
10.0% to 49.9%	<i>Low Confidence</i>
Less than 10% and/or any <i>Not Met</i> element has significant bias on the results	<i>No Confidence</i>

No indicators were identified as *Low Confidence* or *No Confidence* designations.

HSAG determined that **MER** met both the time and distance standards and the ratio standard requirements for 100 percent of its members across all indicators or submitted an exception to MDHHS. The exceptions indicated that **MER** was aware of a gap and while corrective steps were underway, the issue had not been fully resolved at the time of reporting. Adequacy was determined based on the MHP’s compliance with MDHHS’ time and distance and ratio standards, with an assessment conducted for each provider type according to county. Table 3-80 outlines the counties and provider specialties for which exceptions were submitted. Results are presented by provider specialty in Table 3-81.

Table 3-80—MER Submitted Exceptions

County Exception Submitted	Specialty Exception Submitted
Presque Isle	PCPs (Adult)
Presque Isle	PCPs (Pediatric)
Crawford	General Dentistry
Kalkaska	General Dentistry
Mason	General Dentistry
Missaukee	General Dentistry
Presque Isle	PCPs (Adult)

County Exception Submitted	Specialty Exception Submitted
Presque Isle	PCPs (Pediatric)
Berrien	Cardiology
Montmorency	Cardiology
Oscoda	Cardiology
Presque Isle	Cardiology
Berrien	General Dentistry
Crawford	General Dentistry
Kalkaska	General Dentistry
Mason	General Dentistry
Midland	General Dentistry
Missaukee	General Dentistry
Clinton	Hospital
Ingham	Hospital
Ionia	Hospital
St. Clair	Hospital
Berrien	OB/GYN
Montmorency	OB/GYN
Oscoda	OB/GYN
Berrien	Outpatient Behavioral Health
Alcona	Endodontist
Alpena	Endodontist
Antrim	Endodontist
Arenac	Endodontist
Bay	Endodontist
Berrien	Endodontist
Cass	Endodontist
Charlevoix	Endodontist
Cheboygan	Endodontist
Clinton	Endodontist
Crawford	Endodontist

County Exception Submitted	Specialty Exception Submitted
Eaton	Endodontist
Emmet	Endodontist
Genesee	Endodontist
Gladwin	Endodontist
Huron	Endodontist
Ingham	Endodontist
Ionia	Endodontist
Iosco	Endodontist
Jackson	Endodontist
Lapeer	Endodontist
Livingston	Endodontist
Macomb	Endodontist
Midland	Endodontist
Monroe	Endodontist
Montmorency	Endodontist
Oakland	Endodontist
Ogemaw	Endodontist
Oscoda	Endodontist
Otsego	Endodontist
Presque Isle	Endodontist
Saginaw	Endodontist
Sanilac	Endodontist
Shiawassee	Endodontist
St. Clair	Endodontist
Tuscola	Endodontist
Washtenaw	Endodontist
Wayne	Endodontist
Berrien	Oral Surgeon
Cass	Oral Surgeon
Muskegon	Oral Surgeon

County Exception Submitted	Specialty Exception Submitted
Allegan	Periodontist
Bay	Periodontist
Benzie	Periodontist
Berrien	Periodontist
Calhoun	Periodontist
Cass	Periodontist
Clinton	Periodontist
Eaton	Periodontist
Grand Traverse	Periodontist
Ingham	Periodontist
Ionia	Periodontist
Kalamazoo	Periodontist
Kent	Periodontist
Lake	Periodontist
Leelanau	Periodontist
Manistee	Periodontist
Mason	Periodontist
Mecosta	Periodontist
Midland	Periodontist
Muskegon	Periodontist
Newaygo	Periodontist
Oceana	Periodontist
Osceola	Periodontist
Ottawa	Periodontist
Saginaw	Periodontist
St. Clair	Periodontist
Van Buren	Periodontist
Wexford	Periodontist
Alcona	Prosthodontist
Allegan	Prosthodontist

County Exception Submitted	Specialty Exception Submitted
Alpena	Prosthodontist
Antrim	Prosthodontist
Arenac	Prosthodontist
Barry	Prosthodontist
Bay	Prosthodontist
Benzie	Prosthodontist
Berrien	Prosthodontist
Branch	Prosthodontist
Calhoun	Prosthodontist
Cass	Prosthodontist
Charlevoix	Prosthodontist
Cheboygan	Prosthodontist
Clare	Prosthodontist
Clinton	Prosthodontist
Crawford	Prosthodontist
Eaton	Prosthodontist
Emmet	Prosthodontist
Genesee	Prosthodontist
Gladwin	Prosthodontist
Grand Traverse	Prosthodontist
Gratiot	Prosthodontist
Hillsdale	Prosthodontist
Huron	Prosthodontist
Ingham	Prosthodontist
Ionia	Prosthodontist
Iosco	Prosthodontist
Jackson	Prosthodontist
Kalamazoo	Prosthodontist
Kalkaska	Prosthodontist
Kent	Prosthodontist

County Exception Submitted	Specialty Exception Submitted
Lake	Prosthodontist
Lapeer	Prosthodontist
Leelanau	Prosthodontist
Lenawee	Prosthodontist
Livingston	Prosthodontist
Manistee	Prosthodontist
Mason	Prosthodontist
Mecosta	Prosthodontist
Midland	Prosthodontist
Missaukee	Prosthodontist
Monroe	Prosthodontist
Montcalm	Prosthodontist
Muskegon	Prosthodontist
Newaygo	Prosthodontist
Oakland	Prosthodontist
Oceana	Prosthodontist
Ogemaw	Prosthodontist
Osceola	Prosthodontist
Oscoda	Prosthodontist
Ottawa	Prosthodontist
Presque Isle	Prosthodontist
Saginaw	Prosthodontist
Shiawassee	Prosthodontist
St. Clair	Prosthodontist
Van Buren	Prosthodontist
Washtenaw	Prosthodontist
Wexford	Prosthodontist

Table 3-81—MER Network Adequacy Compliance

Provider Specialty	Non-Rural Time and Distance	Rural Time and Distance	Non-Rural Ratio	Rural Ratio
PCPs (Adult)	Compliant	Compliant	Compliant	Compliant
PCPs (Pediatric)	Compliant	Compliant	Compliant	Compliant
OB/GYN	Compliant	Compliant	NA	NA
Cardiology	Compliant	Compliant	NA	NA
Outpatient Behavioral Health	Compliant	Compliant	NA	NA
Hospital	Compliant	Compliant	NA	NA
Pharmacy	Compliant	Compliant	NA	NA
General Dentistry	Compliant	Compliant	Compliant	Compliant
Endodontist	Compliant	Compliant	NA	NA
Oral Surgeon	Compliant	Compliant	NA	NA
Periodontist	Compliant	Compliant	NA	NA
Prosthodontist	Compliant	Compliant	NA	NA

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: MER demonstrated its capability of maintaining an adequate provider network to service its members that included comprehensive contracting, provider data maintenance, and reporting methods. **MER** addressed any gaps in its network by submitting exception requests to MDHHS and increasing contracting efforts to fill network gaps. **[Access]**

Weaknesses and Recommendations

Weakness #1: No specific opportunities were identified related to the data collection and management processes that **MER** had in place to inform network adequacy standard and indicator calculations.

Why the weakness exists: NA

Recommendation: NA

Network Validation Survey

Performance Results

HSAG’s reviewers evaluated 393 randomly sampled cases by comparing provider data submitted to HSAG by **MER** against **MER**’s online directory. The sample included 177 PCPs, 177 pediatric providers, and only 39 OB/GYN providers.⁶⁸ Overall, 13.7 percent of the sampled providers were located in the online directory at the sampled location, while 36.1 percent of the sampled providers located in the online directory were not at the sampled location. Additionally, 50.1 percent of the overall sampled providers could not be located in the online directory.

Table 3-82 summarizes the findings regarding the number of sampled providers and provider locations (i.e., “cases”) that HSAG’s reviewers located in the MHP’s online directory.

Table 3-82—Summary of Providers Present in Online Directory by Provider Category

Provider Category	Number of Sampled Providers	Providers Not Found in Directory		Providers Found in Directory—Not at Sampled Location		Providers Found in Directory—At Sampled Location	
		Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
PCPs	177	93	52.5%	64	36.2%	20	11.3%
Pediatric Providers	177	84	47.5%	65	36.7%	28	15.8%
OB/GYN Providers	39	20	51.3%	13	33.3%	6	15.4%
MER Total	393	197	50.1%	142	36.1%	54	13.7%

¹ The denominator includes the number of sampled providers.

Table 3-83 displays the total number and percentage of cases with matched data values for indicators that were reviewed between data values shown in **MER**’s provider data submission to HSAG and **MER**’s online directory. Cases with unmatched results may include incorrect information or information not listed in the directory (e.g., the provider data included a data value for a study indicator, but the online directory did not include a data value for the study indicator).

⁶⁸ A low number of OB/GYN providers was sampled due to the eligible population criteria (i.e., providers with the PCP indicator), which reduced the number of eligible OB/GYN providers. Caution should be exercised when interpreting OB/GYN results for **MER**.

Table 3-83—Provider Demographic Indicators Matching Online Directory

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		Overall	
	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
Provider Name	84	100%	93	100%	19	100%	196	100%
Provider Street Address	20	23.8%	28	30.1%	6	31.6%	54	27.6%
Provider Suite Number	67	79.8%	79	84.9%	12	63.2%	158	80.6%
Provider City	47	56.0%	42	45.2%	10	52.6%	99	50.5%
Provider State	81	96.4%	92	98.9%	18	94.7%	191	97.4%
Provider ZIP Code	40	47.6%	39	41.9%	7	36.8%	86	43.9%
Provider Telephone Number	37	44.0%	43	46.2%	6	31.6%	86	43.9%
Provider Type/Specialty	82	97.6%	89	95.7%	18	94.7%	189	96.4%
Provider Accepting New Patients	79	94.0%	90	96.8%	16	84.2%	185	94.4%
Provider Gender	84	100%	93	100%	19	100%	196	100%
Provider Primary Language ²	69	82.1%	76	81.7%	11	57.9%	156	79.6%
Non-English Language Speaking Provider (including American Sign Language) ²	84	100%	91	97.8%	18	94.7%	193	98.5%

¹ The denominator for each study indicator includes the number of cases in which the provider was found in the directory.

² The PDV review evaluated whether the indicator was present in the directory, but specific values were not validated.

For the secret shopper telephone survey, HSAG attempted to contact 50 sampled provider locations for **MER**, with an overall response rate of 90.0 percent. Table 3-84 summarizes the survey response rates (i.e., cases reached) for all MHPs and for **MER**, by provider category.

Table 3-84—Response Rates

Provider Category	Total Number of Cases ¹	Cases Reached	Response Rate
PCPs	19	18	94.7%
Pediatric Providers	26	24	92.3%
OB/GYN Providers	5	3	60.0%
MER Total	50	45	90.0%
All MHPs Total	2,633	1,775	67.4%

¹ Total number of cases includes cases that were found in the online directory and matched on eight key provider indicators (i.e., name, address, city, state, ZIP Code, telephone number, provider type/specialty, and new patient acceptance).

Table 3-85 summarizes the provider data validation and accuracy results for all MHPs and **MER**, by provider category.

Table 3-85—Provider Data Validation and Accuracy Results

Provider Category	Denom ¹	Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance		Accepting New Patients	
		Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
PCPs	18	14	77.8%	14	77.8%	14	77.8%	11	61.1%	11	61.1%
Pediatric Providers	24	19	79.2%	19	79.2%	18	75.0%	18	75.0%	17	70.8%
OB/GYN Providers	3	3	100%	3	100%	3	100%	1	33.3%	1	33.3%
MER Total	45	36	80.0%	36	80.0%	35	77.8%	30	66.7%	29	64.4%
All MHPs Total	1,775	1,280	72.1%	1,215	68.5%	1,082	61.0%	822	46.3%	731	41.2%

¹ The denominator includes cases reached.

Table 3-86 displays the number of survey respondents who offered appointments to new patients for routine PCP and prenatal care visits for all MHPs and **MER**, by provider category.

Table 3-86—Appointment Availability for Routine PCP and Prenatal Care Visits¹

Provider Category	Cases Reached	Cases Offered an Appointment	
		Count	Rate ²
PCPs	18	6	33.3%
Pediatric Providers	24	8	33.3%
OB/GYN Providers	3	1	33.3%
MER Total	45	15	33.3%
All MHPs Total	1,775	424	23.9%

¹ Appointment availability rates were calculated using cases accepting new patients and total survey cases as the denominator in the 2022 and 2023 reports. However, the denominator used in the 2024 report was cases reached. Caution should be exercised when comparing 2024 appointment availability rates with the rates in the 2022 and 2023 reports.

² The denominator includes cases reached.

Table 3-87 displays the new patient wait time results for all MHPs and **MER**, by provider category.

Table 3-87—Appointment Wait Time Results

Provider Category	Appointment Wait Time (Business Days)				Rate of Cases Within Standard ^{1,2}
	Min	Max	Average	Median	
PCPs	2	31	11	7	83.3%
Pediatric Providers	4	30	13	13	100%
OB/GYN Providers	3	3	3	3	100%
MER Total	2	31	11	8	93.3%
All MHPs Total	0	261	18	8	80.9%

¹ The denominator includes cases offered an appointment.

² Rate of cases within standard represents the percentage of cases that were offered an appointment that was compliant with the 30-business-day standard for routine appointments and seven-business-day standard for prenatal care appointments.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: The response rate for the secret shopper telephone survey was 90.0 percent. [**Access**]

Strength #2: Of the cases that offered an appointment, 93.3 percent were compliant with the appointment wait time standard. [**Timeliness**]

Weaknesses and Recommendations

Weakness #1: Reviewers located 49.8 percent of the sampled providers in **MER**'s online provider directory. Of the providers located in the online directory, six of the 12 indicators had match rates below 90.0 percent. [**Access**]

Why the weakness exists: While **MER** submitted provider data to HSAG, the providers listed in the data were not confirmed within **MER**'s online provider directory. The mismatch indicates inaccurate provider information within the provider data and/or online provider directory.

Recommendation: HSAG recommends that **MER** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., inaccurate and/or missing provider information) to address the provider data deficiencies.

Weakness #2: Of the cases reached, 80.0 percent confirmed the provider is affiliated at the confirmed sampled address, 77.8 percent confirmed the services were offered, 66.7 percent confirmed the requested insurance, and 64.4 percent confirmed new patient acceptance. [Quality and Access]

Why the weakness exists: MER's provider data included invalid provider, address, specialty, new patient acceptance, and insurance information.

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

Weakness #3: Among the responsive cases, only 33.3 percent of locations offered an appointment date, including 33.3 percent of PCPs, 33.3 percent of pediatric providers and 33.3 percent of OB/GYNs. [Access]

Why the weakness exists: For new MER members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included pre-registration as well as requiring additional personal information, a Medicaid ID, or an MRR.

Recommendation: HSAG recommends that MER work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that MER 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 MER procured medical records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*, to identify discrepancies and ensure alignment between the medical records and the encounter data submitted to MDHHS.

Table 3-88 outlines the key findings for MER based on the assessment of encounter data completeness and accuracy conducted through a review of members' medical records for services rendered from October 1, 2022, through September 30, 2023.

Table 3-88—Key Findings for MER

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	<ul style="list-style-type: none"> The medical record procurement rate was 92.2 percent, indicating that most of the requested records were procured and submitted. Of the medical records not submitted, nearly 70 percent were not submitted due to non-responsive providers or provider did not respond in a timely manner.
Second Date of Service Submission Rate	<ul style="list-style-type: none"> Among the procured medical records, 26.4 percent included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	<ul style="list-style-type: none"> All key data elements, except for <i>Date of Service</i>, had relatively high medical record omission rates, ranging from 6.9 percent (<i>Date of Service</i>) to 21.5 percent (<i>Procedure Code Modifier</i>). This suggests that the data elements in the encounter data were not adequately supported by the members' medical records. The high medical record omission rates for those data elements were partially influenced by medical record non-submission. In cases where no medical records were submitted for a requested case, all associated data elements were categorized as medical record omissions.
Encounter Data Omission Rate	<ul style="list-style-type: none"> All key data elements exhibited relatively low encounter data omission rates, with <i>Procedure Code</i> having the highest encounter data omission rate at 5.3 percent.
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Diagnosis Code</i> data element was accurate in 99.8 percent of instances where codes were present in both the medical records and encounter data, with all errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code</i> data element was accurate in 97.8 percent of instances where codes were present in both the medical records and encounter data, with all errors related to inaccurate coding.
Procedure Code Modifier Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code Modifier</i> data element was accurate in 99.7 percent of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	<ul style="list-style-type: none"> Dates of service with accurate values for all key data elements (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, and <i>Procedure Code Modifier</i>) were observed in 71.8 percent of the dates of service present in both data sources (i.e., encounter data and medical records).

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: A high percentage of *Date of Service* data element values in the encounter data were supported by the members' medical records, as evidenced by the low medical record omission rate of 6.9 percent. [Quality]

Strength #2: The *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data element values identified in the medical records were generally present in the encounter data, as evidenced by the low encounter data omission rates of 4.8 percent, 3.0 percent, 5.3 percent, and 0.0 percent, respectively. [Quality]

Strength #3: When key data elements were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate with rates of at least 97.8 percent each. [Quality]

Weaknesses and Recommendations

Weakness #1: MER was unable to procure all of the requested medical records from its contracted providers mostly due to providers being non-responsive or providers not responding in a timely manner. [Quality and Timeliness]

Why the weakness exists: The non-submission reason for non-responsive providers or providers who did not respond in a timely manner may indicate that the contracted providers were unaware of the submission requirements or the deadline.

Recommendation: MER should ensure its contracted providers' accountability in responding to medical record requests for the purposes of auditing, inspection, and oversight. HSAG recommends MER consider strengthening and/or enforcing its contract requirements with its providers in providing the requested documentation.

Weakness #2: More than 15.0 percent of the *Procedure Code* and more than 21.0 percent of the *Procedure Code Modifier* data element values identified in the encounter data were not supported by the members' medical records. [Quality]

Why the weakness exists: Non-submitted medical records contribute to medical record omissions, as the expected information within the medical records cannot be compared to the encounter data. Additional contributing factors include provider documentation practices (e.g., incomplete or inaccurate documentation, coding errors, lack of detail), data submission (e.g., incorrect coding during data submission or data entry errors), or processing issues (e.g., data mapping or translation issues, or errors in data transmission).

Recommendation: **MER** should investigate the root cause(s) for these omissions, with a focus on both provider documentation practices and data handling processes. Periodic MRRs of submitted claims should be conducted to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should be used to develop and provide ongoing education and training for providers. Topics should include encounter data submissions, medical record documentation requirements, and coding practices to reduce future omissions and improve data accuracy.

Consumer Assessment of Healthcare Providers and Systems Analysis

Adult and Child Medicaid

Performance Results

Table 3-89 presents **MER**'s 2023 and 2024 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2024 scores were statistically significantly higher or lower than the 2023 national average. Triangles (▲ or ▼) indicate 2024 scores were statistically significantly higher or lower than the 2023 scores.

Table 3-89—Summary of Adult and Child Medicaid CAHPS Top-Box Scores for MER

	2023 Adult Medicaid	2024 Adult Medicaid	2023 Child Medicaid	2024 Child Medicaid
Global Ratings				
<i>Rating of Health Plan</i>	63.76%	60.10%	70.29%	69.01%
<i>Rating of All Health Care</i>	56.58%	49.62%	68.64%	59.87% ↓
<i>Rating of Personal Doctor</i>	65.22%	70.22%	73.58%	72.34%
<i>Rating of Specialist Seen Most Often</i>	64.65% ⁺	63.44% ⁺	75.76% ⁺	80.00% ⁺
Composite Measures				
<i>Getting Needed Care</i>	81.81%	77.97%	87.24%	82.50%
<i>Getting Care Quickly</i>	82.68%	81.67%	89.03%	89.74% ⁺
<i>How Well Doctors Communicate</i>	91.44%	95.35% ↑	95.61%	93.98%
<i>Customer Service</i>	90.55% ⁺	85.22% ⁺	96.14% ⁺	79.92% ⁺ ▼
Individual Item Measure				
<i>Coordination of Care</i>	87.37% ⁺	80.00% ⁺	94.19% ⁺	87.32% ⁺
Medical Assistance With Smoking and Tobacco Use Cessation Items*				
<i>Advising Smokers and Tobacco Users to Quit</i>	78.13%	80.45% ↑	—	—

	2023 Adult Medicaid	2024 Adult Medicaid	2023 Child Medicaid	2024 Child Medicaid
<i>Discussing Cessation Medications</i>	55.20%	60.77% ↑	—	—
<i>Discussing Cessation Strategies</i>	50.39%	54.96% ↑	—	—

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

* These rates follow NCQA's methodology of calculating a rolling two-year average.

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.

▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.

No triangles (▲ or ▼) indicate the 2024 score was not statistically significantly higher or lower than the 2023 score.

↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.

↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.

No arrows (↑ or ↓) indicate the 2024 score was not statistically significantly higher or lower than the 2023 national average.

— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the CAHPS 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: MER's 2024 top-box scores were statistically significantly higher than the 2023 NCQA adult Medicaid national averages for four measures: *How Well Doctors Communicate* and all three of the medical assistance with smoking and tobacco use cessation items. [Quality]

Weaknesses and Recommendations

Weakness #1: MER's 2024 top-box score was statistically significantly lower than the 2023 NCQA child Medicaid national average for one measure, *Rating of All Health Care*. [Quality]

Why the weakness exists: When compared to national benchmarks, parents/caretakers of child members enrolled in MER had less positive overall experiences with their child's healthcare.

Recommendation: HSAG recommends that MER conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of care and services they received to determine what could be driving the lower score for *Rating of All Health Care* compared to the national average and implement appropriate interventions to improve the performance related to the care members need.

Weakness #2: MER's 2024 top-box score was statistically significantly lower than the 2023 child Medicaid top-box score for one measure, *Customer Service*. [Quality]

Why the weakness exists: When compared to national benchmarks and the previous year's top-box score, members enrolled in MER may not be receiving the information or help needed or may be dissatisfied with the level of courtesy and respect offered by their child's customer service.

However, HSAG is unable to identify the MHP-specific barriers or other factors impacting drivers for this measure based on the information provided through this EQR.

Recommendation: HSAG recommends that **MER** assess the performance of customer service representatives (i.e., call satisfaction, call resolution, time on hold, etc.) by periodically auditing calls, providing subsequent feedback, rewarding excellent performance, and provide ongoing customer service representative service training, as applicable.

CSHCS

Performance Results

Table 3-90 presents **MER**'s 2023 and 2024 CSHCS CAHPS top-box scores. Upward green or downward red arrows (↑ or ↓) indicate 2024 scores were statistically significantly higher or lower than the 2023 national average. Upward green or downward red triangles (▲ or ▼) indicate 2024 scores were statistically significantly higher or lower than the 2023 scores.

Table 3-90—Summary of CSHCS CAHPS Survey Top-Box Scores for MER

	2023 Top-Box Score	2024 Top-Box Score
Global Ratings		
<i>Rating of Health Plan</i>	63.98%	65.69%
<i>Rating of Health Care</i>	68.69%	68.06% NA
<i>Rating of Specialist Seen Most Often</i>	75.54%	66.96% ▼
Composite Measures		
<i>Customer Service</i>	83.12% ⁺	87.01% ⁺
<i>How Well Doctors Communicate</i>	93.08%	93.18% NA
<i>Access to Specialized Services</i>	64.39% ⁺	61.98% ⁺ NA
<i>Transportation</i>	54.66% ⁺	60.54% ⁺ NA
Individual Item Measures		
<i>Access to Prescription Medicines</i>	86.92%	87.76%
<i>Not Felt Treated Unfairly: Race and Ethnicity</i>	96.98%	96.02% NA
<i>Not Felt Treated Unfairly: Health Insurance Type</i>	92.78%	93.25% NA

⁺ Indicates fewer than 100 respondents. Caution should be exercised when evaluating the results.

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.

▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.

No triangle (▲ or ▼) indicates the 2024 score was not statistically significantly higher or lower than the 2023 score.

↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.

↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.

No arrow (↑ or ↓) indicates the 2024 score was not statistically significantly higher or lower than the 2023 national average.

NA Indicates a national average is not available for the measure.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the CAHPS 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: MER's 2024 top-box scores were not statistically significantly higher than the 2023 NCQA child Medicaid national averages or the 2023 top-box scores for any reportable measure; therefore, no strengths were identified.

Weaknesses and Recommendations

Weakness #1: MER's 2024 top-box score was statistically significantly lower than the 2023 top-box score for one measure, *Rating of Specialist Seen Most Often*. [Quality]

Why the weakness exists: When compared to 2023 top-box scores, the results indicate that parents/caretakers of child members enrolled in MER are reporting negative experiences with their child's most seen specialist.

Recommendation: HSAG recommends that MER explore drivers of this lower experience score and develop initiatives designed to improve parent/caregivers of child members perception of specialists.

Quality Rating

The 2024 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2024 Michigan Consumer Guide, which is inclusive of MER's performance.

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

HSAG performed a comprehensive assessment of MER's aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within MER that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how MER's overall performance contributed to the CHCP's progress in achieving the CQS goals and objectives. Table 3-91 displays each MDHHS CQS goal and the EQR activity results that indicate whether the MHP positively (✓), negatively (✗), or minimally (m) impacted the CHCP's progress toward achieving the applicable goals and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to MER's Medicaid members. Not applicable (NA) was used when EQR activities do not produce data to assess the impact of a quality measure(s) under an objective.

Table 3-91—Overall Performance Impact to CQS and Quality, Timeliness, and Access

Objective	Program	Quality Measure	Overall Performance Impact	Performance Domain
Goal #1: Ensure high quality and high levels of access to care				
1.1	CHCP	Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	✓	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	CHCP	Prenatal and Postpartum Care—Postpartum Care	m	
	CHCP	Childhood Immunization Status—Combination 3	✗	
	CSHCS	Global Rating of Health Plan	m	
	CSHCS	Global Rating of Specialist Seen Most Often	✗	
	CSHCS	Global Rating of Health Care	✗	
	CSHCS	Composite Measure for Access to Specialized Services	✗	
	CSHCS	Composite Measure for Transportation	m	
1.2	CHCP	Asthma Medication Ratio—Total	m	
	CHCP	Controlling High Blood Pressure	✗	
	CHCP	Comprehensive Diabetes Care (CDC)—Eye Exams ¹	✓	
	CSHCS	Composite Measure for How Well Doctors Communicate	m	
	CSHCS	Composite Measure for Customer Service	m	
1.3	CHCP	Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	NA	
	CHCP	Getting Care Quickly Composite (Adult CAHPS)	✗	
	CSHCS	Global Rating of Health Care	✗	
	CSHCS	Composite Measure for Access to Specialized Services	✗	
	CSHCS	Access to Prescription Medicines	m	
Goal #2: Strengthen person and family-centered approaches				
2.1	CHCP	Rating of Health Plan ²	✗	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	CHCP	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years Old	✗	
	CHCP	Access to Dental Care	✗	
	CHCP	Completion of Annual Health Risk Assessment	NA	
	CSHCS	Composite Measure for How Well Doctors Communicate	m	
	CSHCS	Global Rating of Health Plan	m	
	CSHCS	Global Rating of Health Care	✗	
	CSHCS	Global Rating of Specialist Seen Most Often	✗	

Objective	Program	Quality Measure	Overall Performance Impact	Performance Domain
2.2	CHCP	SDOH: Total Member Screening Rate	NA	
	CHCP	SDOH: Total Member Referral Rate	NA	
	CHCP	Social Need Screening and Intervention	NA	
	CSHCS	Composite Measure for Access to Specialized Services	✗	
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)				
3.1	CHCP	Follow-Up After Hospitalization for Mental Illness Within 30 Days (FUH) (Adults)	NA	☑ Quality ☑ Timeliness ☑ Access
	CSHCS	Coordination of Care	NA	
3.2	CHCP	Implementation of Joint Care Management Processes	NA	
	CSHCS	Global Rating of Health Plan	m	
	CSHCS	Global Rating of Health Care	✗	
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes				
4.1	CHCP	Chlamydia Screening in Women—Total ³	NA	☑ Quality ☑ Timeliness ☑ Access
	CHCP	Prenatal and Postpartum Care—Postpartum Care ³	NA	
	CHCP	Children Immunization Combo 3 ³	NA	
	CHCP	Lead Screening in Children ³	NA	
	CHCP	Comprehensive Diabetes Care—Eye Exam ³	NA	
	CHCP	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years Old ³	NA	
	CSHCS	Not Felt Treated Unfairly: Race and Ethnicity	✗	
Goal #5: Improve quality outcomes through value-based initiatives and payment reform				
5.1	CHCP	Average Percentage of Plan Payments to Providers Who Are in APM Arrangements ("Big Numerator")	NA	☑ Quality ☐ Timeliness ☐ Access
	CHCP	Average Percentage of Plan Payments to Providers That Are Tied to Quality ("Small Numerator")	NA	

✓ = The MHP's rate met the 2026 statewide performance target; or the MHP's rate did not meet the 2026 statewide performance target but demonstrated a statistically significant increase in performance from the prior year.

m = The MHP's rate did not meet the 2026 statewide performance target and while the MHP's rate increased in performance from the prior year, the increase was not statistically significant.

x = The MHP's rate did not meet the 2026 statewide performance target and/or the MHP's rate decreased in performance from the prior year.

NA = EQR activities published in this report do not produce data to assess the impact of a quality measure(s) under an objective.

¹ NCQA replaced the *Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed* performance measure with the *Eye Exam for Patients With Diabetes (EED)* performance measure, the overall performance impact was based on the MHP's reported rate for *Eye Exam for Patients With Diabetes (EED)*.

² As the CQS did not identify whether this quality measure applies to the adult or child CAHPS, HSAG assessed performance using the adult rate.

³ While there are reported HEDIS rates that are stratified by race/ethnicity, the EQR deliverables did not include an analysis of these data.

Molina Healthcare of Michigan

Validation of Performance Improvement Projects

Performance Results

HSAG’s validation evaluated the technical methods of **MOL**’s PIP (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-92 displays the overall validation rating, the baseline rate, Remeasurement 1, and Remeasurement 2 results for the performance indicators, and if a disparity existed within the most recent measurement period.

Table 3-92—Overall Validation Rating for MOL

PIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
Addressing Disparities for Timeliness of Prenatal Care	High Confidence	No Confidence	1. Timeliness of Prenatal Care—Black	66.2%	68.4% ⇌	68.0% ⇌	Yes
			2. Timeliness of Prenatal Care—White	71.1%	71.0% ⇌	72.5% ⇌	

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).

The goals for **MOL**’s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black women) will demonstrate a statistically significant increase over the baseline rate without a decline in performance for the comparison subgroup (White women). Table 3-93 displays the barriers identified through QI and causal/barrier analysis processes and the interventions initiated by the MHP to support achievement of the PIP goals and address the barriers.

Table 3-93—Remeasurement 2 Barriers and Interventions for MOL

Barriers	Interventions
Using monthly claim reports to identify pregnant members delays outreach and providing the program information to members.	To increase the number of Black members identified at the earliest point in their pregnancies, MOL utilizes a vendor, Lucina, which employs a pregnancy-specific algorithm daily to all submitted claims. The reports are available on demand and allow for timely outreach, ensuring members are connected with pregnancy care and resources earlier in the pregnancy.
Members delay the initiation of prenatal care.	Members are offered a \$100 gift card incentive for completion of a prenatal visit within the first trimester of their pregnancy or within 42 days of health plan enrollment.
	Members of childbearing age are emailed information regarding the importance of prenatal care, services to support a healthy pregnancy, and who to contact for additional information.
Many Black pregnant members do not engage with doulas.	The MHP partnered with Mae, a culturally competent, Black owned doula organization to support Black pregnant members in the MHPs service area to improve successful prenatal and postpartum pregnancy management. Mae’s contracted doulas and lactation consulting network support pregnant Black members in the lower peninsula.
Many pregnant Medicaid members do not engage with an OB/GYN in the 1st trimester.	The MHP partnered with Ouma Health and collaboratively outreaches to pregnant members to provide access to early prenatal care through Ouma’s platform. Ouma’s “Total Maternal Telehealth” solution assists with outreach and early prenatal visits to members in 1st trimester and have not had a prenatal visit.
Some members have health-related social needs related to food security.	The MHP partnered with Instacart to develop an innovative home-delivered meals/nutrition supports initiative targeting prenatal/postpartum members with food insecurity throughout the MHPs service area.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PIP 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: MOL initiated timely interventions that were reasonably linked to their corresponding barriers. The interventions were evaluated to determine the effectiveness of each effort, with decisions to continue, discontinue, or revise an effort being data driven. [Quality, Timeliness, and Access]

Weaknesses and Recommendations

Weakness #1: MOL did not achieve the state-defined goal of eliminating the existing disparity with the second remeasurement period [Quality, Timeliness, and Access]

Why the weakness exists: While it is unclear why the goal was not achieved, **MOL** has made progress in improving performance for both populations as compared to the baseline.

Recommendation: HSAG recommends that **MOL** continue testing or implement intervention strategies that have demonstrated improvement on the performance indicator. The MHP should revisit its causal/barrier analysis to ensure appropriate identification of barriers or the need to develop new or modified intervention strategies.

Performance Measure Validation

Performance Results

MOL was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2023 Compliance Audit Report findings, **MOL** was fully compliant with all four IS standards.

According to the auditor's review, **MOL** followed the NCQA HEDIS MY 2023 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-94 displays the MDHHS-selected performance measures, HEDIS MY 2022 and MY 2023 rates, MY 2022 and MY 2023 comparisons, and MY 2023 performance levels based on comparisons to

national percentiles⁶⁹ for **MOL**. Additional performance measures and performance measure results for **MOL** can be referenced in Appendix B.

Table 3-94—HEDIS MY 2023 Performance Measure Results for MOL

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
Child & Adolescent Care				
<i>Childhood Immunization Status (CIS)</i>				
<i>Combination 3</i>	57.18%	56.93%	-0.24	★
<i>Combination 7</i>	48.91%	48.18%	-0.73	★
<i>Combination 10</i>	23.84%	22.63%	-1.22	★
<i>Well-Child Visits in the First 30 Months of Life (W30)</i>				
<i>Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	60.34%	61.48%	+1.14	★★★★
<i>Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i>	62.30%	65.58%	+3.27+	★★
<i>Lead Screening in Children (LSC)</i>				
<i>Lead Screening in Children</i>	57.66%	59.85%	+2.19	★★
<i>Child and Adolescent Well-Care Visits (WCV)</i>				
<i>Ages 3 to 11 Years</i>	59.81%	62.17%	+2.36+	★★★★
<i>Ages 12 to 17 Years</i>	52.58%	54.18%	+1.60+	★★★★
<i>Ages 18 to 21 Years</i>	30.90%	33.12%	+2.22+	★★★★★
<i>Total</i>	52.05%	54.51%	+2.46+	★★★★
<i>Immunizations for Adolescents (IMA)</i>				
<i>Combination 1 (Meningococcal, Tdap)</i>	77.09%	82.00%	+4.91+	★★★★
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	29.88%	36.25%	+6.37+	★★★★
Women—Adult Care				
<i>Chlamydia Screening in Women (CHL)</i>³				
<i>Ages 16 to 20 Years</i>	62.27%	62.80%	+0.53	★★★★★
<i>Ages 21 to 24 Years</i>	67.89%	68.74%	+0.85	★★★★★
<i>Total</i>	64.89%	65.51%	+0.62	★★★★★

⁶⁹ HEDIS MY 2023 performance measure rates are compared to NCQA’s Quality Compass National Medicaid Health Maintenance Organization (HMO) percentiles for HEDIS MY 2022 (referred to as “percentiles” throughout this section of the report).

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
Cervical Cancer Screening (CCS-E)				
Cervical Cancer Screening	59.37%	55.92%	-3.45	★★
Breast Cancer Screening (BCS-E)				
Breast Cancer Screening	53.34%	55.49%	+2.16+	★★★
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Ages 20 to 44 Years	74.44%	75.08%	+0.63+	★★★★★
Ages 45 to 64 Years	84.26%	84.44%	+0.18	★★★★★
Ages 65 Years and Older	91.93%	91.83%	-0.10	★★★★★
Total	78.22%	78.76%	+0.54+	★★★★★
Pregnancy Care				
Prenatal and Postpartum Care (PPC)³				
Timeliness of Prenatal Care	81.02%	84.50%	+3.48	★★★
Postpartum Care	71.53%	73.39%	+1.86	★
Living With Illness				
Hemoglobin A1c Control for Patients With Diabetes (HBD)				
HbA1c Control (<8.0%)	50.61%	56.93%	+6.33	★★★
Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*	41.85%	37.47%	-4.38	★★★
Blood Pressure Control for Patients With Diabetes (BPD)				
Blood Pressure Control for Patients With Diabetes	67.64%	69.59%	+1.95	★★★
Eye Exam for Patients With Diabetes (EED)³				
Eye Exam for Patients With Diabetes	53.53%	53.53%	0.00	★★★
Kidney Health Evaluation for Patients With Diabetes (KED)				
Ages 18 to 64 Years	28.90%	36.57%	+7.67+	★★★
Ages 65 to 74 Years	31.82%	35.76%	+3.93+	★★
Ages 75 to 85 Years	26.87%	34.21%	+7.34+	★★
Total	29.07%	36.46%	+7.39+	★★★
Asthma Medication Ratio (AMR)				
Total	55.51%	57.57%	+2.05+	★

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
Controlling High Blood Pressure (CBP)				
<i>Controlling High Blood Pressure</i>	63.26%	61.72%	-1.54	★★★
Diagnosed Mental Health Disorders (DMH)				
<i>Ages 1 to 17 Years</i>	17.10%	18.19%	+1.09+	★★
<i>Ages 18 to 64 Years</i>	29.65%	30.92%	+1.27+	★★★
<i>Ages 65 Years and Older</i>	38.02%	37.71%	-0.31	★★★
<i>Total</i>	24.65%	25.77%	+1.12+	★★
Utilization				
Plan All-Cause Readmissions (PCR)				
<i>Observed Readmissions—Total</i>	8.82%	8.38%	-0.44	NC
<i>Expected Readmissions—Total</i>	9.65%	9.67%	+0.02	NC
<i>O/E Ratio—Total</i>	0.9145	0.8666	-0.05	★★★★★

¹ HEDIS MY 2022 to HEDIS MY 2023 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2022–MY 2023 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2022–MY 2023 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

² Performance Levels for MY 2023 were based on comparisons of the HEDIS MY 2023 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2022 benchmark

³ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

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

Please note that for the *Diagnosed Mental Health Disorders (DMH)* measure, a higher or lower rate does not indicate better performance, as the measure provides information on the diagnosed prevalence of mental health disorders. Therefore, this measure is not included in the evaluation of strengths and weaknesses below.

Green Shading⁺ Indicates that the HEDIS MY 2023 rate demonstrated a significant improvement from the HEDIS MY 2022 rate.

Red Shading⁺⁺ Indicates that the HEDIS MY 2023 rate demonstrated a significant decline from the HEDIS MY 2022 rate.

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

HEDIS MY 2023 Performance Levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PMV 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: MOL's performance ranked between the 75th and 89th percentiles for the *Child and Adolescent Well-Care Visits (WCV)—Ages 18 to 21 Years* measure indicator and demonstrated significant improvement from MY 2022 to MY 2023, indicating members between the ages of 18 and 21 years received one or more well-care visits with a PCP or OB/GYN practitioner during the measurement year most of the time. More frequent well-child visits in the first years of life and one or more well-child visits from ages 3–21 are recommended. Well-child visits should include, but are not limited to, an initial/interval medical history, physical exam, developmental assessment, immunization, and anticipatory guidance.⁷⁰ [Quality, Timeliness, and Access]

Strength #2: MOL's performance ranked between the 75th and 89th percentiles for the *Chlamydia Screening in Women (CHL)—Ages 16 to 20 Years, Ages 21 to 24 Years, and Total* measure indicators, indicating women 16 to 24 years of age identified as sexually active had at least one test for chlamydia during the measurement year most of the time. Untreated chlamydia infections can lead to serious and irreversible complications. Screening is important, as approximately 75 percent of chlamydia infections in women are asymptomatic and 95 percent of infections in men are asymptomatic. This results in delayed medical care and treatment.⁷¹ [Quality]

Strength #3: MOL's performance ranked between the 75th and 89th percentiles for the *Adults' Access to Preventive/Ambulatory Health Services (AAP)—Ages 20 to 44 Years, Ages 45 to 64 Years, Ages 65 Years and Older, and Total* measure indicators, indicating that members ages 20 years and older had an ambulatory or preventive care visit most of the time. Healthcare visits are an opportunity for individuals to receive preventive services and counseling on topics such as diet and exercise. These visits also can help them to address acute issues or manage chronic conditions.⁷² [Quality and Access]

Strength #4: MOL's performance ranked between the 75th and 89th percentiles for the *Plan All-Cause Readmissions (PCR)—O/E Ratio—Total* measure indicator, indicating that there were less

⁷⁰ National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (WCV). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/child-and-adolescent-well-care-visits-wcv/>. Accessed on: Apr 2, 2025.

⁷¹ National Committee for Quality Assurance. Chlamydia Screening in Women (CHL). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/chlamydia-screening-chl/>. Accessed on: Apr 1, 2025.

⁷² National Committee for Quality Assurance. Adults' Access to Preventive/Ambulatory Health Services (AAP). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/adults-access-to-preventive-ambulatory-health-services-aap/>. Accessed on: Apr 1, 2025.

unplanned acute readmissions within 30 days after discharge than expected for members 18 to 64 years of age. A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination. Unplanned readmissions are associated with increased mortality and higher healthcare costs. Unplanned readmissions can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management.⁷³ [Quality, Timeliness, and Access]

Strength #5: MOL demonstrated overall strength in its HEDIS data reporting, as **MOL** was fully compliant with all four IS standards and all performance measure rates were determined to be *Reportable*. [Quality]

Weaknesses and Recommendations

Weakness #1: MOL's performance for the *Childhood Immunization Status (CIS)*—*Combination 3*, *Combination 7*, and *Combination 10* measure indicators ranked below the 25th percentile, indicating that children 2 years of age were not receiving some vaccinations by their second birthday. Childhood immunizations help prevent serious illnesses such as polio, tetanus, and hepatitis. Vaccines are a proven way to help a child stay healthy and avoid the potentially harmful effects of childhood diseases like mumps and measles.⁷⁴ [Quality and Timeliness]

Why the weakness exists: The rates for the *Childhood Immunization Status (CIS)*—*Combination 3*, *Combination 7*, and *Combination 10* measure indicators ranked below the 25th percentile, suggesting barriers exist for children 2 years of age to receive some vaccinations by their second birthday. Potential barriers to improved measure performance may include, but are not limited to, provider challenges with vaccination storage protocols, providers obtaining necessary vaccination certifications, provider cost deterrents related to the short shelf life for vaccines/maintaining inventory, and parental vaccination hesitancy.

Recommendation: HSAG recommends that **MOL** develop targeted interventions to improve performance for the *Childhood Immunization Status (CIS)* measure. Initiatives should be monitored and expanded upon as contributing factors to rate performance are identified. **MOL** could consider exploring avenues to increase awareness of vaccination importance among parents to reduce vaccination hesitancy such as a “speculation versus fact” pamphlet which includes a phone number for care management support. **MOL** could also consider issuing provider incentives for maintaining complete inventory of vaccinations.

Weakness #2: MOL's performance for the *Prenatal and Postpartum Care (PPC)*—*Postpartum Care* measure indicator ranked below the 25th percentile, indicating that pregnant women were not always having a postpartum visit on or between 7 and 84 days after delivery during the measurement

⁷³ National Committee for Quality Assurance. Plan All-Cause Readmissions (PCR). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/plan-all-cause-readmissions-PCR/>. Accessed on: Apr 2, 2025.

⁷⁴ National Committee for Quality Assurance. Childhood Immunization Status (CIS-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/childhood-immunization-status-cis-e/>. Accessed on: Apr 2, 2025.

year. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.⁷⁵ [Quality, Timeliness, and Access]

Why the weakness exists: The rate for the *Prenatal and Postpartum Care (PPC)—Postpartum Care* measure indicator ranked below the 25th percentile, suggesting that barriers exist for some pregnant women to have timely postpartum visits. A barrier noted by **MOL** included having the incorrect contact information for members, and therefore not being able to easily engage pregnant members.

Recommendation: While **MOL** noted interventions currently in place to target improvement such as partnering with Instacart to provide home-delivered meals/nutrition support to prenatal and postpartum members, measure performance for *Prenatal and Postpartum Care (PPC)—Postpartum Care* remained low. Therefore, HSAG recommends that **MOL** continue its efforts to improve performance for the *Prenatal and Postpartum Care (PPC)* measure. Initiatives should continue to be monitored and expanded upon as additional contributing factors are identified. **MOL** could consider creating member incentives to promote increased prenatal and postpartum engagement, such a baby registry for pre-approved baby items and supplies.

Weakness #3: **MOL**'s performance for the *Asthma Medication Ratio (AMR)* measure ranked below the 25th percentile, indicating that some members 5–64 years of age, who were identified as having persistent asthma, did not have a ratio of controller medication to total asthma medication of 0.50 or greater during the measurement year. Appropriate medication management for patients with asthma could reduce the need for rescue medication, the costs associated with ED visits, inpatient admissions, and missed days of work or school.⁷⁶ [Quality]

Why the weakness exists: While the rate for the *Asthma Medication Ratio (AMR)* measure demonstrated significant improvement from MY 2022 to MY 2023, the rate ranked below the 25th percentile. Potential barriers to improved rate performance may include, but are not limited to, utilization of ED services for management of asthma symptoms, and underutilization of primary care services for treatment and management of asthma.

Recommendation: HSAG recommends that **MOL** develop targeted interventions to improve performance for the *Asthma Medication Ratio (AMR)* measure. Initiatives should be monitored and expanded upon as contributing factors to rate performance are identified. **MOL** could consider providing education to members on proper medication management in order to avoid ED visits.

⁷⁵ National Committee for Quality Assurance. Prenatal and Postpartum Care (PPC). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/prenatal-and-postpartum-care-ppc/>. Accessed on: Apr 2, 2025.

⁷⁶ National Committee for Quality Assurance. Asthma Medication Ratio (AMR). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/asthma-medication-ratio-amr/>. Accessed on: Apr 2, 2025.

Compliance Review

Performance Results

Table 3-95 presents the total number of criteria for each standard that received a score of *Met*, *Satisfied*, or *Not Met*. Table 3-95 also presents **MOL**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. *NA* was used when MDHHS determined the review element was not applicable during the compliance review. For elements scored as *Not Met*, **MOL** was subject to a corrective action review process outlined in Appendix A.

Table 3-95—Compliance Review Results for Mol

Standard		Number of Scores				Compliance Scores	
		<i>Met</i>	<i>Satisfied</i> ¹	<i>Not Met</i>	<i>NA</i>	MOL ²	Statewide ³
1	Administrative	5	0	0	0	100%	100%
2	Providers	23	0	1	0	96%	95.4%
3	Members	28	0	1	1	97%	98.9%
4	Quality	24	0	0	0	100%	100%
5	MIS/Financial	51	0	0	0	100%	94.6%
6	OIG/Program Integrity	9	0	1	0	90%	85.6%
Overall		140	0	2	1	98%	96.0%

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

¹ A score of *Satisfied* was only allowable for select elements under the MIS/Financial standard.

² MDHHS calculated the total compliance score for each standard by totaling the number of *Met* (i.e., 1 point) elements and the number of *Not Met* and *Satisfied* (i.e., 0 points) elements, then dividing the summed score by the total number of elements for that standard.

³ MDHHS calculated the statewide performance scores to the tenth decimal place; however, MHP performance scores were calculated using whole number percentages.

Additionally, to supplement the compliance review activity, MDHHS conducted staff interviews, referred to as focus studies, in the following three areas: CSHCS, Operations, and Quality. While the results of the focus studies are not incorporated into the scoring of the compliance review, **MOL** met MDHHS' expectations for participation in the studies.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the compliance review 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: MOL achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. [Quality]

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

Strength #3: MOL achieved full compliance in the MIS/Financial standard, demonstrating the MHP maintained a health information system that collected, analyzed, integrated, and reported data in various program areas and functions, including, but not limited to, provider data; financial statements and reports; third-party recovery and subrogation requests; claims and encounter data process; provider data; and a physician incentive program. [Quality]

Weaknesses and Recommendations

Weakness #1: While **MOL** demonstrated high performance overall (i.e., 90 percent or higher but less than 100 percent) in the Members standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for element *November 3.6-A – Member Appeals*. [Timeliness and Access]

Why the weakness exists: **MOL** did not submit any grievances on the grievance and appeal log for the period of October 2022 to September 2023. **MOL** reported that it received a new reporting log on November 2, 2023, and when the data were transferred from the original log to the new log, grievances were inadvertently left off.

Recommendation: **MOL** was required to submit a CAP to address element *November 3.6-A*, which was approved by MDHHS. As such, HSAG recommends that **MOL** continue to implement action plans and monitoring processes to ensure grievance data are reported timely to MDHHS.

Network Adequacy Validation

Network Adequacy Analysis

Performance Results

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MHP's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each MHP according to Table 3-96.

Table 3-96—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	<i>High Confidence</i>
50.0% to 89.9%	<i>Moderate Confidence</i>
10.0% to 49.9%	<i>Low Confidence</i>
Less than 10% and/or any <i>Not Met</i> element has significant bias on the results	<i>No Confidence</i>

No indicators were identified as *Low Confidence* or *No Confidence* designations.

HSAG determined that **MOL** met both the time and distance standards and the ratio standard requirements for 100 percent of its members across all indicators or submitted an exception to MDHHS. The exceptions indicated that **MOL** was aware of a gap and while corrective steps were underway, the issue had not been fully resolved at the time of reporting. Adequacy was determined based on the MHP's compliance with MDHHS' time and distance and ratio standards, with an assessment conducted for each provider type according to county. Table 3-97 outlines the counties and provider specialties for which exceptions were submitted. Results are presented by provider specialty in Table 3-98.

Table 3-97—MOL Submitted Exceptions

County Exception Submitted	Specialty Exception Submitted
Alcona	Endodontist
Alpena	Endodontist
Alpena	Prosthodontist
Antrim	Endodontist
Antrim	Prosthodontist
Barry	Periodontist
Bay	Endodontist

County Exception Submitted	Specialty Exception Submitted
Bay	Periodontist
Benzie	Periodontist
Benzie	Prosthodontist
Berrien	PCPs (Adult)
Berrien	Cardiology
Berrien	General Dentistry
Berrien	PCPs (Pediatric)
Berrien	OB/GYN
Berrien	Outpatient Behavioral Health
Berrien	General Dentistry
Berrien	Endodontist
Berrien	Periodontist
Berrien	Prosthodontist
Calhoun	Periodontist
Cass	OB/GYN
Cass	Endodontist
Cass	Periodontist
Charlevoix	Endodontist
Charlevoix	Prosthodontist
Cheboygan	OB/GYN
Cheboygan	Endodontist
Cheboygan	Prosthodontist
Clinton	Cardiology
Clinton	Endodontist
Crawford	General Dentistry
Crawford	Endodontist
Crawford	Prosthodontist
Emmet	Endodontist
Emmet	Prosthodontist
Grand Traverse	Periodontist

County Exception Submitted	Specialty Exception Submitted
Grand Traverse	Prosthodontist
Ingham	Endodontist
Iosco	Endodontist
Kalamazoo	Periodontist
Kalkaska	General Dentistry
Kalkaska	Prosthodontist
Kent	Periodontist
Leelanau	Periodontist
Leelanau	Prosthodontist
Mason	General Dentistry
Midland	Endodontist
Midland	Periodontist
Missaukee	General Dentistry
Montcalm	Endodontist
Montcalm	Periodontist
Montcalm	Prosthodontist
Montmorency	Endodontist
Montmorency	Prosthodontist
Muskegon	Prosthodontist
Ogemaw	Endodontist
Oscoda	Endodontist
Otsego	Endodontist
Presque Isle	Endodontist
Presque Isle	Prosthodontist
Saginaw	Endodontist
Saginaw	Periodontist
St. Clair	Endodontist
St. Clair	Periodontist
Van Buren	Periodontist

Table 3-98—MOL Network Adequacy Compliance

Provider Specialty	Non-Rural Time and Distance	Rural Time and Distance	Non-Rural Ratio	Rural Ratio
PCPs (Adult)	Compliant	Compliant	Compliant	Compliant
PCPs (Pediatric)	Compliant	Compliant	Compliant	Compliant
OB/GYN	Compliant	Compliant	NA	NA
Cardiology	Compliant	Compliant	NA	NA
Outpatient Behavioral Health	Compliant	Compliant	NA	NA
Hospital	Compliant	Noncompliant	NA	NA
Pharmacy	Compliant	Compliant	NA	NA
General Dentistry	Compliant	Compliant	Compliant	Compliant
Endodontist	Compliant	Compliant	NA	NA
Oral Surgeon	Compliant	Compliant	NA	NA
Periodontist	Compliant	Compliant	NA	NA
Prosthodontist	Compliant	Compliant	NA	NA

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: MOL demonstrated its capability of maintaining an adequate provider network to service its members that included comprehensive contracting, provider data maintenance, and reporting methods. **MOL** addressed any gaps in its network by submitting exception requests to MDHHS and increasing contracting efforts to fill network gaps. [Access]

Weaknesses and Recommendations

Weakness #1: No specific opportunities were identified related to the data collection and management processes that **MOL** had in place to inform network adequacy standard and indicator calculations.

Why the weakness exists: NA

Recommendation: NA

Network Validation Survey

Performance Results

HSAG’s reviewers evaluated 423 randomly sampled cases by comparing provider data submitted to HSAG by **MOL** against **MOL**’s online provider directory. The sample included 141 PCPs, 141 pediatric providers, and 141 OB/GYN providers. Overall, 96.0 percent of the sampled providers were located in the online directory at the sampled location, while 1.9 percent of the sampled providers located in the online directory were not at the sampled location. Additionally, 2.1 percent of the overall sampled providers could not be located in the online directory.

Table 3-99 summarizes the findings regarding the number of sampled providers and provider locations (i.e., “cases”) that HSAG’s reviewers located in the MHP’s online directory.

Table 3-99—Summary of Providers Present in Online Directory by Provider Category

Provider Category	Number of Sampled Providers	Providers Not Found in Directory		Providers Found in Directory—Not at Sampled Location		Providers Found in Directory—At Sampled Location	
		Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
PCPs	141	1	0.7%	1	0.7%	139	98.6%
Pediatric Providers	141	4	2.8%	2	1.4%	135	95.7%
OB/GYN Providers	141	4	2.8%	5	3.5%	132	93.6%
MOL Total	423	9	2.1%	8	1.9%	406	96.0%

¹ The denominator includes the number of sampled providers.

Table 3-100 displays the total number and percentage of cases with matched data values for indicators that were reviewed between data values shown in **MOL**’s provider data submission to HSAG and **MOL**’s online provider directory. Cases with unmatched results may include incorrect information or information not listed in the directory (e.g., the provider data included a data value for a study indicator, but the online provider directory did not include a data value for the study indicator).

Table 3-100—Provider Demographic Indicators Matching Online Directory

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		Overall	
	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
Provider Name	140	100%	137	100%	137	100%	414	100%
Provider Street Address	139	99.3%	135	98.5%	132	96.4%	406	98.1%
Provider Suite Number	140	100%	133	97.1%	135	98.5%	408	98.6%

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		Overall	
	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
Provider City	138	98.6%	135	98.5%	134	97.8%	407	98.3%
Provider State	140	100%	136	99.3%	137	100%	413	99.8%
Provider ZIP Code	140	100%	135	98.5%	133	97.1%	408	98.6%
Provider Telephone Number	139	99.3%	135	98.5%	130	94.9%	404	97.6%
Provider Type/Specialty	140	100%	137	100%	137	100%	414	100%
Provider Accepting New Patients	138	98.6%	132	96.4%	116	84.7%	386	93.2%
Provider Gender	139	99.3%	137	100%	137	100%	413	99.8%
Provider Primary Language ²	140	100%	137	100%	137	100%	414	100%
Non-English Language Speaking Provider (including American Sign Language) ²	139	99.3%	136	99.3%	137	100%	412	99.5%

¹ The denominator for each study indicator includes the number of cases in which the provider was found in the directory.

² The PDV review evaluated whether the indicator was present in the directory, but specific values were not validated.

For the secret shopper telephone survey, HSAG attempted to contact 376 sampled provider locations for **MOL**, with an overall response rate of 71.8 percent. Table 3-101 summarizes the survey response rates (i.e., cases reached) for all MHPs and for **MOL**, by provider category.

Table 3-101—Response Rates

Provider Category	Number of Total Cases ¹	Cases Reached	Response Rate
PCPs	135	97	71.9%
Pediatric Providers	130	87	66.9%
OB/GYN Providers	111	86	77.5%
MOL Total	376	270	71.8%
All MHPs Total	2,633	1,775	67.4%

¹ Total number of cases includes cases that were found in the online directory and matched on eight key indicators (i.e., name, address, city, state, ZIP Code, telephone number, provider type/specialty, and new patient acceptance).

Table 3-102 summarizes the provider data validation and accuracy results for all MHPs and **MOL**, by provider category.

Table 3-102—Provider Data Validation and Accuracy Results

Provider Category	Denom ¹	Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance		Accepting New Patients	
		Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
PCPs	97	67	69.1%	66	68.0%	62	63.9%	51	52.6%	46	47.4%
Pediatric Providers	87	62	71.3%	60	69.0%	53	60.9%	38	43.7%	29	33.3%
OB/GYN Providers	86	50	58.1%	43	50.0%	32	37.2%	28	32.6%	27	31.4%
MOL Total	270	179	66.3%	169	62.6%	147	54.4%	117	43.3%	102	37.8%
All MHPs Total	1,775	1,280	72.1%	1,215	68.5%	1,082	61.0%	822	46.3%	731	41.2%

¹ The denominator includes cases reached.

Table 3-103 displays the number of survey respondents who offered appointments to new patients for routine PCP and prenatal care visits for all MHPs and **MOL**, by provider category.

Table 3-103—Appointment Availability for Routine PCP and Prenatal Care Visits¹

Provider Category	Cases Reached	Cases Offered an Appointment	
		Count	Rate ²
PCPs	97	27	27.8%
Pediatric Providers	87	18	20.7%
OB/GYN Providers	86	6	7.0%
MOL Total	270	51	18.9%
All MHPs Total	1,775	424	23.9%

¹ Appointment availability rates were calculated using cases accepting new patients and total survey cases as the denominator in the 2022 and 2023 reports. However, the denominator used in the 2024 report was cases reached. Caution should be exercised when comparing 2024 appointment availability rates with the rates in the 2022 and 2023 reports.

² The denominator includes cases reached.

Table 3-104 displays the new patient wait time results for all MHPs and **MOL**, by provider category.

Table 3-104—Appointment Wait Time Results

Provider Category	Appointment Wait Time (Business Days)				Rate of Cases Within Standard ^{1,2}
	Min	Max	Average	Median	
PCPs	1	138	22	7	74.1%
Pediatric Providers	0	261	35	8	72.2%

Provider Category	Appointment Wait Time (Business Days)				Rate of Cases Within Standard ^{1,2}
	Min	Max	Average	Median	
OB/GYN Providers	1	20	7	5	83.3%
MOL Total	0	261	25	7	74.5%
All MHPs Total	0	261	18	8	80.9%

¹ The denominator includes cases offered an appointment.

² Rate of cases within standard represents the percentage of cases that were offered an appointment that was compliant with the 30-business-day standard for routine appointments and seven-business-day standard for prenatal care appointments.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NVS 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: Reviewers located 97.9 percent of the sampled providers in **MOL**'s online provider directory. [**Access**]

Strength #2: Of the providers matched in **MOL**'s online provider directory, all indicators had match rates above 95.0 percent. [**Access**]

Weaknesses and Recommendations

Weakness #1: Among the cases reached, only 66.3 percent confirmed affiliation with the sampled provider. Additionally, 62.6 percent confirmed accuracy of the sampled address, 54.4 percent confirmed the services were offered, 43.3 percent confirmed the requested insurance, and 37.8 percent confirmed new patient acceptance. [**Quality** and **Access**]

Why the weakness exists: **MOL**'s provider data included invalid provider, address, specialty, new patient acceptance, and insurance information.

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

Weakness #2: Overall, 71.8 percent of the sampled provider locations were reached. [**Access**]

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

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

Weakness #3: Among the cases reached, only 18.9 percent of locations offered an appointment date. While pediatric provider locations had an appointment availability rate of 20.7 percent, PCP locations had an appointment availability rate of 27.8 percent, and OB/GYN provider locations had an appointment availability rate of 7.0 percent. Of the cases that offered an appointment, 74.5 percent were compliant with the appointment wait time standard. [**Timeliness and Access**]

Why the weakness exists: For new **MOL** members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included pre-registration as well as requiring additional personal information, a Medicaid ID, or an MRR.

Recommendation: HSAG recommends that **MOL** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **MOL** 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 **MOL** procured medical records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*, to identify discrepancies and ensure alignment between the medical records and the encounter data submitted to MDHHS.

Table 3-105 outlines the key findings for **MOL** based on the assessment of encounter data completeness and accuracy conducted through a review of members' medical records for services rendered from October 1, 2022, through September 30, 2023.

Table 3-105—Key Findings for MOL

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	<ul style="list-style-type: none"> The medical record procurement rate was 85.6 percent, indicating that nearly 15 percent of the requested records were not procured and submitted.

Analysis	Key Findings
	<ul style="list-style-type: none"> Of the medical records not submitted, approximately 86 percent were not submitted due to non-responsive providers or provider did not respond in a timely manner.
Second Date of Service Submission Rate	<ul style="list-style-type: none"> Among the procured medical record, 59.7 percent included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	<ul style="list-style-type: none"> All key data elements (i.e., <i>Date of Service</i>, <i>Diagnosis Code</i>, <i>Procedure Code</i>, and <i>Procedure Code Modifier</i>) had relatively high medical record omission rates, ranging from 10.7 percent (<i>Date of Service</i>) to 26.6 percent (<i>Procedure Code Modifier</i>). The high medical record omission rates for all key data elements were partially influenced by medical record non-submission. In cases where no medical records were submitted for a requested case, all associated data elements were categorized as medical record omissions.
Encounter Data Omission Rate	<ul style="list-style-type: none"> All key data elements exhibited relatively low encounter data omission rates, with <i>Date of Service</i> having the highest encounter data omission rate at 6.2 percent.
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Diagnosis Code</i> data element was accurate in 99.6 percent of instances where codes were present in both the medical records and encounter data, with all errors related to inaccurate coding.
Procedure Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code</i> data element was accurate in 98.5 percent of instances where codes were present in both the medical records and encounter data, with all errors related to inaccurate coding.
Procedure Code Modifier Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code Modifier</i> data element was accurate in 100 percent of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	<ul style="list-style-type: none"> Dates of service with accurate values for all key data elements (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, and <i>Procedure Code Modifier</i>) were observed in 70.6 percent of the dates of service present in both data sources (i.e., encounter data and medical records).

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the EDV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one

or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: The *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data element values identified in the medical records were generally present in the encounter data, as evidenced by the low encounter data omission rates of 6.2 percent, 3.0 percent, 5.6 percent, and 0.6 percent, respectively. [Quality]

Strength #2: When key data elements were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate with rates of at least 98.5 percent each. [Quality]

Weaknesses and Recommendations

Weakness #1: MOL was unable to procure all of the requested medical records from its contracted providers mostly due to providers being non-responsive or providers not responding in a timely manner. [Quality and Timeliness]

Why the weakness exists: The non-submission reason for non-responsive providers or providers who did not respond in a timely manner may indicate that the contracted providers were unaware of the submission requirements or the deadline.

Recommendation: MOL should ensure its contracted providers' accountability in responding to medical record requests for the purposes of auditing, inspection, and oversight. HSAG recommends that MOL consider strengthening and/or enforcing its contract requirements with its providers in providing the requested documentation.

Weakness #2: All data elements had more than 10.0 percent identified in the encounter data that were not supported by the members' medical records. [Quality]

Why the weakness exists: Non-submitted medical records contribute to medical record omissions, as the expected information in the medical records cannot be compared to the encounter data. Additional contributing factors include provider documentation practices (e.g., incomplete or inaccurate documentation, coding errors, lack of detail), data submission (e.g., incorrect coding during data submission or data entry errors), or processing issues (e.g., data mapping or translation issues, or errors in data transmission).

Recommendation: MOL should investigate the root cause(s) for these omissions, with a focus on both provider documentation practices and data handling processes. Periodic MRRs of submitted claims should be conducted to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should be used to develop and provide ongoing education and training for providers. Topics should include encounter data submissions, medical record documentation requirements, and coding practices to reduce future omissions and improve data accuracy.

Consumer Assessment of Healthcare Providers and Systems Analysis

Adult and Child Medicaid

Performance Results

Table 3-106 presents **MOL**'s 2023 and 2024 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2024 scores were statistically significantly higher or lower than the 2023 national average. Triangles (▲ or ▼) indicate 2024 scores were statistically significantly higher or lower than the 2023 scores.

Table 3-106—Summary of Adult and Child Medicaid CAHPS Top-Box Scores for MOL

	2023 Adult Medicaid	2024 Adult Medicaid	2023 Child Medicaid	2024 Child Medicaid
Global Ratings				
<i>Rating of Health Plan</i>	65.67%	64.29%	71.05%	69.23%
<i>Rating of All Health Care</i>	62.50%	59.70%	65.07%	66.41%
<i>Rating of Personal Doctor</i>	65.67%	68.05%	74.65%	72.04%
<i>Rating of Specialist Seen Most Often</i>	68.00%	77.91% ⁺ ↑	70.91% ⁺	63.83% ⁺
Composite Measures				
<i>Getting Needed Care</i>	82.10%	80.48%	85.43%	81.86% ⁺
<i>Getting Care Quickly</i>	79.94%	82.85% ⁺	89.65%	83.91% ⁺
<i>How Well Doctors Communicate</i>	90.47%	92.02%	95.04%	92.53%
<i>Customer Service</i>	83.68%	89.96% ⁺	91.67% ⁺	86.35% ⁺
Individual Item Measure				
<i>Coordination of Care</i>	87.18%	86.49% ⁺	80.60% ⁺	87.69% ⁺
Medical Assistance With Smoking and Tobacco Use Cessation Items*				
<i>Advising Smokers and Tobacco Users to Quit</i>	82.45%	74.82%	—	—
<i>Discussing Cessation Medications</i>	62.11%	53.15%	—	—
<i>Discussing Cessation Strategies</i>	55.38%	48.20%	—	—

⁺ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

* These rates follow NCQA's methodology of calculating a rolling two-year average.

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.

▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.

No triangles (▲ or ▼) indicate the 2024 score was not statistically significantly higher or lower than the 2023 score.

↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.

↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.
 No arrows (↑ or ↓) indicate the 2024 score was not statistically significantly higher or lower than the 2023 national average.
 — Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the CAHPS 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: MOL's 2024 top-box score was statistically significantly higher than the 2023 adult Medicaid national average for one measure, *Rating of Specialist Seen Most Often*. [Quality]

Weaknesses and Recommendations

Weakness #1: MOL's 2024 top-box scores were not statistically significantly lower than the 2023 NCQA adult and child Medicaid national averages or 2023 top-box scores for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

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

CSHCS

Performance Results

Table 3-107 presents **MOL's** 2023 and 2024 CSHCS CAHPS top-box scores. Upward green or downward red arrows (↑ or ↓) indicate 2024 scores were statistically significantly higher or lower than the 2023 national average. Upward green or downward red triangles (▲ or ▼) indicate 2024 scores were statistically significantly higher or lower than the 2023 scores.

Table 3-107—Summary of CSHCS CAHPS Survey Top-Box Scores for MOL

	2023 Top-Box Score	2024 Top-Box Score
Global Ratings		
<i>Rating of Health Plan</i>	66.67%	67.45%
<i>Rating of Health Care</i>	66.43%	73.04% NA
<i>Rating of Specialist Seen Most Often</i>	75.13%	76.41%
Composite Measures		
<i>Customer Service</i>	86.68% ⁺	89.13% ⁺

	2023 Top-Box Score	2024 Top-Box Score
<i>How Well Doctors Communicate</i>	94.99%	95.12% NA
<i>Access to Specialized Services</i>	67.36% ⁺	70.57% ⁺ NA
<i>Transportation</i>	64.84% ⁺	69.91% ⁺ NA
Individual Item Measures		
<i>Access to Prescription Medicines</i>	89.62%	92.58% [↑]
<i>Not Felt Treated Unfairly: Race and Ethnicity</i>	96.65%	97.16% NA
<i>Not Felt Treated Unfairly: Health Insurance Type</i>	90.87%	93.81% NA

⁺ Indicates fewer than 100 respondents. Caution should be exercised when evaluating the results.

[▲] Indicates the 2024 score is statistically significantly higher than the 2023 score.

[▼] Indicates the 2024 score is statistically significantly lower than the 2023 score.

No triangle ([▲] or [▼]) indicates the 2024 score was not statistically significantly higher or lower than the 2023 score.

[↑] Indicates the 2024 score is statistically significantly higher than the 2023 national average.

[↓] Indicates the 2024 score is statistically significantly lower than the 2023 national average.

No arrow ([↑] or [↓]) indicates the 2024 score was not statistically significantly higher or lower than the 2023 national average.

NA Indicates a national average is not available for the measure.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the CAHPS 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: MOL's 2024 top-box score was statistically significantly higher than the 2023 NCQA child Medicaid national average for one measure, *Access to Prescription Medicines*.

Weaknesses and Recommendations

Weakness #1: MOL's 2024 top-box scores were not statistically significantly lower than the 2023 NCQA child Medicaid national averages or the 2023 top-box scores for any reportable measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

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

Quality Rating

The 2024 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2024 Michigan Consumer Guide, which is inclusive of **MOL**'s performance.

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

HSAG performed a comprehensive assessment of **MOL**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **MOL** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **MOL**'s overall performance contributed to the CHCP's progress in achieving the CQS goals and objectives. Table 3-108 displays each MDHHS CQS goal and the EQR activity results that indicate whether the MHP positively (✓), negatively (✗), or minimally (m) impacted the CHCP's progress toward achieving the applicable goals and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to **MOL**'s Medicaid members. Not applicable (NA) was used when EQR activities do not produce data to assess the impact of a quality measure(s) under an objective.

Table 3-108—Overall Performance Impact to CQS and Quality, Timeliness, and Access

Objective	Program	Quality Measure	Overall Performance Impact	Performance Domain
Goal #1: Ensure high quality and high levels of access to care				
1.1	CHCP	<i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	m	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	CHCP	<i>Prenatal and Postpartum Care—Postpartum Care</i>	m	
	CHCP	<i>Childhood Immunization Status—Combination 3</i>	✗	
	CSHCS	<i>Global Rating of Health Plan</i>	m	
	CSHCS	<i>Global Rating of Specialist Seen Most Often</i>	✓	
	CSHCS	<i>Global Rating of Health Care</i>	✓	
	CSHCS	<i>Composite Measure for Access to Specialized Services</i>	m	
	CSHCS	<i>Composite Measure for Transportation</i>	m	
1.2	CHCP	<i>Asthma Medication Ratio—Total</i>	✓	
	CHCP	<i>Controlling High Blood Pressure</i>	✗	
	CHCP	<i>Comprehensive Diabetes Care (CDC)—Eye Exams¹</i>	✗	
	CSHCS	<i>Composite Measure for How Well Doctors Communicate</i>	✓	
	CSHCS	<i>Composite Measure for Customer Service</i>	m	

Objective	Program	Quality Measure	Overall Performance Impact	Performance Domain	
1.3	CHCP	Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	NA		
	CHCP	Getting Care Quickly Composite (Adult CAHPS)	m		
	CSHCS	Global Rating of Health Care	✓		
	CSHCS	Composite Measure for Access to Specialized Services	m		
	CSHCS	Access to Prescription Medicines	✓		
Goal #2: Strengthen person and family-centered approaches					
2.1	CHCP	Rating of Health Plan ²	✗	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access	
	CHCP	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years Old	✓		
	CHCP	Access to Dental Care	m		
	CHCP	Completion of Annual Health Risk Assessment	NA		
	CSHCS	Composite Measure for How Well Doctors Communicate	✓		
	CSHCS	Global Rating of Health Plan	m		
	CSHCS	Global Rating of Health Care	✓		
	CSHCS	Global Rating of Specialist Seen Most Often	✓		
2.2	CHCP	SDOH: Total Member Screening Rate	NA		
	CHCP	SDOH: Total Member Referral Rate	NA		
	CHCP	Social Need Screening and Intervention	NA		
	CSHCS	Composite Measure for Access to Specialized Services	m		
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)					
3.1	CHCP	Follow-Up After Hospitalization for Mental Illness Within 30 Days (FUH) (Adults)	NA	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access	
	CSHCS	Coordination of Care	NA		
3.2	CHCP	Implementation of Joint Care Management Processes	NA		
	CSHCS	Global Rating of Health Plan	m		
	CSHCS	Global Rating of Health Care	✓		
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes					
4.1	CHCP	Chlamydia Screening in Women—Total ³	NA	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access	
	CHCP	Prenatal and Postpartum Care—Postpartum Care ³	NA		
	CHCP	Children Immunization Combo 3 ³	NA		
	CHCP	Lead Screening in Children ³	NA		

Objective	Program	Quality Measure	Overall Performance Impact	Performance Domain
	CHCP	Comprehensive Diabetes Care—Eye Exam ³	NA	
	CHCP	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years Old ³	NA	
	CSHCS	Not Felt Treated Unfairly: Race and Ethnicity	m	
Goal #5: Improve quality outcomes through value-based initiatives and payment reform				
5.1	CHCP	Average Percentage of Plan Payments to Providers Who Are in APM Arrangements ("Big Numerator")	NA	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access
	CHCP	Average Percentage of Plan Payments to Providers That Are Tied to Quality ("Small Numerator")	NA	

✓ = The MHP's rate met the 2026 statewide performance target; or the MHP's rate did not meet the 2026 statewide performance target but demonstrated a statistically significant increase in performance from the prior year.

m = The MHP's rate did not meet the 2026 statewide performance target and while the MHP's rate increased in performance from the prior year, the increase was not statistically significant.

✗ = The MHP's rate did not meet the 2026 statewide performance target and/or the MHP's rate decreased in performance from the prior year.

NA = EQR activities published in this report do not produce data to assess the impact of a quality measure(s) under an objective.

¹ NCQA replaced the *Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed* performance measure with the *Eye Exam for Patients With Diabetes (EED)* performance measure, the overall performance impact was based on the MHP's reported rate for *Eye Exam for Patients With Diabetes (EED)*.

² As the CQS did not identify whether this quality measure applies to the adult or child CAHPS, HSAG assessed performance using the adult rate.

³ While there are reported HEDIS rates that are stratified by race/ethnicity, the EQR deliverables did not include an analysis of these data.

Priority Health Choice

Validation of Performance Improvement Projects

Performance Results

HSAG’s validation evaluated the technical methods of **PRI**’s PIP (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-109 displays the overall validation rating, the baseline rate, Remeasurement 1, and Remeasurement 2 results for the performance indicators, and if a disparity existed within the most recent measurement period.

Table 3-109—Overall Validation Rating for PRI

PIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
Improving Timeliness of Prenatal Care for African American Women	High Confidence	No Confidence	1. The percentage of African American women that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment with Priority Health	69.4%	65.8% ⇄	77.6% ⇄	Yes
			2. The percentage of Caucasian women that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment with Priority Health	86.1%	85.4% ⇄	88.3% ⇄	

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).

The goals for **PRI**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African-American women) will demonstrate a statistically significant increase over the baseline rate without a decline in performance for the comparison subgroup (Caucasian women). Table 3-110 displays the barriers identified through QI and causal/barrier analysis processes and the interventions initiated by the MHP to support achievement of the PIP goals and address the barriers.

Table 3-110—Remeasurement 2 Barriers and Interventions for PRI

Barriers	Interventions
Low prenatal engagement for African American women due to the lack of understanding of prenatal care.	<p>PriorityMOM: Program engages pregnant women via email to provide resources for a healthy pregnancy and postpartum period. Topics include cost/coverage, hypertension, diabetes, mental health, finding an obstetrician (OB), healthy nutrition, pre-term birth prevention, and postpartum care. Members receive a blood pressure cuff and baby sleep sack as a gift. Members also provide feedback on their experience.</p> <p>Strong Beginnings: Program focuses on improving health outcomes for minority pregnant members. Provider is incentivized if pregnant women complete their first trimester visit. The program focuses on provider engagement, addresses social determinants of health and racial equity. Family engagement is also a focus area along with mental/behavioral health services.</p>
Member has good insecurity	The MHP partnered with Moms Meals to provide heart healthy, low sodium meals to pregnant individuals.
Members have mental health challenges that impact their ability to receive prenatal care.	PriorityMOM: Program engages pregnant women to provide resources for a healthy pregnancy and postpartum period. Mental health topics included mental health diagnosis, mental health awareness, postpartum depression, and mental health support.
Members have mental health challenges that impact their ability to receive prenatal care.	Michigan Clinical Consultation and Care (MC3) Partnership: Priority Health partnered with MC3 to help support women with their mental health needs. MC3 offers no-cost psychiatry support to pediatric and prenatal care providers in Michigan. Providers can connect with MC3 via phone to receive guidance on diagnostic questions, safe medications, and appropriate psychotherapy.
Low engagement in Maternal Infant Health Program (MIHP).	Priority Health encourages members to enroll in an MIHP program to help address social as well as racial needs. Members who enroll in an MIHP program and complete their postpartum visit receive free diapers. Priority Health also meets with MIHPs to share resources and information that benefits members and the MIHPs.

Barriers	Interventions
Member may need transportation to and from provider office.	The MHP partnered with Health Net to improve the health of our members by bridging the healthcare and social services systems. Health Net conducted a health-related social need screening with members, measures unmet needs, and offers community resource navigation.
Initial prenatal care visit is conducted with a nurse or other office staff instead of with an obstetrician/gynecologist (OB/GYN) or other prenatal/primary care practitioner.	Provided training to providers on prenatal care visit requirements via the provider newsletter.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PIP 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: PRI initiated timely interventions that were reasonably linked to their corresponding barriers. The interventions were evaluated to determine the effectiveness of each effort, with decisions to continue, discontinue, or revise an effort being data driven. [Quality, Timeliness, and Access]

Weaknesses and Recommendations

Weakness #1: PRI did not achieve the state-defined goal of eliminating the existing disparity with the second remeasurement period [Quality, Timeliness, and Access]

Why the weakness exists: While it is unclear why the goal was not achieved, PRI has made progress in improving performance for both populations as compared to the baseline.

Recommendation: HSAG recommends that PRI continue testing or implement intervention strategies that have demonstrated improvement on the performance indicator. The MHP should revisit its causal/barrier analysis to ensure appropriate identification of barriers or the need to develop new or modified intervention strategies.

Performance Measure Validation

Performance Results

PRI was evaluated against NCQA’s IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2023 Compliance Audit Report findings, **PRI** was fully compliant with all four IS standards.

According to the auditor’s review, **PRI** followed the NCQA HEDIS MY 2023 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-111 displays the MDHHS-selected performance measures, HEDIS MY 2022 and MY 2023 rates, MY 2022 and MY 2023 comparisons, and MY 2023 performance levels based on comparisons to national percentiles⁷⁷ for **PRI**. Additional performance measures and performance measure results for **PRI** can be referenced in Appendix B.

Table 3-111—HEDIS MY 2023 Performance Measure Results for PRI

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
Child & Adolescent Care				
<i>Childhood Immunization Status (CIS)</i>				
<i>Combination 3</i>	63.50%	68.13%	+4.62	★★★★
<i>Combination 7</i>	55.72%	59.61%	+3.89	★★★★
<i>Combination 10</i>	32.85%	34.06%	+1.22	★★★★
<i>Well-Child Visits in the First 30 Months of Life (W30)</i>				
<i>Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	53.15%	66.39%	+13.24+	★★★★★
<i>Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i>	59.86%	69.86%	+10.00+	★★★★
<i>Lead Screening in Children (LSC)</i>				
<i>Lead Screening in Children</i>	60.83%	65.94%	+5.11	★★★★
<i>Child and Adolescent Well-Care Visits (WCV)</i>				
<i>Ages 3 to 11 Years</i>	61.72%	62.07%	+0.35	★★★★
<i>Ages 12 to 17 Years</i>	51.71%	51.91%	+0.20	★★★★

⁷⁷ HEDIS MY 2023 performance measure rates are compared to NCQA’s Quality Compass National Medicaid Health Maintenance Organization (HMO) percentiles for HEDIS MY 2022 (referred to as “percentiles” throughout this section of the report).

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
<i>Ages 18 to 21 Years</i>	29.23%	30.69%	+1.46+	★★★★
<i>Total</i>	52.87%	53.82%	+0.95+	★★★
Immunizations for Adolescents (IMA)				
<i>Combination 1 (Meningococcal, Tdap)</i>	77.99%	76.64%	-1.35	★★
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	33.60%	34.06%	+0.46	★★
Women—Adult Care				
<i>Chlamydia Screening in Women (CHL)</i>³				
<i>Ages 16 to 20 Years</i>	57.75%	53.89%	-3.86 ⁺⁺	★★★
<i>Ages 21 to 24 Years</i>	65.55%	63.33%	-2.23 ⁺⁺	★★★
<i>Total</i>	61.47%	58.35%	-3.12 ⁺⁺	★★★
<i>Cervical Cancer Screening (CCS-E)</i>				
<i>Cervical Cancer Screening</i>	61.31%	55.04%	-6.27 ⁺⁺	★★
<i>Breast Cancer Screening (BCS-E)</i>				
<i>Breast Cancer Screening</i>	53.70%	54.52%	+0.83	★★★
Access to Care				
<i>Adults' Access to Preventive/Ambulatory Health Services (AAP)</i>				
<i>Ages 20 to 44 Years</i>	70.74%	71.97%	+1.23+	★★★
<i>Ages 45 to 64 Years</i>	81.44%	81.65%	+0.22	★★★
<i>Ages 65 Years and Older</i>	89.64%	88.46%	-1.19	★★★★
<i>Total</i>	74.58%	75.46%	+0.88+	★★★
Pregnancy Care				
<i>Prenatal and Postpartum Care (PPC)</i>³				
<i>Timeliness of Prenatal Care</i>	80.78%	85.40%	+4.62	★★★
<i>Postpartum Care</i>	80.05%	77.86%	-2.19	★★
Living With Illness				
<i>Hemoglobin A1c Control for Patients With Diabetes (HBD)</i>				
<i>HbA1c Control (<8.0%)</i>	57.66%	63.26%	+5.60	★★★★★
<i>Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*</i>	30.41%	28.22%	-2.19	★★★★★
<i>Blood Pressure Control for Patients With Diabetes (BPD)</i>				
<i>Blood Pressure Control for Patients With Diabetes</i>	68.61%	77.37%	+8.76+	★★★★★

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
Eye Exam for Patients With Diabetes (EED)³				
Eye Exam for Patients With Diabetes	54.48%	62.04%	+7.56+	★★★★★
Kidney Health Evaluation for Patients With Diabetes (KED)				
Ages 18 to 64 Years	35.93%	39.33%	+3.40+	★★★★
Ages 65 to 74 Years	39.29%	41.12%	+1.83	★★★★
Ages 75 to 85 Years	41.40%	46.41%	+5.01	★★★★
Total	36.20%	39.55%	+3.36+	★★★★
Asthma Medication Ratio (AMR)				
Total	65.61%	64.64%	-0.96	★★
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	73.24%	69.10%	-4.14	★★★★★
Diagnosed Mental Health Disorders (DMH)				
Ages 1 to 17 Years	22.40%	22.85%	+0.45+	★★★★
Ages 18 to 64 Years	35.62%	36.87%	+1.25+	★★★★
Ages 65 Years and Older	37.96%	36.07%	-1.89	★★★★
Total	30.35%	31.20%	+0.85+	★★★★
Utilization				
Plan All-Cause Readmissions (PCR)				
Observed Readmissions—Total	8.61%	7.59%	-1.02+	NC
Expected Readmissions—Total	9.64%	9.69%	+0.05	NC
O/E Ratio—Total	0.8936	0.7829	-0.11	★★★★★

¹ HEDIS MY 2022 to HEDIS MY 2023 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2022–MY 2023 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2022–MY 2023 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

² Performance Levels for MY 2023 were based on comparisons of the HEDIS MY 2023 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2022 benchmark.

³ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

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

Please note that for the *Diagnosed Mental Health Disorders (DMH)* measure, a higher or lower rate does not indicate better performance, as the measure provides information on the diagnosed prevalence of mental health disorders. Therefore, this measure is not included in the evaluation of strengths and weaknesses below.

Green Shading⁺ Indicates that the HEDIS MY 2023 rate demonstrated a significant improvement from the HEDIS MY 2022 rate.

Red Shading⁺⁺ Indicates that the HEDIS MY 2023 rate demonstrated a significant decline from the HEDIS MY 2022 rate.

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

HEDIS MY 2023 Performance Levels represent the following percentile comparisons:

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

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PMV 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: PRI's performance ranked between the 75th and 89th percentiles for the *Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator and demonstrated significant improvement from MY 2022 to MY 2023, indicating children who turned 15 months old during the measurement year were having at least six well-child visits with a PCP during their first 15 months of life most of the time. Research shows that early intervention treatment services can greatly improve a child's development. Early intervention services help children from birth through 3 years of age (36 months) learn important skills.⁷⁸ [Quality, Timeliness, and Access]

Strength #2: PRI's performance ranked between the 75th and 89th percentiles for the *Child and Adolescent Well-Care Visits (WCV)—Ages 18 to 21 Years* measure indicator and demonstrated significant improvement from MY 2022 to MY 2023, indicating members between the ages of 18 and 21 years received one or more well-care visits with a PCP or OB/GYN practitioner during the measurement year most of the time. More frequent well-child visits in the first years of life and one or more well-child visits from ages 3–21 are recommended. Well-child visits should include, but are not limited to, an initial/interval medical history, physical exam, developmental assessment, immunization, and anticipatory guidance.⁷⁹ [Quality, Timeliness, and Access]

Strength #3: PRI's performance ranked between the 75th and 89th percentiles for the *Adults' Access to Preventive/Ambulatory Health Services (AAP)—Ages 65 Years and Older* measure indicator, indicating that members 65 years of age and older had an ambulatory or preventive care visit most of the time. Healthcare visits are an opportunity for individuals to receive preventive

⁷⁸ National Committee for Quality Assurance. Well-Child Visits in the First 30 Months of Life (W30). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/well-child-visits-in-the-first-30-months-of-life-w30/>. Accessed on: Apr 2, 2025.

⁷⁹ National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (WCV). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/child-and-adolescent-well-care-visits-wcv/>. Accessed on: Apr 2, 2025.

services and counseling on topics such as diet and exercise. These visits also can help them to address acute issues or manage chronic conditions.⁸⁰ [Quality and Access]

Strength #4: PRI's performance ranked above the 90th percentile for the *Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Control (<8.0%)* and *Hemoglobin A1c (HbA1c) Poor Control (>9.0%)* measure indicators, indicating members with diabetes had controlled HbA1c levels most of the time during the measurement year. Glycemic control is management of blood sugar levels to reduce the risk of microvascular complications (eye, kidney, and nerve diseases). Many complications such as heart disease, stroke, blindness, kidney failure and amputation can be prevented if diabetes is detected and addressed in the early stages.⁸¹ [Quality and Access]

Strength #5: PRI's performance ranked above the 90th percentile for the *Blood Pressure Control for Patients With Diabetes (BPD)* measure indicator and demonstrated significant improvement from MY 2022 to MY 2023, indicating members 18–75 years of age, with a diagnosis of diabetes, had controlled blood pressure levels most of the time. Diabetes is a chronic condition marked by high blood sugar due to the body's inability to make or use insulin. Left unmanaged, diabetes can lead to more serious health conditions, including high blood pressure. Proper blood pressure management is essential to avoid further complications, including heart attack, stroke, kidney disease, and blindness. With support from healthcare providers, patients can manage their blood pressure to maintain a healthy and productive life.⁸² [Quality]

Strength #6: PRI's performance ranked between the 75th and 89th percentiles for the *Eye Exam for Patients With Diabetes (EED)* measure indicator and demonstrated significant improvement from MY 2022 to MY 2023, indicating members with diabetes had an eye exam to screen or monitor for diabetic retinal disease most of the time. Adults with diabetes should receive regular eye exams to help detect and manage visual complications. Regular eye exams are the best way to reduce the risk of blindness and maintain a healthy and productive life.⁸³ [Quality and Access]

Strength #7: PRI's performance ranked between the 75th and 89th percentiles for the *Controlling High Blood Pressure (CBP)* measure indicator, indicating members ages 18–85 years of age, with a diagnosis of hypertension, had blood pressure adequately controlled. Controlling high blood pressure

⁸⁰ National Committee for Quality Assurance. Adults' Access to Preventive/Ambulatory Health Services (AAP). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/adults-access-to-preventive-ambulatory-health-services-aap/>. Accessed on: Apr 1, 2025.

⁸¹ National Committee for Quality Assurance. Glycemic Status Assessment for Patients With Diabetes (GSD). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/glycemic-status-assessment-for-patients-with-diabetes-gsd/>. Accessed on: Apr 1, 2025.

⁸² National Committee for Quality Assurance. Blood Pressure Control for Patients With Diabetes (BPD). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/blood-pressure-control-for-patients-with-diabetes-bpd/>. Accessed on: Apr 2, 2025.

⁸³ National Committee for Quality Assurance. Eye Exam for Patients With Diabetes (EED). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/eye-exam-for-patients-with-diabetes-eed/>. Accessed on: Apr 2, 2025.

is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.⁸⁴ [Quality]

Strength #8: PRI's performance ranked above the 90th percentile for the *Plan All-Cause Readmissions (PCR)—O/E Ratio—Total* measure indicator, indicating that there were less unplanned acute readmissions within 30 days after discharge than expected for members 18 to 64 years of age. A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination. Unplanned readmissions are associated with increased mortality and higher healthcare costs. Unplanned readmissions can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management.⁸⁵ [Quality, Timeliness, and Access]

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

Weaknesses and Recommendations

Weakness #1: PRI's performance for the *Immunizations for Adolescents (IMA)—Combination 1* and *Combination 2* measure indicators ranked between the 25th and 49th percentiles, indicating that members 13 years of age were not always receiving one dose of the meningococcal vaccine, one Tdap vaccine, and the complete human papillomavirus vaccine series by their 13th birthday during the measurement year. These vaccines are available for adolescents to prevent them from acquiring serious diseases and help protect against disease in populations that lack immunity, such as infants, the elderly, and individuals with chronic conditions.⁸⁶ [Quality, Timeliness, and Access]

Why the weakness exists: The rates for the *Immunizations for Adolescents—Combination 1* and *Combination 2* measure indicators ranked between the 25th percentile and 49th percentiles. Potential barriers to improved measure performance that were identified by PRI include determining the best method of communication with members and having outdated contact information. Other potential barriers may be provider challenges with vaccination storage protocols, providers obtaining necessary vaccination certifications, provider cost deterrents related to the short shelf life for vaccines/maintaining inventory, and parental vaccination hesitancy.

Recommendation: HSAG recommends that PRI explore avenues to increase awareness of vaccination importance among parents to reduce vaccination hesitancy, such as a “speculation versus fact” pamphlet, which includes a phone number for care management support. PRI could also

⁸⁴ National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/controlling-high-blood-pressure-cbp/>. Accessed on: Apr 2, 2025.

⁸⁵ National Committee for Quality Assurance. Plan All-Cause Readmissions (PCR). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/plan-all-cause-readmissions-pcr/>. Accessed on: Apr 2, 2025.

⁸⁶ National Committee for Quality Assurance. Immunizations for Adolescents (IMA-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/immunizations-for-adolescents-ima-e/>. Accessed on: Apr 2, 2025.

consider issuing provider incentives for maintaining a complete inventory of vaccinations for the *Immunizations for Adolescents* measure.

Weakness #2: PRI's performance for the *Cervical Cancer Screening (CCS-E)* measure ranked between the 25th percentile and 49th percentiles, indicating women were not always being screened for cervical cancer during the specified time frame. Cervical cancer can be detected in its early stages by regular screening. Due to the success of cervical cancer screening in the U.S., dramatic decreases have been observed in both mortality and incidence of invasive cervical cancer.⁸⁷

[Quality and Access]

Why the weakness exists: The rate for the *Cervical Cancer Screening (CCS-E)* measure ranked between the 25th percentile and 49th percentiles, suggesting that barriers exist for some women to be screened for cervical cancer.

Recommendation: While PRI noted interventions currently in place to target improvement, such as conducting outreach via email campaigns to re-engage members with no service for a year and reeducating members, performance remains low for the *Cervical Cancer Screening (CCS-E)* measure. Therefore, HSAG recommends that PRI continue its efforts to improve performance for the *Cervical Cancer Screening (CCS-E)* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified. PRI could consider the development and deployment of a digital notification system for members needing cervical cancer screening and incorporating screening reminders into current care coordination member touchpoints. Another option to consider would be to develop partnerships with local partners or vendors for transportation services.

Weakness #3: PRI's performance for the *Prenatal and Postpartum Care (PPC)—Postpartum Care* measure indicator ranked between the 25th percentile and 49th percentiles, indicating that pregnant women were not always having a postpartum visit on or between 7 and 84 days after delivery during the measurement year. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.⁸⁸ **[Quality, Timeliness, and Access]**

Why the weakness exists: The rate for the *Prenatal and Postpartum Care (PPC)—Postpartum Care* measure indicator ranked between the 25th percentile and 49th percentiles, suggesting that barriers exist for some pregnant women to have timely postpartum visits.

Recommendation: HSAG recommends that PRI continue developing targeted interventions to improve the performance of the *Prenatal and Postpartum Care (PPC)* measure indicators. Initiatives should be monitored and expanded upon as additional contributing factors are identified. PRI could

⁸⁷ National Committee for Quality Assurance. Cervical Cancer Screening (CCS-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/cervical-cancer-screening-ccs-e/>. Accessed on: Apr 2, 2025.

⁸⁸ National Committee for Quality Assurance. Prenatal and Postpartum Care (PPC). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/prenatal-and-postpartum-care-ppc/>. Accessed on: Apr 2, 2025.

consider creating member incentives to promote increased prenatal and postpartum engagement, such a baby registry for pre-approved baby items and supplies.

Weakness #4: **PRI**'s performance for the *Asthma Medication Ratio (AMR)* measure ranked between the 25th percentile and 49th percentiles, indicating that some members 5–64 years of age, who were identified as having persistent asthma, did not have a ratio of controller medication to total asthma medication of 0.50 or greater during the measurement year. Appropriate medication management for patients with asthma could reduce the need for rescue medication, the costs associated with ED visits, inpatient admissions, and missed days of work or school.⁸⁹ **[Quality]**

Why the weakness exists: The rate for the *Asthma Medication Ratio (AMR)* measure ranked between the 25th percentile and 49th percentiles. Potential barriers to improved rate performance may include, but are not limited to, utilization of ED services for management of asthma symptoms, and underutilization of primary care services for treatment and management of asthma.

Recommendation: HSAG recommends that **PRI** develop targeted interventions to improve performance for the *Asthma Medication Ratio (AMR)* measure. Initiatives should be monitored and expanded upon as contributing factors to rate performance are identified. **PRI** could consider providing education to members on proper medication management in order to avoid ED visits.

Compliance Review

Performance Results

Table 3-112 presents the total number of criteria for each standard that received a score of *Met*, *Satisfied*, or *Not Met*. Table 3-112 also presents **PRI**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. *NA* was used when MDHHS determined the review element was not applicable during the compliance review. For elements scored as *Not Met*, **PRI** was subject to a corrective action review process outlined in Appendix A.

Table 3-112—Compliance Review Results for PRI

Standard		Number of Scores				Compliance Scores	
		<i>Met</i>	<i>Satisfied</i> ¹	<i>Not Met</i>	<i>NA</i>	PRI ²	Statewide ³
1	Administrative	5	0	0	0	100%	100%
2	Providers	23	0	1	0	96%	95.4%
3	Members	27	0	2	1	93%	98.9%
4	Quality	24	0	0	0	100%	100%
5	MIS/Financial	47	1	3	0	92%	94.6%

⁸⁹ National Committee for Quality Assurance. Asthma Medication Ratio (AMR). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/asthma-medication-ratio-amr/>. Accessed on: Apr 2, 2025.

Standard		Number of Scores				Compliance Scores	
		Met	Satisfied ¹	Not Met	NA	PRI ²	Statewide ³
6	OIG/Program Integrity	9	0	1	0	90%	85.6%
Overall		135	1	7	1	94%	96.0%

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

¹ A score of *Satisfied* was only allowable for select elements under the MIS/Financial standard.

² MDHHS calculated the total compliance score for each standard by totaling the number of *Met* (i.e., 1 point) elements and the number of *Not Met* and *Satisfied* (i.e., 0 points) elements, then dividing the summed score by the total number of elements for that standard.

³ MDHHS calculated the statewide performance scores to the tenth decimal place; however, MHP performance scores were calculated using whole number percentages.

Additionally, to supplement the compliance review activity, MDHHS conducted staff interviews, referred to as focus studies, in the following three areas: CSHCS, Operations, and Quality. While the results of the focus studies are not incorporated into the scoring of the compliance review, **PRI** met MDHHS' expectations for participation in the studies.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the compliance review 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: PRI achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. [Quality]

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

Weaknesses and Recommendations

Weakness #1: While **PRI** demonstrated high performance overall (i.e., 90 percent or higher but less than 100 percent) in the Members standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for elements *NCQA 3.16–Out of Network Cost to Member* and *June 3.24 Covered Services*. [Quality, Timeliness, and Access]

Why the weakness exists: Regarding element *NCQA 3.16* findings, **PRI** did not provide policies and procedures that described the MHP's process for how it coordinates payment with out-of-network providers, ensuring that the cost to the member is no greater than it would be if the service were provided in-network when a member must go out-of-network because the MHP is unable to provide a necessary and covered service in-network. Regarding element *June 3.24* findings, **PRI**'s documentation was missing statements confirming the MHP's responsibility for covering services that address the ability for a member to attain, maintain, or regain functional capacity, and that the MHP will not arbitrarily deny or reduce the amount, duration, or scope of a required service because of the diagnosis, type of illness, or condition of a member.

Recommendation: **PRI** was required to submit a CAP to address element *June 3.24*, which was approved by MDHHS. Additionally, as **PRI** submitted a correction action report to NCQA, MDHHS did not require additional follow-up for element *NCQA 3.16*. As such, HSAG recommends that **PRI** continue to implement action plans and monitoring processes to ensure members have adequate access to covered services.

Weakness #2: While **PRI** demonstrated high performance overall (i.e., 90 percent or higher but less than 100 percent) in the MIS/Financial standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for elements *February 5.15–Monthly Encounter Record Acceptance Rate in CHAMPS*, *March 5.15–Quarterly Encounter Record Acceptance Rate in CHAMPS*, and *April 5.15–Quarterly Encounter Record Acceptance Rate in CHAMPS*, and a *Satisfied* score for element *September 5.15–Monthly Encounter Record Acceptance Rate in CHAMPS*. **[Quality]**

Why the weakness exists: Regarding element *February 5.15* findings, **PRI** did not meet the minimum encounter acceptance date for dental encounters during the month of December 2023 due to a technical issue with the eligibility files to its vendor. **PRI** continued to not meet the acceptable rate for dental encounters for January 2024 and February 2024 as identified during the review of elements *March 5.15* and *April 5.15*. Regarding element *September 5.15*, **PRI** did not meet the minimum acceptance rate for professional encounters submitted in July 2024. **PRI** indicated that it received a partially accepted response file from MDHHS and then resubmitted duplicate accepted claims in error.

Recommendation: **PRI** was required to submit a CAP to address elements *February 5.15*, *March 5.15*, and *April 5.15* which were approved by MDHHS. MDHHS did not require a CAP to address element *September 5.15* as **PRI** met the acceptance rate for professional encounters for the subsequent month. As such, HSAG recommends that **PRI** continue to implement action plans and monitoring processes to improve the accuracy of claims data reported to MDHHS, improve the encounter acceptance rate for dental and professional encounters.

Network Adequacy Validation

Performance Results

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if MHP's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each MHP according to Table 3-113.

Table 3-113—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	<i>High Confidence</i>
50.0% to 89.9%	<i>Moderate Confidence</i>
10.0% to 49.9%	<i>Low Confidence</i>
Less than 10% and/or any <i>Not Met</i> element has significant bias on the results	<i>No Confidence</i>

No indicators were identified as *Low Confidence* or *No Confidence* designations.

HSAG determined that **PRI** met both the time and distance standards and the ratio standard requirements for 100 percent of its members across all indicators or submitted an exception to MDHHS. The exceptions indicated that **PRI** was aware of a gap and while corrective steps were underway, the issue had not been fully resolved at the time of reporting. Adequacy was determined based on the MHP's compliance with MDHHS' time and distance and ratio standards, with an assessment conducted for each provider type according to county. Table 3-114 outlines the counties and provider specialties for which exceptions were submitted. Results are presented by provider specialty in Table 3-115.

Table 3-114—PRI Submitted Exceptions

County Exception Submitted	Specialty Exception Submitted
Berrien	Cardiology
Berrien	Endodontist
Berrien	General Dentistry
Berrien	Hospital
Berrien	OB/GYN
Calhoun	Prosthodontist
Cass	Endodontist
Cass	Periodontist
Kalamazoo	Periodontist

County Exception Submitted	Specialty Exception Submitted
Kalamazoo	Prosthodontist
Kent	Prosthodontist
Lake	Prosthodontist
Mason	General Dentistry
Mason	Prosthodontist
Muskegon	Endodontist
Muskegon	Prosthodontist
Oceana	Prosthodontist
Osceola	General Dentistry
Ottawa	Prosthodontist

Table 3-115—PRI Network Adequacy Compliance

Provider Specialty	Non-Rural Time and Distance	Rural Time and Distance	Non-Rural Ratio	Rural Ratio
PCPs (Adult)	Compliant	Compliant	Compliant	Compliant
PCPs (Pediatric)	Compliant	Compliant	Compliant	Compliant
OB/GYN	Compliant	Compliant	NA	NA
Cardiology	Compliant	Compliant	NA	NA
Outpatient Behavioral Health	Compliant	Compliant	NA	NA
Hospital	Compliant	Compliant	NA	NA
Pharmacy	Compliant	Compliant	NA	NA
General Dentistry	Compliant	Compliant	Compliant	Compliant
Endodontist	Compliant	Compliant	NA	NA
Oral Surgeon	Compliant	Compliant	NA	NA
Periodontist	Compliant	Compliant	NA	NA
Prosthodontist	Compliant	Compliant	NA	NA

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: PRI demonstrated its capability of maintaining an adequate provider network to service its members that included comprehensive contracting, provider data maintenance, and reporting methods. **PRI** addressed any gaps in its network by submitting exception requests to MDHHS and increasing contracting efforts to fill network gaps. [**Access**]

Strength #2: PRI used Informatica Master Data Management to identify and prevent duplicates of practitioner and facility/provider groups to enable consistent and accurate network adequacy reporting of its provider network data. [**Access**]

Weaknesses and Recommendations

Weakness #1: No specific opportunities were identified related to the data collection and management processes that **PRI** had in place to inform network adequacy standard and indicator calculations.

Why the weakness exists: NA

Recommendation: NA

Network Validation Survey

Performance Results

HSAG’s reviewers evaluated 428 randomly sampled cases by comparing provider data submitted to HSAG by **PRI** against **PRI**’s online provider directory. The sample included 210 PCPs, 210 pediatric providers, and only eight OB/GYN providers.⁹⁰ Overall, 93.9 percent of the sampled providers were located in the online directory at the sampled location, while 3.0 percent of the sampled providers located in the online directory were not at the sampled location. Additionally, 3.0 percent of the overall sampled providers could not be located in the online directory.

Table 3-116 summarizes the findings regarding the number of sampled providers and provider locations (i.e., “cases”) that HSAG’s reviewers located in the MHP’s online directory.

Table 3-116—Summary of Providers Present in Online Directory by Provider Category

Provider Category	Number of Sampled Providers	Providers Not Found in Directory		Providers Found in Directory—Not at Sampled Location		Providers Found in Directory—At Sampled Location	
		Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
PCPs	210	7	3.3%	8	3.8%	195	92.9%
Pediatric Providers	210	6	2.9%	5	2.4%	199	94.8%
OB/GYN Providers	8	0	0.0%	0	0.0%	8	100%
PRI Total	428	13	3.0%	13	3.0%	402	93.9%

¹ The denominator includes the number of sampled providers.

Table 3-117 displays the total number and percentage of cases with matched data values for indicators that were reviewed between data values shown in **PRI**’s provider data submission to HSAG and **PRI**’s online provider directory. Cases with unmatched results may include incorrect information or information not listed in the directory (e.g., the provider data included a data value for a study indicator, but the online provider directory did not include a data value for the study indicator).

⁹⁰ A low number of OB/GYN providers was sampled due to the eligible population criteria (i.e., providers with the PCP indicator) which reduced the number of eligible OB/GYN providers. Caution should be exercised when interpreting OB/GYN results for **PRI**.

Table 3-117—Provider Demographic Indicators Matching Online Directory

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		Overall	
	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
Provider Name	203	100%	204	100%	8	100%	415	100%
Provider Street Address	195	96.1%	199	97.5%	8	100%	402	96.9%
Provider Suite Number	202	99.5%	203	99.5%	8	100%	413	99.5%
Provider City	197	97.0%	199	97.5%	8	100%	404	97.3%
Provider State	200	98.5%	203	99.5%	8	100%	411	99.0%
Provider ZIP Code	197	97.0%	199	97.5%	8	100%	404	97.3%
Provider Telephone Number	196	96.6%	197	96.6%	8	100%	401	96.6%
Provider Type/Specialty	201	99.0%	204	100%	8	100%	413	99.5%
Provider Accepting New Patients	203	100%	204	100%	8	100%	415	100%
Provider Gender	202	99.5%	204	100%	8	100%	414	99.8%
Provider Primary Language ²	203	100%	203	99.5%	8	100%	414	99.8%
Non-English Language Speaking Provider (including American Sign Language) ²	203	100%	204	100%	8	100%	415	100%

¹ The denominator for each study indicator includes the number of cases in which the provider was found in the directory.

² The PDV review evaluated whether the indicator was present in the directory, but specific values were not validated.

For the secret shopper telephone survey, HSAG attempted to contact 399 sampled provider locations for **PRI**, with an overall response rate of 60.9 percent. Table 3-118 summarizes the survey response rates (i.e., cases reached) for all MHPs and for **PRI**, by provider category.

Table 3-118—Response Rates

Provider Category	Total Number of Cases ¹	Cases Reached	Response Rate
PCPs	195	109	55.9%
Pediatric Providers	196	128	65.3%
OB/GYN Providers	8	6	75.0%
PRI Total	399	243	60.9%
All MHPs Total	2,633	1,775	67.4%

¹ Total number of cases includes cases that were found in the online directory and matched on eight key indicators (i.e., name, address, city, state, ZIP Code, telephone number, provider type/specialty, and new patient acceptance).

Table 3-119 summarizes the provider data validation and accuracy results for all MHPs and **PRI**, by provider category.

Table 3-119—Provider Data Validation and Accuracy Results

Provider Category	Denom ¹	Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance		Accepting New Patients	
		Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
PCPs	109	75	68.8%	73	67.0%	61	56.0%	40	36.7%	36	33.0%
Pediatric Providers	128	90	70.3%	86	67.2%	83	64.8%	56	43.8%	44	34.4%
OB/GYN Providers	6	2	33.3%	1	16.7%	1	16.7%	1	16.7%	1	16.7%
PRI Total	243	167	68.7%	160	65.8%	145	59.7%	97	39.9%	81	33.3%
All MHPs Total	1,775	1,280	72.1%	1,215	68.5%	1,082	61.0%	822	46.3%	731	41.2%

¹ The denominator includes cases reached.

Table 3-120 displays the number of survey respondents who offered appointments to new patients for routine PCP and prenatal care visits for all MHPs and **PRI**, by provider category.

Table 3-120—Appointment Availability for Routine PCP and Prenatal Care Visits¹

Provider Category	Cases Reached	Cases Offered an Appointment	
		Count	Rate ²
PCPs	109	20	18.3%
Pediatric Providers	128	14	10.9%
OB/GYN Providers	6	0	0.0%
PRI Total	243	34	14.0%
All MHPs Total	1,775	424	23.9%

¹ Appointment availability rates were calculated using cases accepting new patients and total survey cases as the denominator in the 2022 and 2023 reports. However, the denominator used in the 2024 report was cases reached. Caution should be exercised when comparing 2024 appointment availability rates with the rates in the 2022 and 2023 reports.

² The denominator includes cases reached.

Table 3-121 displays the new patient wait time results for all MHPs and **PRI**, by provider category.

Table 3-121—Appointment Wait Time Results

Provider Category	Appointment Wait Time (Business Days)				Rate of Cases Within Standard ^{1,2}
	Min	Max	Average	Median	
PCPs	4	66	19	12	80.0%
Pediatric Providers	0	90	18	8	78.6%
OB/GYN Providers	NA	NA	NA	NA	NA
PRI Total	0	90	18	10	79.4%
All MHPs Total	0	261	18	8	80.9%

¹ The denominator includes cases offered an appointment.

² Rate of cases within standard represents the percentage of cases that were offered an appointment that was compliant with the 30-business-day standard for routine appointments and seven-business-day standard for prenatal care appointments.

NA indicates “not applicable” since no appointments were offered.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NVS 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: Reviewers located 96.9 percent of the sampled providers in **PRI**’s online provider directory. [**Quality and Access**]

Strength #2: Of the providers located in **PRI**’s online provider directory, all indicators had match rates above 95.0 percent. [**Quality and Access**]

Weaknesses and Recommendations

Weakness #1: Only 60.9 percent of the sampled provider locations could be reached, with 55.9 percent of PCPs, 65.3 percent of pediatric providers, and 75.0 percent of OB/GYN providers. [**Access**]

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

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

information) to address the provider data deficiencies. HSAG recommends that **PRI** review PCP provider data, as this provider type was lower than the overall average.

Weakness #2: Overall, 60.9 percent of sampled provider locations were reached. Of the cases reached, only 68.7 percent confirmed affiliation with the sampled provider. Additionally, 65.8 percent confirmed accuracy of the sampled address, 59.7 percent confirmed the services were offered, 39.9 percent confirmed the requested insurance, and 33.3 percent confirmed new patient acceptance. **[Quality and Access]**

Why the weakness exists: **PRI**'s provider data included invalid phone number, provider, address, specialty, new patient acceptance, and insurance information.

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

Weakness #3: Among the cases reached, only 14.0 percent of locations offered an appointment date. While PCPs had an appointment availability rate of 18.3 percent, pediatric providers had an appointment availability rate of 10.9 percent, and OB/GYN provider locations had an appointment availability rate of 0.0 percent. Of the cases that offered an appointment, 79.4 percent were compliant with the appointment wait time standard. **[Timeliness and Access]**

Why the weakness exists: For new **PRI** members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included pre-registration as well as requiring additional personal information, a Medicaid ID, or an MRR.

Recommendation: HSAG recommends that **PRI** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **PRI** 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 **PRI** procured medical records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*, to identify discrepancies and ensure alignment between the medical records and the encounter data submitted to MDHHS.

Table 3-122 outlines the key findings for **PRI** based on the assessment of encounter data completeness and accuracy conducted through a review of members' medical records for services rendered from October 1, 2022, through September 30, 2023.

Table 3-122—Key Findings for PRI

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	<ul style="list-style-type: none"> The record procurement rate was 99.0 percent, indicating that nearly all of the requested records were successfully procured and submitted.
Second Date of Service Submission Rate	<ul style="list-style-type: none"> Among the procured medical records, 40.3 percent included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	<ul style="list-style-type: none"> All key data elements, with the exception of <i>Procedure Code Modifier</i>, had relatively low medical record omission rates, ranging from 1.3 percent (<i>Date of Service</i>) to 17.7 percent (<i>Procedure Code Modifier</i>).
Encounter Data Omission Rate	<ul style="list-style-type: none"> All key data elements exhibited relatively low encounter data omission rates with <i>Procedure Code</i> having the largest encounter data omission rate at 3.7 percent.
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Diagnosis Code</i> data element was accurate in 99.7 percent of instances where codes were present in both the medical records and encounter data, with all errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code</i> data element was accurate in 98.2 percent of instances where codes were present in both the medical records and encounter data; most errors were related to inaccurate coding, while some were attributed to providers

Analysis	Key Findings
	submitting higher-level service codes than those supported in the medical records.
Procedure Code Modifier Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code Modifier</i> data element was accurate in 99.7 percent of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	<ul style="list-style-type: none"> Dates of service with accurate values for all key data elements (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, and <i>Procedure Code Modifier</i>) were observed in 76.1 percent of the dates of service present in both data sources (i.e., encounter data and medical records).

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: A high percentage of *Date of Service*, *Diagnosis Code*, and *Procedure Code* data element values in the encounter data were supported by the members' medical records, as evidenced by the low medical record omission rates of 1.3 percent, 5.2 percent, 8.8 percent, respectively.

[Quality]

Strength #2: The *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data element values identified in the medical records were generally present in the encounter data, as evidenced by the low encounter data omission rates of 3.2 percent, 2.1 percent, 3.7 percent, and 1.1 percent, respectively. [Quality]

Strength #3: When key data elements were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate with rates of at least 98.2 percent each. [Quality]

Weaknesses and Recommendations

Weakness #1: More than 17.0 percent of the *Procedure Code Modifier* data element values identified in the encounter data were not supported by the members' medical records. [Quality]

Why the weakness exists: The findings where encounter data are not supported by the medical records can stem from several potential reasons, which can involve both provider documentation practices (e.g., incomplete or inaccurate documentation, coding errors, lack of detail) and data submission (e.g., incorrect coding during data submission or data entry errors) or processing issues (e.g., data mapping or translation issues, errors in data transmission).

Recommendation: PRI should investigate the root cause(s) for these omissions, with a focus on both provider documentation practices and data handling processes. Periodic MRRs of submitted claims should be conducted to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should be used to develop and provide ongoing education and training for providers. Topics should include encounter data submissions, medical record documentation requirements, and coding practices to reduce future omissions and improve data accuracy.

Consumer Assessment of Healthcare Providers and Systems Analysis

Adult and Child Medicaid

Performance Results

Table 3-123 presents PRI's 2023 and 2024 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2024 scores were statistically significantly higher or lower than the 2023 national average. Triangles (▲ or ▼) indicate 2024 scores were statistically significantly higher or lower than the 2023 scores.

Table 3-123—Summary of Adult and Child Medicaid CAHPS Top-Box Scores for PRI

	2023 Adult Medicaid	2024 Adult Medicaid	2023 Child Medicaid	2024 Child Medicaid
Global Ratings				
<i>Rating of Health Plan</i>	61.72%	66.94%	69.83%	67.00%
<i>Rating of All Health Care</i>	52.00%	55.28%	67.07%	62.04%
<i>Rating of Personal Doctor</i>	64.80%	66.36%	75.85%	75.00%
<i>Rating of Specialist Seen Most Often</i>	60.20% ⁺	66.04%	72.22% ⁺	65.45% ⁺
Composite Measures				
<i>Getting Needed Care</i>	83.70%	84.74%	93.49%	80.78% ⁺ ▼
<i>Getting Care Quickly</i>	90.11% ⁺	84.49%	90.60%	87.43% ⁺
<i>How Well Doctors Communicate</i>	93.49%	91.82%	96.36%	94.11%
<i>Customer Service</i>	92.35% ⁺	88.85% ⁺	94.10% ⁺	92.65% ⁺
Individual Item Measure				
<i>Coordination of Care</i>	91.78% ⁺	84.55%	91.43% ⁺	86.44% ⁺
Medical Assistance With Smoking and Tobacco Use Cessation Items*				
<i>Advising Smokers and Tobacco Users to Quit</i>	74.80%	75.83%	—	—

	2023 Adult Medicaid	2024 Adult Medicaid	2023 Child Medicaid	2024 Child Medicaid
<i>Discussing Cessation Medications</i>	51.56%	54.62%	—	—
<i>Discussing Cessation Strategies</i>	40.77%	41.67%	—	—

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

* These rates follow NCQA's methodology of calculating a rolling two-year average.

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.

▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.

No triangles (▲ or ▼) indicate the 2024 score was not statistically significantly higher or lower than the 2023 score.

↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.

↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.

No arrows (↑ or ↓) indicate the 2024 score was not statistically significantly higher or lower than the 2023 national average.

— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the CAHPS 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: PRI's 2024 top-box scores were not statistically significantly higher than the 2023 NCQA adult and child Medicaid national averages or the 2023 top-box scores for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: PRI's 2024 top-box score was statistically significantly lower than the 2023 child Medicaid top-box score for one measure, *Getting Needed Care*. [Quality and Access]

Why the weakness exists: When compared to national benchmarks, members enrolled in PRI may not be receiving the care they need. However, HSAG is unable to identify the MHP-specific barriers or other factors impacting drivers for this measure based on the information provided through this EQR.

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

CSHCS

Performance Results

Table 3-124 presents **PRI**'s 2023 and 2024 CSHCS CAHPS top-box scores. Upward green or downward red arrows (↑ or ↓) indicate 2024 scores were statistically significantly higher or lower than the 2023 national average. Upward green or downward red triangles (▲ or ▼) indicate 2024 scores were statistically significantly higher or lower than the 2023 scores.

Table 3-124—Summary of CSHCS CAHPS Survey Top-Box Scores for PRI

	2023 Top-Box Score	2024 Top-Box Score
Global Ratings		
<i>Rating of Health Plan</i>	67.62%	72.43%▲
<i>Rating of Health Care</i>	65.87%	69.20% NA
<i>Rating of Specialist Seen Most Often</i>	70.06%	70.20%
Composite Measures		
<i>Customer Service</i>	85.96% ⁺	88.09% ⁺
<i>How Well Doctors Communicate</i>	93.89%	95.01% NA
<i>Access to Specialized Services</i>	72.60% ⁺	73.11% ⁺ NA
<i>Transportation</i>	70.54% ⁺	70.18% ⁺ NA
Individual Item Measures		
<i>Access to Prescription Medicines</i>	91.71%	87.05%
<i>Not Felt Treated Unfairly: Race and Ethnicity</i>	97.47%	97.38% NA
<i>Not Felt Treated Unfairly: Health Insurance Type</i>	94.44%	94.30% NA

⁺ Indicates fewer than 100 respondents. Caution should be exercised when evaluating the results.

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.

▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.

No triangle (▲ or ▼) indicates the 2024 score was not statistically significantly higher or lower than the 2023 score.

↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.

↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.

No arrow (↑ or ↓) indicates the 2024 score was not statistically significantly higher or lower than the 2023 national average.

NA Indicates a national average is not available for the measure.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the CAHPS 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: **PRI**'s 2024 top-box score was statistically significantly higher than the 2023 NCQA child Medicaid national average for one measure, *Rating of Health Plan*. [Quality]

Weaknesses and Recommendations

Weakness #1: **PRI**'s 2024 top-box scores were not statistically significantly lower than the 2023 NCQA child Medicaid national averages or 2023 top-box scores for any reportable measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

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

Quality Rating

The 2024 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2024 Michigan Consumer Guide, which is inclusive of **PRI**'s performance.

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

HSAG performed a comprehensive assessment of **PRI**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **PRI** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **PRI**'s overall performance contributed to the CHCP's progress in achieving the CQS goals and objectives. Table 3-125 displays each MDHHS CQS goal and the EQR activity results that indicate whether the MHP positively (✓), negatively (✗), or minimally (m) impacted the CHCP's progress toward achieving the applicable goals and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to **PRI**'s Medicaid members. Not applicable (NA) was used when EQR activities do not produce data to assess the impact of a quality measure(s) under an objective.

Table 3-125—Overall Performance Impact to CQS and Quality, Timeliness, and Access

Objective	Program	Quality Measure	Overall Performance Impact	Performance Domain
Goal #1: Ensure high quality and high levels of access to care				
1.1	CHCP	<i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	✓	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	CHCP	<i>Prenatal and Postpartum Care—Postpartum Care</i>	✗	

Objective	Program	Quality Measure	Overall Performance Impact	Performance Domain
	CHCP	Childhood Immunization Status—Combination 3	✓	
	CSHCS	Global Rating of Health Plan	✓	
	CSHCS	Global Rating of Specialist Seen Most Often	m	
	CSHCS	Global Rating of Health Care	✓	
	CSHCS	Composite Measure for Access to Specialized Services	✓	
	CSHCS	Composite Measure for Transportation	✗	
1.2	CHCP	Asthma Medication Ratio—Total	✗	
	CHCP	Controlling High Blood Pressure	✓	
	CHCP	Comprehensive Diabetes Care (CDC)—Eye Exams ^l	✓	
	CSHCS	Composite Measure for How Well Doctors Communicate	✓	
	CSHCS	Composite Measure for Customer Service	m	
1.3	CHCP	Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	NA	
	CHCP	Getting Care Quickly Composite (Adult CAHPS)	✗	
	CSHCS	Global Rating of Health Care	✓	
	CSHCS	Composite Measure for Access to Specialized Services	✓	
	CSHCS	Access to Prescription Medicines	✗	
Goal #2: Strengthen person and family-centered approaches				
2.1	CHCP	Rating of Health Plan ²	m	☒ Quality ☐ Timeliness ☒ Access
	CHCP	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years Old	✓	
	CHCP	Access to Dental Care	m	
	CHCP	Completion of Annual Health Risk Assessment	NA	
	CSHCS	Composite Measure for How Well Doctors Communicate	✓	
	CSHCS	Global Rating of Health Plan	✓	
	CSHCS	Global Rating of Health Care	✓	
	CSHCS	Global Rating of Specialist Seen Most Often	m	
2.2	CHCP	SDOH: Total Member Screening Rate	NA	
	CHCP	SDOH: Total Member Referral Rate	NA	
	CHCP	Social Need Screening and Intervention	NA	
	CSHCS	Composite Measure for Access to Specialized Services	✓	

Objective	Program	Quality Measure	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)				
3.1	CHCP	Follow-Up After Hospitalization for Mental Illness Within 30 Days (FUH) (Adults)	NA	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	CSHCS	Coordination of Care	NA	
3.2	CHCP	Implementation of Joint Care Management Processes	NA	
	CSHCS	Global Rating of Health Plan	✓	
	CSHCS	Global Rating of Health Care	✓	
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes				
4.1	CHCP	Chlamydia Screening in Women—Total ³	NA	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	CHCP	Prenatal and Postpartum Care—Postpartum Care ³	NA	
	CHCP	Children Immunization Combo 3 ³	NA	
	CHCP	Lead Screening in Children ³	NA	
	CHCP	Comprehensive Diabetes Care—Eye Exam ³	NA	
	CHCP	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years Old ³	NA	
	CSHCS	Not Felt Treated Unfairly: Race and Ethnicity	✗	
Goal #5: Improve quality outcomes through value-based initiatives and payment reform				
5.1	CHCP	Average Percentage of Plan Payments to Providers Who Are in APM Arrangements ("Big Numerator")	NA	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access
	CHCP	Average Percentage of Plan Payments to Providers That Are Tied to Quality ("Small Numerator")	NA	

✓ = The MHP's rate met the 2026 statewide performance target; or the MHP's rate did not meet the 2026 statewide performance target but demonstrated a statistically significant increase in performance from the prior year.

m = The MHP's rate did not meet the 2026 statewide performance target and while the MHP's rate increased in performance from the prior year, the increase was not statistically significant.

✗ = The MHP's rate did not meet the 2026 statewide performance target and/or the MHP's rate decreased in performance from the prior year.

NA = EQR activities published in this report do not produce data to assess the impact of a quality measure(s) under an objective.

¹ NCQA replaced the *Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed* performance measure with the *Eye Exam for Patients With Diabetes (EED)* performance measure, the overall performance impact was based on the MHP's reported rate for *Eye Exam for Patients With Diabetes (EED)*.

² As the CQS did not identify whether this quality measure applies to the adult or child CAHPS, HSAG assessed performance using the adult rate.

³ While there are reported HEDIS rates that are stratified by race/ethnicity, the EQR deliverables did not include an analysis of these data.

UnitedHealthcare Community Plan

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **UNI**'s PIP (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-126 displays the overall validation rating, the baseline rate, Remeasurement 1, and Remeasurement 2 results for the performance indicators, and if a disparity existed within the most recent measurement period.

Table 3-126—Overall Validation Rating for UNI

PIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
Addressing Disparities in Timeliness of Prenatal Care	High Confidence	No Confidence	Timeliness of prenatal care for African American/Black members in Region 10.	61.5%	59.2% ⇔	60.5% ⇔	NA

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).

NA = The MHP did not identify a disparity within its population; therefore, an assessment of an existing disparity during R2 is not applicable.

Due to its lack of an identified disparity, **UNI** determined through data analysis that the focus for the PIP should be improving timeliness of prenatal care for its African-American/Black members who reside in Region 10, as this population was the lowest-performing subgroup. The overall goal is to achieve statistically significant improvement over the baseline performance for the subsequent remeasurement periods. Table 3-127 displays the barriers identified through QI and causal/barrier analysis processes and the interventions initiated by the MHP to support achievement of the PIP goals and address the barriers.

Table 3-127—Remeasurement 2 Barriers and Interventions for UNI

Barriers	Interventions
Access to quality care	Maternal Infant Health Program (MIHP) referrals
Members—Access to prenatal care—social determinants of health	Mommy coach—perinatal community health workers
Members—Access to prenatal care	Healthy first steps—case management services to break down barriers
Providers—Providing prenatal care	Cultural competency training. Provider incentives to improve access and quality of care by closing gaps
Biomedical—Prenatal care models	Doula pilot and doula services
Health plan—Support of members and providers—health literacy	Babyscripts—provider and member education and incentives Member Advisory Group meetings with maternal health focus

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PIP 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: UNI used appropriate QI tools to conduct its causal/barrier analysis and interventions were initiated in a timely manner and reasonably linked to the identified barriers. [**Quality, Timeliness, and Access**]

Weaknesses and Recommendations

Weakness #1: UNI demonstrated a decrease in performance for the second remeasurement period as compared to the baseline performance [**Quality, Timeliness, and Access**]

Why the weakness exists: While it is unclear why the performance indicator demonstrated a decrease in performance, the data suggest that barriers exist for the targeted population in the receipt of timely prenatal care.

Recommendation: HSAG recommends that **UNI** consider evidence-based intervention efforts and risk factors in quality and timeliness of care for the targeted population. **UNI** should also closely evaluate the success of each intervention strategy to determine any needs for modifications in order to achieve the desired improvement:

Performance Measure Validation

Performance Results

UNI was evaluated against NCQA’s IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2023 Compliance Audit Report findings, **UNI** was fully compliant with all four IS standards.

According to the auditor’s review, **UNI** followed the NCQA HEDIS MY 2023 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-128 displays the MDHHS-selected performance measures, HEDIS MY 2022 and MY 2023 rates, MY 2022 and MY 2023 comparisons, and MY 2023 performance levels based on comparisons to national percentiles⁹¹ for **UNI**. Additional performance measures and performance measure results for **UNI** can be referenced in Appendix B.

Table 3-128—HEDIS MY 2023 Performance Measure Results for UNI

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
Child & Adolescent Care				
<i>Childhood Immunization Status (CIS)</i>				
<i>Combination 3</i>	54.42%	59.37%	+4.95	★★
<i>Combination 7</i>	45.21%	48.66%	+3.45	★
<i>Combination 10</i>	22.19%	19.71%	-2.48	★
<i>Well-Child Visits in the First 30 Months of Life (W30)</i>				
<i>Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	63.74%	64.92%	+1.17	★★★★
<i>Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i>	60.54%	63.62%	+3.08+	★★
<i>Lead Screening in Children (LSC)</i>				
<i>Lead Screening in Children</i>	59.12%	58.39%	-0.73	★★
<i>Child and Adolescent Well-Care Visits (WCV)</i>				
<i>Ages 3 to 11 Years</i>	57.05%	60.23%	+3.18+	★★★★
<i>Ages 12 to 17 Years</i>	50.53%	53.14%	+2.61+	★★★★

⁹¹ HEDIS MY 2023 performance measure rates are compared to NCQA’s Quality Compass National Medicaid Health Maintenance Organization (HMO) percentiles for HEDIS MY 2022 (referred to as “percentiles” throughout this section of the report).

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
<i>Ages 18 to 21 Years</i>	30.71%	32.82%	+2.11+	★★★★
<i>Total</i>	50.04%	53.09%	+3.06+	★★★
Immunizations for Adolescents (IMA)				
<i>Combination 1 (Meningococcal, Tdap)</i>	76.89%	79.08%	+2.19	★★
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	31.14%	31.14%	0.00	★★
Women—Adult Care				
<i>Chlamydia Screening in Women (CHL)</i>³				
<i>Ages 16 to 20 Years</i>	59.47%	59.17%	-0.31	★★★
<i>Ages 21 to 24 Years</i>	63.50%	62.51%	-0.99	★★★
<i>Total</i>	61.33%	60.67%	-0.67	★★★
<i>Cervical Cancer Screening (CCS-E)</i>				
<i>Cervical Cancer Screening</i>	58.88%	54.41%	-4.47	★★
<i>Breast Cancer Screening (BCS-E)</i>				
<i>Breast Cancer Screening</i>	53.28%	55.49%	+2.21+	★★★
Access to Care				
<i>Adults’ Access to Preventive/Ambulatory Health Services (AAP)</i>				
<i>Ages 20 to 44 Years</i>	73.00%	73.02%	+0.02	★★★
<i>Ages 45 to 64 Years</i>	84.17%	84.27%	+0.10	★★★★
<i>Ages 65 Years and Older</i>	90.27%	91.05%	+0.78	★★★★
<i>Total</i>	77.02%	77.29%	+0.27	★★★
Pregnancy Care				
<i>Prenatal and Postpartum Care (PPC)</i>³				
<i>Timeliness of Prenatal Care</i>	77.37%	83.45%	+6.08+	★★
<i>Postpartum Care</i>	74.70%	71.78%	-2.92	★
Living With Illness				
<i>Hemoglobin A1c Control for Patients With Diabetes (HBD)</i>				
<i>HbA1c Control (<8.0%)</i>	59.12%	62.29%	+3.16	★★★★★
<i>Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*</i>	33.09%	27.98%	-5.11	★★★★★
<i>Blood Pressure Control for Patients With Diabetes (BPD)</i>				
<i>Blood Pressure Control for Patients With Diabetes</i>	75.18%	73.48%	-1.70	★★★★

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
Eye Exam for Patients With Diabetes (EED)³				
Eye Exam for Patients With Diabetes	56.93%	52.55%	-4.38	★★★
Kidney Health Evaluation for Patients With Diabetes (KED)				
Ages 18 to 64 Years	40.62%	41.46%	+0.84	★★★★★
Ages 65 to 74 Years	51.15%	50.25%	-0.90	★★★★★
Ages 75 to 85 Years	57.46%	51.85%	-5.61	★★★★★
Total	41.30%	42.10%	+0.80	★★★★★
Asthma Medication Ratio (AMR)				
Total	62.79%	63.47%	+0.68	★★
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	65.45%	71.78%	+6.33	★★★★★
Diagnosed Mental Health Disorders (DMH)				
Ages 1 to 17 Years	—	NR	NC	NC
Ages 18 to 64 Years	—	NR	NC	NC
Ages 65 Years and Older	—	NR	NC	NC
Total	—	NR	NC	NC
Utilization				
Plan All-Cause Readmissions (PCR)				
Observed Readmissions—Total	10.49%	10.24%	-0.25	NC
Expected Readmissions—Total	10.88%	10.65%	-0.23	NC
O/E Ratio—Total	0.9645	0.9619	0.00	★★★

¹ HEDIS MY 2022 to HEDIS MY 2023 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2022–MY 2023 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2022–MY 2023 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

² Performance Levels for MY 2023 were based on comparisons of the HEDIS MY 2023 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2022 benchmark.

³ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

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

Please note that for the *Diagnosed Mental Health Disorders (DMH)* measure, a higher or lower rate does not indicate better performance, as the measure provides information on the diagnosed prevalence of mental health disorders. Therefore, this measure is not included in the evaluation of strengths and weaknesses below.

Green Shading⁺ Indicates that the HEDIS MY 2023 rate demonstrated a significant improvement from the HEDIS MY 2022 rate.

Red Shading⁺⁺ Indicates that the HEDIS MY 2023 rate demonstrated a significant decline from the HEDIS MY 2022 rate.

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

NR indicates that the measure was not required to be reported by the plan.

HEDIS MY 2023 Performance Levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PMV 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: UNI's performance ranked between the 75th and 89th percentiles for the *Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator, indicating children who turned 15 months old during the measurement year were having at least six well-child visits with a PCP during their first 15 months of life most of the time. Research shows that early intervention treatment services can greatly improve a child's development. Early intervention services help children from birth through 3 years of age (36 months) learn important skills.⁹² [Quality, Timeliness, and Access]

Strength #2: UNI's performance ranked between the 75th and 89th percentiles for the *Child and Adolescent Well-Care Visits (WCV)—Ages 18 to 21 Years* measure indicator and demonstrated significant improvement from MY 2022 to MY 2023, indicating members between the ages of 18 and 21 years received one or more well-care visits with a PCP or OB/GYN practitioner during the measurement year most of the time. More frequent well-child visits in the first years of life and one or more well-child visits from ages 3–21 are recommended. Well-child visits should include, but are not limited to, an initial/interval medical history, physical exam, developmental assessment, immunization, and anticipatory guidance.⁹³ [Quality, Timeliness, and Access]

Strength #3: UNI's performance ranked between the 75th and 89th percentiles for the *Adults' Access to Preventive/Ambulatory Health Services (AAP)—Ages 45 to 64 Years and Ages 65 Years and Older* measure indicators, indicating that members 45 years of age and older had an ambulatory or preventive care visit most of the time. Healthcare visits are an opportunity for individuals to

⁹² National Committee for Quality Assurance. Well-Child Visits in the First 30 Months of Life (W30). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/well-child-visits-in-the-first-30-months-of-life-w30/>. Accessed on: Apr 2, 2025.

⁹³ National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (WCV). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/child-and-adolescent-well-care-visits-wcv/>. Accessed on: Apr 2, 2025.

receive preventive services and counseling on topics such as diet and exercise. These visits also can help them to address acute issues or manage chronic conditions.⁹⁴ [Quality and Access]

Strength #4: UNI's performance ranked above the 90th percentile for the *Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Control (<8.0%)* and *Hemoglobin A1c (HbA1c) Poor Control (>9.0%)* measure indicators, indicating members with diabetes had controlled HbA1c levels most of the time during the measurement year. Glycemic control is management of blood sugar levels to reduce the risk of microvascular complications (eye, kidney, and nerve diseases). Many complications such as heart disease, stroke, blindness, kidney failure, and amputation can be prevented if diabetes is detected and addressed in the early stages.⁹⁵ [Quality and Access]

Strength #5: UNI's performance ranked between the 75th and 89th percentiles for the *Blood Pressure Control for Patients With Diabetes (BPD)* measure indicator, indicating members 18–75 years of age, with a diagnosis of diabetes, had controlled blood pressure levels most of the time. Diabetes is a chronic condition marked by high blood sugar due to the body's inability to make or use insulin. Left unmanaged, diabetes can lead to more serious health conditions, including high blood pressure. Proper blood pressure management is essential to avoid further complications, including heart attack, stroke, kidney disease, and blindness. With support from healthcare providers, patients can manage their blood pressure to maintain a healthy and productive life.⁹⁶ [Quality]

Strength #6: UNI's performance ranked between the 75th and 89th percentiles for the *Kidney Health Evaluation for Patients With Diabetes (KED)—Ages 18 to 64 Years, Ages 65 to 74 Years, Ages 75 to 85 Years, and Total* measure indicators, indicating members ages 18–85 years of age, with a diagnosis of diabetes, received an annual kidney health evaluation, including a blood test for kidney function and a urine test for kidney damage. Diabetes is the leading cause of chronic kidney disease (CKD). CKD gets worse over time and can lead to heart disease, stroke and kidney failure. For these reasons, annual monitoring of kidney health is crucial for people with diabetes.⁹⁷ [Quality]

Strength #7: UNI's performance ranked between the 75th and 89th percentiles for the *Controlling High Blood Pressure (CBP)* measure indicator, indicating members 18–85 years of age, with a diagnosis of hypertension, had blood pressure adequately controlled. Controlling high blood pressure

⁹⁴ National Committee for Quality Assurance. Adults' Access to Preventive/Ambulatory Health Services (AAP). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/adults-access-to-preventive-ambulatory-health-services-aap/>. Accessed on: Apr 1, 2025.

⁹⁵ National Committee for Quality Assurance. Glycemic Status Assessment for Patients With Diabetes (GSD). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/glycemic-status-assessment-for-patients-with-diabetes-gsd/>. Accessed on: Apr 1, 2025.

⁹⁶ National Committee for Quality Assurance. Blood Pressure Control for Patients With Diabetes (BPD). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/blood-pressure-control-for-patients-with-diabetes-bpd/>. Accessed on: Apr 2, 2025.

⁹⁷ National Committee for Quality Assurance. Kidney Health Evaluation for Patients With Diabetes. Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/kidney-health-evaluation-for-patients-with-diabetes-ked/>. Accessed on: Apr 2, 2025.

is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.⁹⁸ [Quality]

Strength #8: UNI demonstrated overall strength in its HEDIS data reporting, as UNI was fully compliant with all four IS standards and all performance measure rates were determined to be Reportable. [Quality]

Weaknesses and Recommendations

Weakness #1: UNI's performance for the *Childhood Immunization Status (CIS)—Combination 7* and *Combination 10* measure indicators ranked below the 25th percentile. In addition, the *Childhood Immunization Status (CIS)—Combination 3* measure indicator ranked between the 25th and 49th percentiles, indicating that children 2 years of age were not receiving some vaccinations by their second birthday. Childhood immunizations help prevent serious illnesses such as polio, tetanus, and hepatitis. Vaccines are a proven way to help a child stay healthy and avoid the potentially harmful effects of childhood diseases like mumps and measles.⁹⁹ [Quality and Timeliness]

Why the weakness exists: The rate for the *Childhood Immunization Status (CIS)—Combination 7* and *Combination 10* measure indicators ranked below the 25th percentile. In addition, the *Childhood Immunization Status (CIS)—Combination 3* measure indicator rate ranked between the 25th and 49th percentiles. Potential barriers to improved measure performance that were identified by UNI include, but are not limited to, provider challenges with vaccination storage protocols, providers obtaining necessary vaccination certifications, provider cost deterrents related to the short shelf life for vaccines/maintaining inventory, and parental vaccination hesitancy.

Recommendation: HSAG recommends that UNI explore avenues to increase awareness of vaccination importance among parents to reduce vaccination hesitancy, such as a “speculation versus fact” pamphlet, which includes a phone number for care management support. AET could also consider issuing provider incentives for maintaining a complete inventory of vaccinations.

Weakness #2: UNI's performance for the *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators ranked between the 25th and 49th percentiles and below the 25th percentile, respectively, indicating that pregnant women were not always having a prenatal visit in the first trimester and not always having a postpartum visit on or between 7 and 84 days after delivery during the measurement year. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.¹⁰⁰ [Quality, Timeliness, and Access]

⁹⁸ National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/controlling-high-blood-pressure-cbp/>. Accessed on: Apr 2, 2025.

⁹⁹ National Committee for Quality Assurance. Childhood Immunization Status (CIS-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/childhood-immunization-status-cis-e/>. Accessed on: Apr 2, 2025.

¹⁰⁰ National Committee for Quality Assurance. Prenatal and Postpartum Care (PPC). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/prenatal-and-postpartum-care-ppc/>. Accessed on: Apr 2, 2025.

Why the weakness exists: While the rate for the *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care* measure indicator demonstrated significant improvement from MY 2022 to MY 2023, both rates for *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care* and *Postpartum Care* ranked between the 25th and 49th percentiles and below the 25th percentile, respectively, suggesting that barriers exist for some pregnant women to have timely prenatal and postpartum visits.

Recommendation: HSAG recommends that **UNI** continue developing targeted interventions to improve the performance of the *Prenatal and Postpartum Care (PPC)* measure indicators. Initiatives should be monitored and expanded upon as additional contributing factors are identified. **MCL** could consider creating member incentives to promote increased prenatal and postpartum engagement, such a baby registry for pre-approved baby items and supplies.

Compliance Review

Performance Results

Table 3-129 presents the total number of criteria for each standard that received a score of *Met*, *Satisfied*, or *Not Met*. Table 3-129 also presents **UNI**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. *NA* was used when MDHHS determined the review element was not applicable during the compliance review. For elements scored as *Not Met*, **UNI** was subject to a corrective action review process outlined in Appendix A.

Table 3-129—Compliance Review Results for UNI

Standard		Number of Scores				Compliance Scores	
		<i>Met</i>	<i>Satisfied</i> ¹	<i>Not Met</i>	<i>NA</i>	UNI ²	Statewide ³
1	Administrative	5	0	0	0	100%	100%
2	Providers	23	0	1	0	96%	95.4%
3	Members	29	0	0	1	100%	98.9%
4	Quality	24	0	0	0	100%	100%
5	MIS/Financial	50	1	0	0	98%	94.6%
6	OIG/Program Integrity	8	0	2	0	80%	85.6%
Overall		139	1	3	1	97%	96.0%

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

¹ A score of *Satisfied* was only allowable for select elements under the MIS/Financial standard.

² MDHHS calculated the total compliance score for each standard by totaling the number of *Met* (i.e., 1 point) elements and the number of *Not Met* and *Satisfied* (i.e., 0 points) elements, then dividing the summed score by the total number of elements for that standard.

³ MDHHS calculated the statewide performance scores to the tenth decimal place; however, MHP performance scores were calculated using whole number percentages.

Additionally, to supplement the compliance review activity, MDHHS conducted staff interviews, referred to as focus studies, in the following three areas: CSHCS, Operations, and Quality. While the results of the focus studies are not incorporated into the scoring of the compliance review, **UNI** met MDHHS' expectations for participation in the studies.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the compliance review 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: **UNI** achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. [Quality]

Strength #2: **UNI** achieved full compliance in the Members standard, demonstrating the MHP maintained sufficient policies and procedures to support its membership, which included, but was not limited to, access to service authorization processes; care coordination procedures; fair grievance and appeal systems; member information materials such as the handbook, newsletters, and website; and choice of PCPs. [Quality, Timeliness, and Access]

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

Weaknesses and Recommendations

Weakness #1: **UNI** demonstrated low performance overall in the OIG/Program Integrity standard and the MHP scored below the statewide average. The MHP received a *Not Met* score for elements *April 6.8–Encounter Adjustment* and *August 6.1-6.7–Quarterly PI Report*. [Quality]

Why the weakness exists: Regarding element *April 6.8*, **UNI** did not meet the minimum match requirements for encounters due to reporting errors resulting from a staff training deficiency. Regarding element *August 6.1-6.7*, the program integrity reports included several data errors/discrepancies and were missing narrative responses. **UNI** updated internal processes to reflect the most recent reporting template and guidance, and reporting analysts have been given an updated guide and job aid to reflect the deficiencies found in the report.

Recommendation: **UNI** was required to submit a CAP to address elements *April 6.8* and *August 6.1-6.7*, which was approved by MDHHS. As such, HSAG recommends that **UNI** continue to implement action plans and monitoring processes to ensure accurate data are reported to MDHHS.

Network Adequacy Validation

Performance Results

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MHP’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each MHP according to Table 3-130.

Table 3-130—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	<i>High Confidence</i>
50.0% to 89.9%	<i>Moderate Confidence</i>
10.0% to 49.9%	<i>Low Confidence</i>
Less than 10% and/or any <i>Not Met</i> element has significant bias on the results	<i>No Confidence</i>

No indicators were identified as *Low Confidence* or *No Confidence* designations.

HSAG determined that **UNI** met both the time and distance standards and the ratio standard requirements for 100 percent of its members across all indicators or submitted an exception to MDHHS. The exceptions indicated that **UNI** was aware of a gap and while corrective steps were underway, the issue had not been fully resolved at the time of reporting. Adequacy was determined based on the MHP’s compliance with MDHHS’ time and distance and ratio standards, with an assessment conducted for each provider type according to county. Table 3-131 outlines the counties and provider specialties for which exceptions were submitted. Results are presented by provider specialty in Table 3-132.

Table 3-131—UNI Submitted Exceptions

County Exception Submitted	Specialty Exception Submitted
Berrien	Cardiology
Berrien	Hospital
Berrien	OB/GYN
Berrien	General Dentistry
Berrien	Endodontist
Calhoun	Periodontist
Cass	Periodontist
Kalamazoo	Periodontist
Berrien	Oral Surgeon

County Exception Submitted	Specialty Exception Submitted
Berrien	Periodontist
Berrien	Prosthodontist

Table 3-132—UNI Network Adequacy Compliance

Provider Specialty	Non-Rural Time and Distance	Rural Time and Distance	Non-Rural Ratio	Rural Ratio
PCPs (Adult)	Compliant	Compliant	Compliant	Compliant
PCPs (Pediatric)	Compliant	Compliant	Compliant	Compliant
OB/GYN	Compliant	Compliant	NA	NA
Cardiology	Compliant	Compliant	NA	NA
Outpatient Behavioral Health	Compliant	Compliant	NA	NA
Hospital	Compliant	Compliant	NA	NA
Pharmacy	Compliant	Compliant	NA	NA
General Dentistry	Compliant	Compliant	Compliant	Compliant
Endodontist	Compliant	Compliant	NA	NA
Oral Surgeon	Compliant	Compliant	NA	NA
Periodontist	Compliant	Compliant	NA	NA
Prosthodontist	Compliant	Compliant	NA	NA

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: UNI leveraged an externally published website to secure Google application programming interface information, which drove demographic comparisons for both facility and professional providers. [Access]

Strength #2: UNI implemented proactive defect detection rules triggered during demographic loading, alerting the data loader of possible issues to review and giving the opportunity to remediate before the error is introduced into production. [Access]

Weaknesses and Recommendations

Weakness #1: Providers continued to be deficient in sending updates even after targeted outreach and education; however, this was a partnership with **UNI** provider partners, and the providers did not necessarily make this a priority. [Access]

Why the weakness exists: **UNI** did not have sufficient measures in place with providers to mandate and facilitate the timely submission of provider data.

Recommendation: HSAG recommends that **UNI** implement additional strategies to improve communication and overall provider engagement.

Network Validation Survey

Performance Results

HSAG’s reviewers evaluated 411 randomly sampled cases by comparing provider data submitted to HSAG by **UNI** against **UNI**’s online provider directory. The sample included 137 PCPs, 137 pediatric providers, and 137 OB/GYN providers. Overall, 91.5 percent of the sampled providers were located in the online directory at the sampled location, while 4.9 percent of the sampled providers located in the online directory were not at the sampled location. Additionally, 3.6 percent of the overall sampled providers could not be located in the online directory.

Table 3-133 summarizes the findings regarding the number of sampled providers and provider locations (i.e., “cases”) that HSAG’s reviewers located in the MHP’s online directory.

Table 3-133—Summary of Providers Present in Online Directory by Provider Category

Provider Category	Number of Sampled Providers	Providers Not Found in Directory		Providers Found in Directory—Not at Sampled Location		Providers Found in Directory—At Sampled Location	
		Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
PCPs	137	2	1.5%	0	0.0%	135	98.5%
Pediatric Providers	137	5	3.6%	1	0.7%	131	95.6%
OB/GYN Providers	137	8	5.8%	19	13.9%	110	80.3%
UNI Total	411	15	3.6%	20	4.9%	376	91.5%

¹ The denominator includes the number of sampled providers.

Table 3-134 displays the total number and percentage of cases with matched data values for indicators that were reviewed between data values shown in **UNI**'s provider data submission to HSAG and **UNI**'s online provider directory. Cases with unmatched results may include incorrect information or information not listed in the directory (e.g., the provider data included a data value for a study indicator, but the online provider directory did not include a data value for the study indicator).

Table 3-134—Provider Demographic Indicators Matching Online Directory

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		Overall	
	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
Provider Name	135	100%	132	100%	129	100%	396	100%
Provider Street Address	135	100%	131	99.2%	110	85.3%	376	94.9%
Provider Suite Number	135	100%	130	98.5%	113	87.6%	378	95.5%
Provider City	135	100%	132	100%	121	93.8%	388	98.0%
Provider State	135	100%	132	100%	129	100%	396	100%
Provider ZIP Code	135	100%	132	100%	118	91.5%	385	97.2%
Provider Telephone Number	135	100%	127	96.2%	110	85.3%	372	93.9%
Provider Type/Specialty	135	100%	132	100%	129	100%	396	100%
Provider Accepting New Patients	135	100%	132	100%	128	99.2%	395	99.7%
Provider Gender	135	100%	132	100%	129	100%	396	100%
Provider Primary Language ²	135	100%	132	100%	129	100%	396	100%
Non-English Language Speaking Provider (including American Sign Language) ²	135	100%	132	100%	129	100%	396	100%

¹ The denominator for each study indicator includes the number of cases in which the provider was found in the directory.

² The PDV review evaluated whether the indicator was present in the directory, but specific values were not validated.

For the secret shopper telephone survey, HSAG attempted to contact 368 sampled provider locations for **UNI**, with an overall response rate of 54.6 percent. Table 3-135 summarizes the survey response rates (i.e., cases reached) for all MHPs and for **UNI**, by provider category.

Table 3-135—Response Rates

Provider Category	Total Number of Cases ¹	Cases Reached	Response Rate
PCPs	135	67	49.6%
Pediatric Providers	127	56	44.1%
OB/GYN Providers	106	78	73.6%

Provider Category	Total Number of Cases ¹	Cases Reached	Response Rate
UNI Total	368	201	54.6%
All MHPs Total	2,633	1,775	67.4%

¹ Total number of cases includes cases that were found in the online directory and matched on eight key indicators (i.e., name, address, city, state, ZIP Code, telephone number, provider type/specialty, and new patient acceptance).

Table 3-136 summarizes the provider data validation and accuracy results for all MHPs and **UNI**, by provider category.

Table 3-136—Provider Data Validation and Accuracy Results

Provider Category	Denom ¹	Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance		Accepting New Patients	
		Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
PCPs	67	51	76.1%	49	73.1%	45	67.2%	31	46.3%	26	38.8%
Pediatric Providers	56	40	71.4%	39	69.6%	36	64.3%	31	55.4%	29	51.8%
OB/GYN Providers	78	58	74.4%	54	69.2%	40	51.3%	33	42.3%	31	39.7%
UNI Total	201	149	74.1%	142	70.6%	121	60.2%	95	47.3%	86	42.8%
All MHPs Total	1,775	1,280	72.1%	1,215	68.5%	1,082	61.0%	822	46.3%	731	41.2%

¹ The denominator includes cases reached.

Table 3-137 displays the number of survey respondents who offered appointments to new patients for routine PCP and prenatal care visits for all MHPs and **UNI**, by provider category.

Table 3-137—Appointment Availability for Routine PCP and Prenatal Care Visits¹

Provider Category	Cases Reached	Cases Offered an Appointment	
		Count	Rate ²
PCPs	67	13	19.4%
Pediatric Providers	56	14	25.0%
OB/GYN Providers	78	18	23.1%
UNI Total	201	45	22.4%
All MHPs Total	1,775	424	23.9%

¹ Appointment availability rates were calculated using cases accepting new patients and total survey cases as the denominator in the 2022 and 2023 reports. However, the denominator used in the 2024 report was cases reached. Caution should be exercised when comparing 2024 appointment availability rates with the rates in the 2022 and 2023 reports.

² The denominator includes cases reached.

Table 3-138 displays the new patient wait time statistics for all MHPs and **UNI**, by provider category.

Table 3-138—Appointment Wait Time Results

Provider Category	Appointment Wait Time (Business Days)				Rate of Cases Within Standard ^{1,2}
	Min	Max	Average	Median	
PCPs	2	145	31	9	61.5%
Pediatric Providers	1	84	23	14	78.6%
OB/GYN Providers	2	60	15	11	38.9%
UNI Total	1	145	22	10	57.8%
All MHPs Total	0	261	18	8	80.9%

¹ The denominator includes cases offered an appointment.

² Rate of cases within standard represents the percentage of cases that were offered an appointment that was compliant with the 30-business-day standard for routine appointments and seven-business-day standard for prenatal care appointments.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NVS 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: Reviewers located 96.4 percent of the sampled providers in **UNI**'s online provider directory. [Access]

Strength #2: Of the providers located in **UNI**'s online provider directory, all indicators had match rates above 90.0 percent. [Quality and Access]

Weaknesses and Recommendations

Weakness #1: Overall, only 54.6 percent of the sampled provider locations could be reached. [Access]

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

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

Weakness #2: Of the locations reached, only 74.1 percent confirmed affiliation with the sampled provider. Additionally, 70.6 percent confirmed accuracy of the sampled address, 60.2 percent confirmed the services were offered, 47.3 percent confirmed the requested insurance, and 42.8 percent confirmed new patient acceptance. [Quality and Access]

Why the weakness exists: UNI's provider data included invalid provider, address, specialty, new patient, and insurance information.

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

Weakness #3: Among the total cases reached, only 22.4 percent of locations offered an appointment date. Pediatric providers had an appointment availability rate of 25.0 percent, while PCPs had an appointment availability rate of 19.4 percent, and OB/GYN providers had an appointment availability rate of 23.1 percent. Of the cases that offered an appointment, 57.8 percent were compliant with the appointment wait time standard. [Timeliness and Access]

Why the weakness exists: For new UNI members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included pre-registration as well as requiring additional personal information, a Medicaid ID, or an MRR.

Recommendation: HSAG recommends that UNI work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that UNI 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 **UNI** procured medical records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*, to identify discrepancies and ensure alignment between the medical records and the encounter data submitted to MDHHS.

Table 3-139 outlines the key findings for **UNI** based on the assessment of encounter data completeness and accuracy conducted through a review of members' medical records for services rendered from October 1, 2022, through September 30, 2023.

Table 3-139—Key Findings for UNI

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	<ul style="list-style-type: none"> The medical procurement rate was 98.3 percent, indicating that most requested records were successfully procured and submitted.
Second Date of Service Submission Rate	<ul style="list-style-type: none"> Among the procured medical records, 52.5 percent included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	<ul style="list-style-type: none"> The <i>Procedure Code</i> and <i>Procedure Code Modifier</i> data elements had relatively high medical record omission rates at 12.7 percent and 21.1 percent, respectively. This indicates that the procedure codes and the modifiers in the encounter data were not adequately supported by the members' medical records.
Encounter Data Omission Rate	<ul style="list-style-type: none"> All key data elements exhibited low encounter data omission rates, with <i>Procedure Code</i> having the highest omission rate at 2.7 percent.
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Diagnosis Code</i> data element was accurate in 99.7 percent of instances where codes were present in both the medical records and encounter data, with all errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code</i> data element was accurate in 97.6 percent of instances where codes were present in both the

Analysis	Key Findings
	medical records and encounter data, with all errors related to inaccurate coding.
Procedure Code Modifier Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code Modifier</i> data element was accurate in 100 percent of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	<ul style="list-style-type: none"> Dates of service with accurate values for all key data elements (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, and <i>Procedure Code Modifier</i>) were observed in 70.6 percent of the dates of service present in both data sources (i.e., encounter data and medical records).

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: A high percentage of *Date of Service* and *Diagnosis Code* data element values in the encounter data were supported by the members' medical records, as evidenced by the low medical record omission rates of 1.6 percent, and 7.7 percent, respectively. [Quality]

Strength #2: The *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data element values identified in the medical records were generally present in the encounter data, as evidenced by the low encounter data omission rates of 1.8 percent, 0.9 percent, 2.7 percent, and 1.8 percent, respectively. [Quality]

Strength #3: When key data elements were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate with rates of at least 97.6 percent each. [Quality]

Weaknesses and Recommendations

Weakness #1: More than 12.0 percent of the *Procedure Code* and more than 21.0 percent of the *Procedure Code Modifier* data element values identified in the encounter data were not supported by the members' medical records. [Quality]

Why the weakness exists: The findings where encounter data are not supported by the medical records can stem from several potential reasons, which can involve both provider documentation practices (e.g., incomplete or inaccurate documentation, coding errors, lack of detail) and data submission (e.g., incorrect coding during data submission or data entry errors) or processing issues (e.g., data mapping or translation issues, errors in data transmission).

Recommendation: UNI should investigate the root cause(s) for these omissions, with a focus on both provider documentation practices and data handling processes. Periodic MRRs of submitted claims should be conducted to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should be used to develop and provide ongoing education and training for providers. Topics should include encounter data submissions, medical record documentation requirements, and coding practices to reduce future omissions and improve data accuracy.

Consumer Assessment of Healthcare Providers and Systems Analysis

Adult and Child Medicaid

Performance Results

Table 3-140 presents UNI's 2023 and 2024 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2024 scores were statistically significantly higher or lower than the 2023 national average. Triangles (▲ or ▼) indicate 2024 scores were statistically significantly higher or lower than the 2023 scores.

Table 3-140—Summary of Adult and Child Medicaid CAHPS Top-Box Scores for UNI

	2023 Adult Medicaid	2024 Adult Medicaid	2023 Child Medicaid	2024 Child Medicaid
Global Ratings				
<i>Rating of Health Plan</i>	62.64%	61.50%	68.65%	63.13% ↓
<i>Rating of All Health Care</i>	62.18%	56.35%	69.57%	66.67%
<i>Rating of Personal Doctor</i>	62.33%	68.99%	72.90%	71.12%
<i>Rating of Specialist Seen Most Often</i>	69.41% ⁺	66.27% ⁺	67.31% ⁺	70.91% ⁺
Composite Measures				
<i>Getting Needed Care</i>	83.65%	81.43%	80.31%	87.26% ⁺
<i>Getting Care Quickly</i>	80.29% ⁺	83.70% ⁺	85.81%	87.58% ⁺
<i>How Well Doctors Communicate</i>	91.76%	91.61%	90.94%	94.71%
<i>Customer Service</i>	82.84% ⁺	90.76% ⁺	88.10% ⁺	82.46% ⁺
Individual Item Measure				
<i>Coordination of Care</i>	79.31% ⁺	83.33% ⁺	79.69% ⁺	89.55% ⁺

	2023 Adult Medicaid	2024 Adult Medicaid	2023 Child Medicaid	2024 Child Medicaid
Medical Assistance With Smoking and Tobacco Use Cessation Items*				
<i>Advising Smokers and Tobacco Users to Quit</i>	78.57%	77.14%	—	—
<i>Discussing Cessation Medications</i>	61.26%	61.32% ↑	—	—
<i>Discussing Cessation Strategies</i>	51.85%	49.04%	—	—

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

* These rates follow NCQA's methodology of calculating a rolling two-year average.

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.

▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.

No triangles (▲ or ▼) indicate the 2024 score was not statistically significantly higher or lower than the 2023 score.

↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.

↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.

No arrows (↑ or ↓) indicate the 2024 score was not statistically significantly higher or lower than the 2023 national average.

— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the CAHPS 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: UNI's 2024 top-box score was statistically significantly higher than the 2023 NCQA adult Medicaid national average for one measure, *Discussing Cessation Medications*. [Quality]

Weaknesses and Recommendations

Weakness #1: UNI's 2024 top-box score was statistically significantly lower than the 2023 NCQA child Medicaid national average for one measure, *Rating of Health Plan* [Quality]

Why the weakness exists: When compared to national benchmarks, the results indicate UNI's members are reporting more negative experiences with their health plan. However, HSAG is unable to identify the MHP-specific barriers or other factors impacting drivers for these measures based on the information provided through this EQR.

Recommendation: HSAG recommends that UNI conduct root cause analyses or focus studies to further explore parents' or caretakers' perceptions regarding the quality of, timeliness of, and access to care and services their child received to determine what could be driving lower scores compared to the national averages and implement appropriate interventions to improve the performance related to the care the child members need.

CSHCS

Performance Results

Table 3-141 presents **UNI**'s 2023 and 2024 CSHCS CAHPS top-box scores. Upward green or downward red arrows (↑ or ↓) indicate 2024 scores were statistically significantly higher or lower than the 2023 national average. Upward green or downward red triangles (▲ or ▼) indicate 2024 scores were statistically significantly higher or lower than the 2023 scores.

Table 3-141—Summary of CSHCS CAHPS Survey Top-Box Scores for UNI

	2023 Top-Box Score	2024 Top-Box Score
Global Ratings		
<i>Rating of Health Plan</i>	71.07%	69.03%
<i>Rating of Health Care</i>	66.67%	68.08% NA
<i>Rating of Specialist Seen Most Often</i>	73.85%	72.99%
Composite Measures		
<i>Customer Service</i>	83.90% ⁺	82.49% ⁺ ↓
<i>How Well Doctors Communicate</i>	90.92%	93.71% NA
<i>Access to Specialized Services</i>	76.47% ⁺	67.29% ⁺ NA
<i>Transportation</i>	79.29% ⁺	62.28% ⁺ NA
Individual Item Measures		
<i>Access to Prescription Medicines</i>	88.26%	88.89%
<i>Not Felt Treated Unfairly: Race and Ethnicity</i>	93.81%	95.93% NA
<i>Not Felt Treated Unfairly: Health Insurance Type</i>	91.75%	94.57% NA

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating the results.

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.

▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.

No triangle (▲ or ▼) indicates the 2024 score was not statistically significantly higher or lower than the 2023 score.

↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.

↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.

No arrow (↑ or ↓) indicates the 2024 score was not statistically significantly higher or lower than the 2023 national average.

NA Indicates a national average is not available for the measure.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the CAHPS 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: UNI's 2024 top-box scores were not statistically significantly higher than the 2023 NCQA child Medicaid national averages or the 2023 top-box scores for any reportable measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: UNI's 2024 top-box score was statistically significantly lower than the 2023 top-box score for one measure, *Customer Service*. [Quality]

Why the weakness exists: When compared to the 2023 NCQA child Medicaid national average, the results indicate that UNI's parent/caregivers are reporting a more negative experience with their child's health plans customer service. UNI customer service staff may not be providing the information parents/caregivers of child members need or treating them with courtesy and respect.

Recommendation: HSAG recommends that UNI conduct an evaluation of current MHP call center hours and practices to determine if the hours and resources meet members' needs. UNI could further promote the use of existing after-hours customer service to improve customer service results. Furthermore, UNI could appoint workgroups from call center staff members to discuss and refine existing service standards to enhance staff interactions with members.

Quality Rating

The 2024 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2024 Michigan Consumer Guide, which is inclusive of UNI's performance.

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

HSAG performed a comprehensive assessment of UNI's aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within UNI that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how UNI's overall performance contributed to the CHCP's progress in achieving the CQS goals and objectives. Table 3-142 displays each MDHHS CQS goal and the EQR activity results that indicate whether the MHP positively (✓), negatively (✗), or minimally (m) impacted the CHCP's progress toward achieving the applicable goals and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to UNI's Medicaid members. Not applicable (NA) was used when EQR activities do not produce data to assess the impact of a quality measure(s) under an objective.

Table 3-142—Overall Performance Impact to CQS and Quality, Timeliness, and Access

Objective	Program	Quality Measure	Overall Performance Impact	Performance Domain	
Goal #1: Ensure high quality and high levels of access to care					
1.1	CHCP	Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	✓	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access	
	CHCP	Prenatal and Postpartum Care—Postpartum Care	✗		
	CHCP	Childhood Immunization Status—Combination 3	m		
	CSHCS	Global Rating of Health Plan	✓		
	CSHCS	Global Rating of Specialist Seen Most Often	✗		
	CSHCS	Global Rating of Health Care	m		
	CSHCS	Composite Measure for Access to Specialized Services	✗		
	CSHCS	Composite Measure for Transportation	✗		
1.2	CHCP	Asthma Medication Ratio—Total	m		
	CHCP	Controlling High Blood Pressure	✓		
	CHCP	Comprehensive Diabetes Care (CDC)—Eye Exams ¹	✗		
	CSHCS	Composite Measure for How Well Doctors Communicate	m		
	CSHCS	Composite Measure for Customer Service	✗		
1.3	CHCP	Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	NA		
	CHCP	Getting Care Quickly Composite (Adult CAHPS)	m		
	CSHCS	Global Rating of Health Care	m		
	CSHCS	Composite Measure for Access to Specialized Services	✗		
	CSHCS	Access to Prescription Medicines	m		
Goal #2: Strengthen person and family-centered approaches					
2.1	CHCP	Rating of Health Plan ²	✗		<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	CHCP	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years Old	m		
	CHCP	Access to Dental Care	✗		
	CHCP	Completion of Annual Health Risk Assessment	NA		
	CSHCS	Composite Measure for How Well Doctors Communicate	m		
	CSHCS	Global Rating of Health Plan	✓		
	CSHCS	Global Rating of Health Care	m		
	CSHCS	Global Rating of Specialist Seen Most Often	✗		

Objective	Program	Quality Measure	Overall Performance Impact	Performance Domain
2.2	CHCP	SDOH: Total Member Screening Rate	NA	
	CHCP	SDOH: Total Member Referral Rate	NA	
	CHCP	Social Need Screening and Intervention	NA	
	CSHCS	Composite Measure for Access to Specialized Services	✖	
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)				
3.1	CHCP	Follow-Up After Hospitalization for Mental Illness Within 30 Days (FUH) (Adults)	NA	☑ Quality ☑ Timeliness ☑ Access
	CSHCS	Coordination of Care	NA	
3.2	CHCP	Implementation of Joint Care Management Processes	NA	
	CSHCS	Global Rating of Health Plan	✓	
	CSHCS	Global Rating of Health Care	m	
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes				
4.1	CHCP	Chlamydia Screening in Women—Total ³	NA	☑ Quality ☑ Timeliness ☑ Access
	CHCP	Prenatal and Postpartum Care—Postpartum Care ³	NA	
	CHCP	Children Immunization Combo 3 ³	NA	
	CHCP	Lead Screening in Children ³	NA	
	CHCP	Comprehensive Diabetes Care—Eye Exam ³	NA	
	CHCP	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years Old ³	NA	
	CSHCS	Not Felt Treated Unfairly: Race and Ethnicity	m	
Goal #5: Improve quality outcomes through value-based initiatives and payment reform				
5.1	CHCP	Average Percentage of Plan Payments to Providers Who Are in APM Arrangements ("Big Numerator")	NA	☑ Quality ☐ Timeliness ☐ Access
	CHCP	Average Percentage of Plan Payments to Providers That Are Tied to Quality ("Small Numerator")	NA	

✓ = The MHP's rate met the 2026 statewide performance target; or the MHP's rate did not meet the 2026 statewide performance target but demonstrated a statistically significant increase in performance from the prior year.

m = The MHP's rate did not meet the 2026 statewide performance target and while the MHP's rate increased in performance from the prior year, the increase was not statistically significant.

✗ = The MHP's rate did not meet the 2026 statewide performance target and/or the MHP's rate decreased in performance from the prior year.

NA = EQR activities published in this report do not produce data to assess the impact of a quality measure(s) under an objective.

¹ NCQA replaced the *Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed* performance measure with the *Eye Exam for Patients With Diabetes (EED)* performance measure, the overall performance impact was based on the MHP's reported rate for *Eye Exam for Patients With Diabetes (EED)*.

² As the CQS did not identify whether this quality measure applies to the adult or child CAHPS, HSAG assessed performance using the adult rate.

³ While there are reported HEDIS rates that are stratified by race/ethnicity, the EQR deliverables did not include an analysis of these data.

Upper Peninsula Health Plan

Validation of Performance Improvement Projects

Performance Results

HSAG’s validation evaluated the technical methods of **UPP**’s PIP (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-143 displays the overall validation rating, the baseline rate, Remeasurement 1, and Remeasurement 2 results for the performance indicators, and if a disparity existed within the most recent measurement period.

Table 3-143—Overall Validation Rating for UPP

PIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
Reducing Racial Disparities in Adult Ambulatory and Preventive Access to Care in Members Ages 20–44	High Confidence	No Confidence	1. Annual ambulatory or preventive visit for UPP Black members.	64.7%	65.8% ↔	65.5% ↔	Yes
			2. Annual ambulatory or preventive visit for UPP White members.	77.4%	75.6% ↓	75.9% ↓	

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).

The goals for **UPP**’s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black members) will demonstrate a significant increase over the baseline rate without a decline in performance for the comparison subgroup (White members). Table 3-144 displays the barriers identified through QI and causal/barrier analysis processes and the interventions initiated by the MHP to support achievement of the PIP goals and address the barriers.

Table 3-144—Remeasurement 2 Barriers and Interventions for UPP

Barriers	Interventions
Member lacks understanding of Medicaid benefits available, SDOH resources, and how programs work.	UPP outreached members of the target population to perform a survey to identify barriers to completing care, along with education and coordination of care as needed.
Member lack of trust in healthcare system.	
Providers have difficulty getting new patients established.	UPP offered an alternative payment method incentive to select provider clinic systems to address and eliminate existing racial disparities for the performance indicator.
UPP 's lack of racial/ethnic diversity in network and lack of reporting of race/ethnicity by network providers.	UPP worked with provider relations staff to increase provider reported race.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PIP 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: UPP used appropriate QI tools to conduct its causal/barrier analysis and interventions were initiated in a timely manner and reasonably linked to the identified barriers. [Quality, Timeliness, and Access]

Weaknesses and Recommendations

Weakness #1: UPP did not achieve the state-defined goal of eliminating the existing disparity without a decline in performance for the comparison group for the second remeasurement period. [Quality, Timeliness, and Access]

Why the weakness exists: While it is unclear why the goal was not achieved or why the comparison population declined in performance, **UPP** has made progress in improving performance for the disparate population as compared to the baseline.

Recommendation: HSAG recommends that **UPP** consider evidence-based intervention efforts and risk factors in quality and timeliness of care for the targeted population. **UPP** should also closely evaluate the success of each intervention strategy to determine any needs for modifications in order to achieve the desired improvement:

Performance Measure Validation

Performance Results

UPP was evaluated against NCQA’s IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2023 Compliance Audit Report findings, **UPP** was fully compliant with three IS standards. For IS standard M (*Medical Record Review Processes*), **UPP** was partially compliant with the standard. During the MRR validation, one exclusion error for a diabetes measure was identified. This case was removed as an exclusion and placed back in the sample.

According to the auditor’s review, **UPP** followed the NCQA HEDIS MY 2023 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-145 displays the MDHHS-selected performance measures, HEDIS MY 2022 and MY 2023 rates, MY 2022 and MY 2023 comparisons, and MY 2023 performance levels based on comparisons to national percentiles¹⁰¹ for **UPP**. Additional performance measures and performance measure results for **UPP** can be referenced in Appendix B.

Table 3-145—HEDIS MY 2023 Performance Measure Results for UPP

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
Child & Adolescent Care				
<i>Childhood Immunization Status (CIS)</i>				
<i>Combination 3</i>	65.69%	61.74%	-3.96	★★
<i>Combination 7</i>	53.28%	50.92%	-2.36	★★
<i>Combination 10</i>	31.39%	24.03%	-7.36 ⁺⁺	★
<i>Well-Child Visits in the First 30 Months of Life (W30)</i>				
<i>Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	70.23%	72.82%	+2.59	★★★★★
<i>Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i>	68.09%	72.18%	+4.09 ⁺	★★★★★
<i>Lead Screening in Children (LSC)</i>				
<i>Lead Screening in Children</i>	52.07%	59.12%	+7.05 ⁺	★★

¹⁰¹ HEDIS MY 2023 performance measure rates are compared to NCQA’s Quality Compass National Medicaid Health Maintenance Organization (HMO) percentiles for HEDIS MY 2022 (referred to as “percentiles” throughout this section of the report).

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
Child and Adolescent Well-Care Visits (WCV)				
<i>Ages 3 to 11 Years</i>	56.40%	58.81%	+2.41+	★★★★
<i>Ages 12 to 17 Years</i>	50.27%	50.57%	+0.29	★★★★
<i>Ages 18 to 21 Years</i>	23.73%	27.97%	+4.24+	★★★★
<i>Total</i>	48.65%	51.22%	+2.57+	★★★★
Immunizations for Adolescents (IMA)				
<i>Combination 1 (Meningococcal, Tdap)</i>	76.40%	75.40%	-1.00	★★
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	28.47%	29.74%	+1.27	★★
Women—Adult Care				
Chlamydia Screening in Women (CHL)³				
<i>Ages 16 to 20 Years</i>	43.20%	40.28%	-2.93	★
<i>Ages 21 to 24 Years</i>	48.69%	51.24%	+2.55	★
<i>Total</i>	45.75%	45.40%	-0.35	★
Cervical Cancer Screening (CCS-E)				
<i>Cervical Cancer Screening</i>	61.80%	54.25%	-7.55 ⁺⁺	★★
Breast Cancer Screening (BCS-E)				
<i>Breast Cancer Screening</i>	59.68%	60.10%	+0.42	★★★★★
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
<i>Ages 20 to 44 Years</i>	75.03%	75.30%	+0.28	★★★★★
<i>Ages 45 to 64 Years</i>	83.39%	83.79%	+0.40	★★★★
<i>Ages 65 Years and Older</i>	94.52%	95.16%	+0.64	★★★★★
<i>Total</i>	79.06%	79.60%	+0.53	★★★★★
Pregnancy Care				
Prenatal and Postpartum Care (PPC)³				
<i>Timeliness of Prenatal Care</i>	92.94%	94.16%	+1.22	★★★★★
<i>Postpartum Care</i>	89.29%	87.35%	-1.95	★★★★★
Living With Illness				
Hemoglobin A1c Control for Patients With Diabetes (HBD)				
<i>HbA1c Control (<8.0%)</i>	61.07%	66.18%	+5.11	★★★★★
<i>Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*</i>	30.17%	25.06%	-5.11	★★★★★

HEDIS Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY2023 Comparison ¹	MY 2023 Performance Level ²
Blood Pressure Control for Patients With Diabetes (BPD)				
Blood Pressure Control for Patients With Diabetes	82.00%	84.67%	+2.68	★★★★★
Eye Exam for Patients With Diabetes (EED)³				
Eye Exam for Patients With Diabetes	60.83%	57.18%	-3.65	★★★
Kidney Health Evaluation for Patients With Diabetes (KED)				
Ages 18 to 64 Years	36.10%	37.83%	+1.73	★★★
Ages 65 to 74 Years	36.67%	39.93%	+3.26	★★★
Ages 75 to 85 Years	29.58%	43.02%	+13.45	★★★
Total	35.99%	38.22%	+2.22	★★★
Asthma Medication Ratio (AMR)				
Total	57.67%	62.28%	+4.61+	★★
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	79.08%	78.10%	-0.97	★★★★★
Diagnosed Mental Health Disorders (DMH)				
Ages 1 to 17 Years	26.57%	27.90%	+1.33+	★★★★★
Ages 18 to 64 Years	43.57%	45.12%	+1.55+	★★★★★
Ages 65 Years and Older	52.61%	53.20%	+0.59	★★★★★
Total	37.95%	39.37%	+1.42+	★★★★★
Utilization				
Plan All-Cause Readmissions (PCR)				
Observed Readmissions—Total	7.69%	7.12%	-0.57	NC
Expected Readmissions—Total	9.82%	9.70%	-0.12	NC
O/E Ratio—Total	0.7834	0.7340	-0.05	★★★★★

¹ HEDIS MY 2022 to HEDIS MY 2023 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2022–MY 2023 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2022–MY 2023 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

² Performance Levels for MY 2023 were based on comparisons of the HEDIS MY 2023 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2022 benchmark

³ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

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

Please note that for the *Diagnosed Mental Health Disorders (DMH)* measure, a higher or lower rate does not indicate better performance, as the measure provides information on the diagnosed prevalence of mental health disorders. Therefore, this measure is not included in the evaluation of strengths and weaknesses below.

Green Shading⁺ Indicates that the HEDIS MY 2023 rate demonstrated a significant improvement from the HEDIS MY 2022 rate.

Red Shading⁺⁺ Indicates that the HEDIS MY 2023 rate demonstrated a significant decline from the HEDIS MY 2022 rate.

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

HEDIS MY 2023 Performance Levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the PMV 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: UPP's performance ranked above the 90th percentile and between the 75th and 89th percentile for the *Well-Child Visits in the First 30 Months of Life (W30)*—*Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicators, respectively. In addition, the *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator demonstrated significant improvement from MY 2022 to MY 2023, indicating children who turned 15 months old during the measurement year were having at least six well-child visits with a PCP during their first 15 months of life and that children who turned 30 months old during the measurement year were having at least two well-child visits with a PCP in their second 15 months most of the time. Research shows that early intervention treatment services can greatly improve a child's development. Early intervention services help children from birth through 3 years of age (36 months) learn important skills.¹⁰² [Quality, Timeliness, and Access]

Strength #2: UPP's performance ranked between the 75th and 89th percentiles for the *Breast Cancer Screening (BCS-E)* measure, demonstrating women 50–74 years of age had at least one mammogram to screen for breast cancer in the past two years most of the time. Screening can improve outcomes and can lead to a greater range of treatment options.¹⁰³ [Quality]

Strength #3: UPP's performance ranked between the 75th and 89th percentiles for the *Adults' Access to Preventive/Ambulatory Health Services (AAP)—20 to 44 Years* and *Total* measure indicators, and above the 90th percentile for the *Ages 65 Years and Older* measure indicator,

¹⁰² National Committee for Quality Assurance. Well-Child Visits in the First 30 Months of Life (W30). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/well-child-visits-in-the-first-30-months-of-life-w30/>. Accessed on: Apr 2, 2025.

¹⁰³ National Committee for Quality Assurance. Breast Cancer Screening (BCS-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/breast-cancer-screening-bcs-e/>. Accessed on: Apr 2, 2025.

indicating that members 20 to 44 years of age and 65 years of age and older had an ambulatory or preventive care visit most of the time. Healthcare visits are an opportunity for individuals to receive preventive services and counseling on topics such as diet and exercise. These visits also can help them to address acute issues or manage chronic conditions.¹⁰⁴ [Quality and Access]

Strength #4: UPP's performance ranked above the 90th percentile for the *Prenatal and Postpartum Care (PPC)*—*Timeliness of Prenatal Care* and *Postpartum Care* measure indicators, demonstrating pregnant members were having a prenatal visit in the first trimester and having a postpartum visit on or between 7 and 84 days after delivery most of the time during the measurement year. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.¹⁰⁵ [Quality and Access]

Strength #5: UPP's performance ranked above the 90th percentile for the *Hemoglobin A1c Control for Patients With Diabetes (HBD)*—*HbA1c Control (<8.0%)* and *Hemoglobin A1c (HbA1c) Poor Control (>9.0%)* measure indicators, indicating members with diabetes had controlled HbA1c levels most of the time during the measurement year. Glycemic control is management of blood sugar levels to reduce the risk of microvascular complications (eye, kidney, and nerve diseases). Many complications such as heart disease, stroke, blindness, kidney failure, and amputation can be prevented if diabetes is detected and addressed in the early stages.¹⁰⁶ [Quality and Access]

Strength #6: UPP's performance ranked above the 90th percentile for the *Blood Pressure Control for Patients With Diabetes (BPD)* measure indicator, indicating members 18–75 years of age, with a diagnosis of diabetes, had controlled blood pressure levels most of the time. Diabetes is a chronic condition marked by high blood sugar due to the body's inability to make or use insulin. Left unmanaged, diabetes can lead to more serious health conditions, including high blood pressure. Proper blood pressure management is essential to avoid further complications, including heart attack, stroke, kidney disease, and blindness. With support from healthcare providers, patients can manage their blood pressure to maintain a healthy and productive life.¹⁰⁷ [Quality]

Strength #7: UPP's performance ranked above the 90th percentile for the *Controlling High Blood Pressure (CBP)* measure indicator, indicating members ages 18–85 years of age, with a diagnosis of hypertension, had blood pressure adequately controlled. Controlling high blood pressure is an

¹⁰⁴ National Committee for Quality Assurance. Adults' Access to Preventive/Ambulatory Health Services (AAP). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/adults-access-to-preventive-ambulatory-health-services-aap/>. Accessed on: Apr 1, 2025.

¹⁰⁵ National Committee for Quality Assurance. Prenatal and Postpartum Care (PPC). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/prenatal-and-postpartum-care-ppc/>. Accessed on: Apr 2, 2025.

¹⁰⁶ National Committee for Quality Assurance. Glycemic Status Assessment for Patients With Diabetes (GSD). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/glycemic-status-assessment-for-patients-with-diabetes-gsd/>. Accessed on: Apr 1, 2025.

¹⁰⁷ National Committee for Quality Assurance. Blood Pressure Control for Patients With Diabetes (BPD). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/blood-pressure-control-for-patients-with-diabetes-bpd/>. Accessed on: Apr 2, 2025.

important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.¹⁰⁸ [Quality]

Strength #8: UPP's performance ranked above the 90th percentile for the *Plan All-Cause Readmissions (PCR)—O/E Ratio—Total* measure indicator, indicating that there were less unplanned acute readmissions within 30 days after discharge than expected for members 18 to 64 years of age. A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination. Unplanned readmissions are associated with increased mortality and higher healthcare costs. Unplanned readmissions can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management.¹⁰⁹ [Quality, Timeliness, and Access]

Weaknesses and Recommendations

Weakness #1: UPP's performance for the *Childhood Immunization Status (CIS)—Combination 10* measure indicator ranked below the 25th percentile. In addition, the *Childhood Immunization Status (CIS)—Combination 3* and *Combination 7* measure indicators ranked between the 25th and 49th percentiles, indicating that children 2 years of age were not receiving some vaccinations by their second birthday. Childhood immunizations help prevent serious illnesses such as polio, tetanus, and hepatitis. Vaccines are a proven way to help a child stay healthy and avoid the potentially harmful effects of childhood diseases like mumps and measles.¹¹⁰ [Quality and Timeliness]

Why the weakness exists: The rates for the *Childhood Immunization Status (CIS)—Combination 3*, *Combination 7*, and *Combination 10* measure indicators all ranked below the 50th percentile, with the *Combination 10* measure indicator ranking below the 25th percentile. Potential barriers to improved measure performance may include, but are not limited to, provider challenges with vaccination storage protocols, providers obtaining necessary vaccination certifications, provider cost deterrents related to the short shelf life of vaccines/maintaining inventory, and parental vaccination hesitancy.

Recommendation: HSAG recommends that UPP develop targeted interventions to improve performance for the *Childhood Immunization Status (CIS)* measure. Initiatives should be monitored and expanded upon as contributing factors to rate performance are identified. UPP could consider exploring avenues to increase awareness of vaccination importance among parents to reduce vaccination hesitancy such as a "speculation versus fact" pamphlet which includes a phone number

¹⁰⁸ National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/controlling-high-blood-pressure-cbp/>. Accessed on: Apr 2, 2025.

¹⁰⁹ National Committee for Quality Assurance. Plan All-Cause Readmissions (PCR). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/plan-all-cause-readmissions-PCR/>. Accessed on: Apr 2, 2025.

¹¹⁰ National Committee for Quality Assurance. Childhood Immunization Status (CIS-E). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/childhood-immunization-status-cis-e/>. Accessed on: Apr 2, 2025.

for care management support. **UPP** could also consider issuing provider incentives for maintaining a complete inventory of vaccinations.

Weakness #2: **UPP**'s performance for the *Chlamydia Screening in Women (CHL)—Ages 16 to 20 Years, Ages 21 to 24 Years*, and *Total* measure indicators ranked below the 25th percentile, indicating that members 16 to 24 years of age identified as sexually active did not have at least one test for chlamydia during the measurement year. Untreated chlamydia infections can lead to serious and irreversible complications. Screening is important, as approximately 75 percent of chlamydia infections in women are asymptomatic and 95 percent of infections in men are asymptomatic. This results in delayed medical care and treatment.¹¹¹ [**Quality and Timeliness**]

Why the weakness exists: The rates for the *Chlamydia Screening in Women (CHL)—Ages 16 to 20 Years, Ages 21 to 24 Years*, and *Total* measure indicators ranked below the 25th percentile. Barriers noted by **UPP** include members declining screening due to use of birth control for reasons aside from preventing pregnancy.

Recommendation: While **UPP** noted several interventions currently in place to target improvement, such as a text message campaign to all eligible members with education on the importance of screening, including a chlamydia article in its provider newsletter, and highlighting chlamydia screening in its annual collaborative Healthy Kids Healthy Futures campaign toolkit for providers and members, performance remains low for the *Chlamydia Screening in Women (CHL)* measure. Therefore, HSAG recommends that **UPP** continue its efforts to improve performance for the *Chlamydia Screening in Women (CHL)* measure; initiatives should be monitored and expanded upon as additional contributing factors are identified.

¹¹¹ National Committee for Quality Assurance. Chlamydia Screening in Women (CHL). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/chlamydia-screening-ch/>. Accessed on: Apr 1, 2025.

Compliance Review

Performance Results

Table 3-146 presents the total number of criteria for each standard that received a score of *Met*, *Satisfied*, or *Not Met*. Table 3-146 also presents **UPP**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. *NA* was used when MDHHS determined the review element was not applicable during the compliance review. For elements scored as *Not Met*, **UPP** was subject to a corrective action review process outlined in Appendix A.

Table 3-146—Compliance Review Results for UPP

Standard		Number of Scores				Compliance Scores	
		<i>Met</i>	<i>Satisfied</i> ¹	<i>Not Met</i>	<i>NA</i>	UPP ²	Statewide ³
1	Administrative	5	0	0	0	100%	100%
2	Providers	23	0	1	0	96%	95.4%
3	Members	29	0	0	1	100%	98.9%
4	Quality	24	0	0	0	100%	100%
5	MIS/Financial	46	3	2	0	90%	94.6%
6	OIG/Program Integrity	9	0	1	0	90%	85.6%
Overall		136	3	4	1	95%	96.0%

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

¹ A score of *Satisfied* was only allowable for select elements under the MIS/Financial standard.

² MDHHS calculated the total compliance score for each standard by totaling the number of *Met* (i.e., 1 point) elements and the number of *Not Met* and *Satisfied* (i.e., 0 points) elements, then dividing the summed score by the total number of elements for that standard.

³ MDHHS calculated the statewide performance scores to the tenth decimal place; however, MHP performance scores were calculated using whole number percentages.

Additionally, to supplement the compliance review activity, MDHHS conducted staff interviews, referred to as focus studies, in the following three areas: CSHCS, Operations, and Quality. While the results of the focus studies are not incorporated into the scoring of the compliance review, **UPP** met MDHHS' expectations for participation in the studies.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the compliance review 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: UPP achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. [Quality]

Strength #2: UPP achieved full compliance in the Members standard, demonstrating the MHP maintained sufficient policies and procedures to support its membership, which included, but was not limited to, access to service authorization processes; care coordination procedures; fair grievance and appeal systems; member information materials such as the handbook, newsletters, and website; and choice of PCPs. [Quality, Timeliness, and Access]

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

Weaknesses and Recommendations

Weakness #1: While **UPP** demonstrated high performance overall (i.e., 90 percent or higher but less than 100 percent) in the MIS/Financial standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for elements *June 5.10–Provider Data Accuracy* and *June 5.15–Monthly Encounter Record Acceptance Rate in CHAMPS*, and a *Satisfied* score for elements *May 5.11–Claims Processing (Non-Pharmacy)*, *March 5.15–Quarterly Encounter Record Acceptance Rate in CHAMPS*, and *July 5.15–Monthly Encounter Record Acceptance Rate in CHAMPS*. [Quality]

Why the weakness exists: Regarding element *June 5.10* findings, **UPP** did not address identifying and tracking of FWA in relation to data accuracy. **UPP** explained that the policy that reflects this requirement was not uploaded due to human error. Regarding elements *June 5.15* findings, **UPP** did not meet the minimum acceptance rate for dental, institutional, or professional encounters submitted in April 2024. **UPP** indicated this was because some files were unintentionally submitted twice, causing all encounters in those files to reject. Similar findings were identified for January 2024 professional encounters during the review of element *March 5.15*. Regarding element *May 5.11* findings, **UPP** did not meet the minimum standard for timely payment of all clean claims in March 2024. Lastly, **UPP** did not meet the minimum acceptance rate for dental encounters submitted in May 2024. **UPP** indicated that its encounter submission vendor inaccurately mapped response files into its system from the previous month's duplicate files, marking some accepted TCNs as rejected, resulting in the files being resubmitted despite being already accepted.

Recommendation: **UPP** was required to submit a CAP to address elements *June 5.10*, which was approved by MDHHS. MDHHS did not require a CAP to address elements *June 5.15*, *May 5.11*, *March 5.15*, and *July 5.15*. As such, HSAG recommends that **UPP** continue to implement action plans and monitoring processes to improve the encounter acceptance rate for dental, institutional, and professional encounters and the rate of timely claims payment.

Network Adequacy Validation

Network Adequacy Analysis

Performance Results

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MHP’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each MHP according to Table 3-147.

Table 3-147—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	<i>High Confidence</i>
50.0% to 89.9%	<i>Moderate Confidence</i>
10.0% to 49.9%	<i>Low Confidence</i>
Less than 10% and/or any <i>Not Met</i> element has significant bias on the results	<i>No Confidence</i>

No indicators were identified as *Low Confidence* or *No Confidence* designations.

HSAG determined that **UPP** met both the time and distance standards and the ratio standard requirements for 100 percent of its members across all indicators or submitted an exception to MDHHS. The exceptions indicated that **UPP** was aware of a gap and while corrective steps were underway, the issue had not been fully resolved at the time of reporting. Adequacy was determined based on the MHP’s compliance with MDHHS’ time and distance and ratio standards, with an assessment conducted for each provider type according to county. Table 3-148 outlines the counties and provider specialties for which exceptions were submitted. Results are presented by provider specialty in Table 3-149.

Table 3-148—UPP Submitted Exceptions

County Exception Submitted	Specialty Exception Submitted
Alger	Endodontist
Alger	OB/GYN
Alger	Oral Surgeon
Alger	Periodontist
Alger	Prosthodontist
Alger	PCPs (Pediatric)
Alger	PCPs (Adult)

County Exception Submitted	Specialty Exception Submitted
Baraga	Endodontist
Baraga	OB/GYN
Baraga	Oral Surgeon
Baraga	Periodontist
Baraga	Prosthodontist
Chippewa	Endodontist
Chippewa	General Dentistry
Chippewa	Oral Surgeon
Chippewa	OB/GYN
Chippewa	PCPs (Pediatric)
Chippewa	Periodontist
Chippewa	PCPs (Adult)
Chippewa	Prosthodontist
Delta	Endodontist
Delta	General Dentistry
Delta	OB/GYN
Delta	Oral Surgeon
Delta	PCPs (Pediatric)
Delta	Periodontist
Delta	Prosthodontist
Dickinson	Endodontist
Dickinson	General Dentistry
Dickinson	Oral Surgeon
Dickinson	Periodontist
Dickinson	Prosthodontist
Gogebic	Endodontist
Gogebic	PCPs (Pediatric)
Gogebic	OB/GYN
Gogebic	Periodontist
Gogebic	Prosthodontist

County Exception Submitted	Specialty Exception Submitted
Houghton	Endodontist
Houghton	General Dentistry
Houghton	Oral Surgeon
Houghton	PCPs (Pediatric)
Houghton	Periodontist
Houghton	OB/GYN
Houghton	Prosthodontist
Iron	Endodontist
Iron	General Dentistry
Iron	Oral Surgeon
Iron	PCPs (Pediatric)
Iron	Periodontist
Iron	Prosthodontist
Keweenaw	Cardiology
Keweenaw	Endodontist
Keweenaw	General Dentistry
Keweenaw	Hospital
Keweenaw	OB/GYN
Keweenaw	Oral Surgeon
Keweenaw	Outpatient Behavioral Health
Keweenaw	PCPs (Adult)
Keweenaw	PCPs (Pediatric)
Keweenaw	Periodontist
Keweenaw	Pharmacy
Keweenaw	Prosthodontist
Luce	Endodontist
Luce	Oral Surgeon
Luce	PCPs (Pediatric)
Luce	Periodontist
Luce	Prosthodontist

County Exception Submitted	Specialty Exception Submitted
Mackinac	General Dentistry
Mackinac	OB/GYN
Mackinac	PCPs (Pediatric)
Mackinac	Periodontist
Mackinac	Prosthodontist
Mackinac	Endodontist
Marquette	Periodontist
Marquette	Periodontist
Marquette	Prosthodontist
Menominee	Cardiology
Menominee	Endodontist
Menominee	General Dentistry
Menominee	Hospital
Menominee	OB/GYN
Menominee	PCPs (Pediatric)
Menominee	Periodontist
Menominee	Prosthodontist
Ontonagon	Endodontist
Ontonagon	Oral Surgeon
Ontonagon	PCPs (Pediatric)
Ontonagon	Periodontist
Ontonagon	Prosthodontist
Schoolcraft	Endodontist
Schoolcraft	General Dentistry
Schoolcraft	OB/GYN
Schoolcraft	Oral Surgeon
Schoolcraft	Periodontist
Schoolcraft	Prosthodontist
Schoolcraft	PCPs (Pediatric)

Table 3-149—UPP Network Adequacy Compliance

Provider Specialty	Non-Rural Time and Distance	Rural Time and Distance	Non-Rural Ratio	Rural Ratio
PCPs (Adult)	Compliant	Compliant	Compliant	Compliant
PCPs (Pediatric)	Compliant	Compliant	Compliant	Compliant
OB/GYN	Compliant	Compliant	NA	NA
Cardiology	Noncompliant	Noncompliant	NA	NA
Outpatient Behavioral Health	Compliant	Compliant	NA	NA
Hospital	Compliant	Compliant	NA	NA
Pharmacy	Noncompliant	Noncompliant	NA	NA
General Dentistry	Compliant	Noncompliant	Noncompliant	Noncompliant
Endodontist	Compliant	Compliant	NA	NA
Oral Surgeon	Compliant	Compliant	NA	NA
Periodontist	Compliant	Compliant	NA	NA
Prosthodontist	Compliant	Compliant	NA	NA

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: UPP had stable processes in place for collecting and maintaining member and provider data for calculating network adequacy indicators. [Access]

Weaknesses and Recommendations

Weakness #1: No opportunities were identified for the member and provider data collection and processes that UPP had in place to calculate network adequacy indicators.

Why the weakness exists: NA

Recommendation: NA

Network Validation Survey

Performance Results

HSAG’s reviewers evaluated 124 randomly sampled cases by comparing provider data submitted to HSAG by **UPP** against **UPP**’s online provider directory. The sample included 89 PCPs, 18 pediatric providers, and only 17 OB/GYN providers.¹¹² Overall, 92.7 percent of the sampled providers were located in the online directory at the sampled location, while 0.8 percent of the sampled providers located in the online directory were not at the sampled location. Additionally, 6.5 percent of the overall sampled providers could not be located in the online directory.

Table 3-150 summarizes the findings regarding the number of sampled providers and provider locations (i.e., “cases”) that HSAG’s reviewers located in the MHP’s online directory.

Table 3-150—Summary of Providers Present in Online Directory by Provider Category

Provider Category	Number of Sampled Providers	Providers Not Found in Directory		Providers Found in Directory—Not at Sampled Location		Providers Found in Directory—At Sampled Location	
		Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
PCPs	89	4	4.5%	1	1.1%	84	94.4%
Pediatric Providers	18	2	11.1%	0	0.0%	16	88.9%
OB/GYN Providers	17	2	11.8%	0	0.0%	15	88.2%
UPP Total	124	8	6.5%	1	0.8%	115	92.7%

¹ The denominator includes the number of sampled providers.

Table 3-151 displays the total number and percentage of cases with matched data values for indicators that were reviewed between data values shown in **UPP**’s provider data submission to HSAG and **UPP**’s online provider directory. Cases with unmatched results may include incorrect information or information not listed in the directory (e.g., the provider data included a data value for a study indicator, but the online provider directory did not include a data value for the study indicator).

Table 3-151—Provider Demographic Indicators Matching Online Directory

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		Overall	
	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
Provider Name	85	100%	16	100%	15	100%	116	100%

¹¹² A low number of OB/GYN providers was sampled due to the eligible population criteria (i.e., providers with the PCP indicator) which reduced the number of eligible OB/GYN providers.

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		Overall	
	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
Provider Street Address	84	98.8%	16	100%	15	100%	115	99.1%
Provider Suite Number	84	98.8%	16	100%	15	100%	115	99.1%
Provider City	84	98.8%	16	100%	15	100%	115	99.1%
Provider State	85	100%	16	100%	15	100%	116	100%
Provider ZIP Code	83	97.6%	15	93.8%	15	100%	113	97.4%
Provider Telephone Number	83	97.6%	16	100%	15	100%	114	98.3%
Provider Type/Specialty	84	98.8%	16	100%	15	100%	115	99.1%
Provider Accepting New Patients	85	100%	16	100%	15	100%	116	100%
Provider Gender	85	100%	16	100%	15	100%	116	100%
Provider Primary Language ²	85	100%	16	100%	15	100%	116	100%
Non-English Language Speaking Provider (including American Sign Language) ²	85	100%	16	100%	15	100%	116	100%

¹ The denominator for each study indicator includes the number of cases in which the provider was found in the directory.

² The PDV review evaluated whether the indicator was present in the directory, but specific values were not validated.

For the secret shopper telephone survey, HSAG attempted to contact 111 sampled provider locations for **UPP**, with an overall response rate of 88.3 percent. Table 3-152 summarizes the survey response rates (i.e., cases reached) for all MHPs and for **UPP**, by provider category.

Table 3-152—Response Rates

Provider Category	Total Number of Cases ¹	Cases Reached	Response Rate
PCPs	81	71	87.7%
Pediatric Providers	15	13	86.7%
OB/GYN Providers	15	14	93.3%
UPP Total	111	98	88.3%
All MHPs Total	2,633	1,775	67.4%

¹ Total number of cases includes cases that were found in the online directory and matched on eight key indicators (i.e., name, address, city, state, ZIP Code, telephone number, provider type/specialty, and new patient acceptance).

Table 3-153 summarizes the provider data validation and accuracy results for all MHPs and **UPP**, by provider category.

Table 3-153—Provider Data Validation and Accuracy Results

Provider Category	Denom ¹	Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance		Accepting New Patients	
		Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
PCPs	71	61	85.9%	59	83.1%	55	77.5%	47	66.2%	44	62.0%
Pediatric Providers	13	8	61.5%	8	61.5%	8	61.5%	6	46.2%	6	46.2%
OB/GYN Providers	14	7	50.0%	7	50.0%	7	50.0%	7	50.0%	7	50.0%
UPP Total	98	76	77.6%	74	75.5%	70	71.4%	60	61.2%	57	58.2%
All MHPs Total	1,775	1,280	72.1%	1,215	68.5%	1,082	61.0%	822	46.3%	731	41.2%

¹ The denominator includes cases reached.

Table 3-154 displays the number of survey respondents who offered appointments to new patients for routine PCP and prenatal care visits for all MHPs and **UPP**, by provider category.

Table 3-154—Appointment Availability for Routine PCP and Prenatal Care Visits¹

Provider Category	Cases Reached	Cases Offered an Appointment	
		Count	Rate ²
PCPs	71	31	43.7%
Pediatric Providers	13	3	23.1%
OB/GYN Providers	14	5	35.7%
UPP Total	98	39	39.8%
All MHPs Total	1,775	424	23.9%

¹ Appointment availability rates were calculated using cases accepting new patients and total survey cases as the denominator in the 2022 and 2023 reports. However, the denominator used in the 2024 report was cases reached. Caution should be exercised when comparing 2024 appointment availability rates with the rates in the 2022 and 2023 reports.

² The denominator includes cases reached.

Table 3-155 displays the new patient wait time results for all MHPs and **UPP**, by provider category.

Table 3-155—Appointment Wait Time Results

Provider Category	Appointment Wait Time (Business Days)				Rate of Cases Within Standard ^{1,2}
	Min	Max	Average	Median	
PCPs	1	155	21	7	77.4%
Pediatric Providers	2	22	15	21	100%
OB/GYN Providers	5	25	15	16	20.0%
UPP Total	1	155	19	10	71.8%
All MHPs Total	0	261	18	8	80.9%

¹ The denominator includes cases offered an appointment.

² Rate of cases within standard represents the percentage of cases that were offered an appointment that was compliant with the 30-business-day standard for routine appointments and seven-business-day standard for prenatal care appointments.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NVS 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: Reviewers located 93.5 percent of the sampled providers in **UPP**'s online provider directory. [Access]

Strength #2: Of the providers located in **UPP**'s online provider directory, all indicators had match rates above 95.0 percent. [Quality and Access]

Weaknesses and Recommendations

Weakness #1: Overall, 88.3 percent of **UPP**'s locations could be reached. Of the locations reached, 77.6 percent confirmed affiliation with the sampled provider. Additionally, 75.5 percent confirmed accuracy of the sampled address, 71.4 percent confirmed the requested services were offered, 61.2 percent confirmed the requested insurance, and 58.2 percent confirmed new patient acceptance. [Quality and Access]

Why the weakness exists: **UPP**'s provider data included invalid phone number, provider, address, specialty, new patient acceptance, and insurance information.

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

Weakness #2: Of the cases reached, only 39.8 percent of locations offered an appointment date. Pediatric providers had an appointment availability rate of 23.1 percent, PCPs had an appointment availability rate of 43.7 percent, while OB/GYN provider locations had an appointment availability rate of 35.7 percent. Of the cases that offered an appointment, 71.8 percent were compliant with the appointment wait time standard. [**Timeliness and Access**]

Why the weakness exists: For new **UPP** members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included pre-registration as well as requiring additional personal information, a Medicaid ID, or an MRR.

Recommendation: HSAG recommends that **UPP** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **UPP** 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 **UPP** procured medical records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*, to identify discrepancies and ensure alignment between the medical records and the encounter data submitted to MDHHS.

Table 3-156 outlines the key findings for **UPP** based on the assessment of encounter data completeness and accuracy conducted through a review of members' medical records for services rendered from October 1, 2022, through September 30, 2023.

Table 3-156—Key Findings for UPP

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	<ul style="list-style-type: none"> The medical procurement rate was 99.3 percent, indicating that nearly all requested records were successfully procured and submitted.
Second Date of Service Submission Rate	<ul style="list-style-type: none"> Among procured medical records, 45.8 percent included a corresponding second date of service.

Analysis	Key Findings
Encounter Data Completeness	
Medical Record Omission Rate	<ul style="list-style-type: none"> All key data elements, with the exception of <i>Procedure Code Modifier</i>, had low medical record omission rates, ranging from 1.1 percent (<i>Date of Service</i>) to 16.4 percent (<i>Procedure Code Modifier</i>).
Encounter Data Omission Rate	<ul style="list-style-type: none"> All key data elements exhibited relatively low encounter data omission rates, with <i>Procedure Code</i> having the highest encounter data omission rate at 4.4 percent.
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Diagnosis Code</i> data element was accurate in 99.9 percent of instances where codes were present in both the medical records and encounter data, with all errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code</i> data element was accurate in 99.6 percent of instances where codes were present in both the medical records and encounter data. Of the identified errors, half were due to inaccurate coding, while the other half were attributed to providers submitting higher-level service codes than those supported in the medical records.
Procedure Code Modifier Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code Modifier</i> data element was accurate in 100 percent of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	<ul style="list-style-type: none"> Dates of service with accurate values for all key data elements (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, and <i>Procedure Code Modifier</i>) were observed in 85.5 percent of the dates of service present in both data sources (i.e., encounter data and medical records).

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: A high percentage of *Date of Service*, *Diagnosis Code*, and *Procedure Code* data element values in the encounter data were supported by the members' medical records, as evidenced by the low medical record omission rates of 1.1 percent, 3.9 percent, and 3.7 percent, respectively.
[Quality]

Strength #2: The *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data element values identified in the medical records were generally present in the encounter data, as evidenced by the low encounter data omission rates of 4.2 percent, 2.6 percent, 4.4 percent, and 1.4 percent, respectively. [Quality]

Strength #3: When key data elements were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate with rates of at least 99.6 percent each. [Quality]

Weaknesses and Recommendations

Weakness #1: More than 16.0 percent of the *Procedure Code Modifier* data element values identified in the encounter data were not supported by the members' medical records. [Quality]

Why the weakness exists: The findings where encounter data are not supported by the medical records can stem from several potential reasons, which can involve both provider documentation practices (e.g., incomplete or inaccurate documentation, coding errors, lack of detail) and data submission (e.g., incorrect coding during data submission or data entry errors) or processing issues (e.g., data mapping or translation issues, errors in data transmission).

Recommendation: UPP should investigate the root cause(s) for these omissions, with a focus on both provider documentation practices and data handling processes. Periodic MRRs of submitted claims should be conducted to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should be used to develop and provide ongoing education and training for providers. Topics should include encounter data submissions, medical record documentation requirements, and coding practices to reduce future omissions and improve data accuracy.

Consumer Assessment of Healthcare Providers and Systems Analysis

Adult and Child Medicaid

Performance Results

Table 3-157 presents UPP's 2023 and 2024 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2024 scores were statistically significantly higher or lower than the 2023 national average. Triangles (▲ or ▼) indicate 2024 scores were statistically significantly higher or lower than the 2023 scores.

Table 3-157—Summary of Adult and Child Medicaid CAHPS Top-Box Scores for UPP

	2023 Adult Medicaid	2024 Adult Medicaid	2023 Child Medicaid	2024 Child Medicaid
Global Ratings				
<i>Rating of Health Plan</i>	64.44%	69.05% ↑	70.43%	66.67%
<i>Rating of All Health Care</i>	52.81%	61.13% ▲↑	60.93%	56.90% ▼↓

	2023 Adult Medicaid	2024 Adult Medicaid	2023 Child Medicaid	2024 Child Medicaid
<i>Rating of Personal Doctor</i>	67.48%	72.75% ↑	73.09%	73.73%
<i>Rating of Specialist Seen Most Often</i>	64.61%	66.67%	63.77% ⁺	64.15% ⁺
Composite Measures				
<i>Getting Needed Care</i>	83.19%	86.48% ↑	89.89%	87.36%
<i>Getting Care Quickly</i>	85.88%	86.94% ↑	92.67%	90.97% ↑
<i>How Well Doctors Communicate</i>	95.44%	95.03% ↑	98.48%	97.08% ↑
<i>Customer Service</i>	92.77%	94.15% ↑	97.30% ⁺	89.47% ⁺
Individual Item Measure				
<i>Coordination of Care</i>	87.65%	89.25% ↑	91.00%	90.67% ⁺ ↑
Medical Assistance With Smoking and Tobacco Use Cessation Items*				
<i>Advising Smokers and Tobacco Users to Quit</i>	73.44%	72.34%	—	—
<i>Discussing Cessation Medications</i>	53.18%	53.79%	—	—
<i>Discussing Cessation Strategies</i>	48.10%	43.93%	—	—

⁺ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

* These rates follow NCQA's methodology of calculating a rolling two-year average.

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.

▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.

No triangles (▲ or ▼) indicate the 2024 score was not statistically significantly higher or lower than the 2023 score.

↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.

↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.

No arrows (↑ or ↓) indicate the 2024 score was not statistically significantly higher or lower than the 2023 national average.

— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the CAHPS 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: UPP's 2024 top-box scores were statistically significantly higher than the 2023 NCQA adult Medicaid national averages for eight measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care*. [Quality, Timeliness, and Access]

Strength #2: UPP's 2024 top-box score was statistically significantly higher than the 2023 adult Medicaid top-box score for one measure, *Rating of All Health Care*. [Quality]

Strength #3: UPP's 2024 top-box scores were statistically significantly higher than the 2023 NCQA child Medicaid national averages for three measures: *Getting Care Quickly*, *How Well Doctors Communicate*, and *Coordination of Care*. [Quality and Timeliness]

Weaknesses and Recommendations

Weakness #1: UPP's 2024 top-box score was statistically significantly lower than the 2023 NCQA child Medicaid national average for one measure, *Rating of All Health Care*. [Quality]

Why the weakness exists: When compared to national benchmarks, parents/caretakers of child members enrolled in UPP had less positive overall experiences with their child's healthcare. The MHP reported that its CAHPS report is reviewed by the CAHPS Taskforce to identify low-performing measures, rate trends, and to identify the questions that are the key drivers for impacting the rate. This information is used to develop initiatives to improve performance, enhance services, and build stronger relationships. However, HSAG is unable to identify the MHP-specific barriers or other factors impacting drivers for these measures based on the information provided through this EQR.

Recommendation: HSAG recommends that UPP conduct root cause analyses or focus studies to further explore members' perceptions regarding the quality of care and services they received to determine what could be driving the lower score for *Rating of All Health Care* compared to the national average and implement appropriate interventions to improve the performance related to the care members need.

CSHCS

Performance Results

Table 3-158 presents UPP's 2023 and 2024 CSHCS CAHPS top-box scores. Upward green or downward red arrows (↑ or ↓) indicate 2024 scores were statistically significantly higher or lower than the 2023 national average. Upward green or downward red triangles (▲ or ▼) indicate 2024 scores were statistically significantly higher or lower than the 2023 scores.

Table 3-158—Summary of CSHCS CAHPS Survey Top-Box Scores for UPP

	2023 Top-Box Score	2024 Top-Box Score
Global Ratings		
<i>Rating of Health Plan</i>	73.33%	75.82% ⁺ ▲
<i>Rating of Health Care</i>	69.16%	73.12% ⁺ NA
<i>Rating of Specialist Seen Most Often</i>	77.42% ⁺	70.49% ⁺
Composite Measures		
<i>Customer Service</i>	92.50% ⁺	98.15% ⁺ ▲
<i>How Well Doctors Communicate</i>	98.77% ⁺	97.56% ⁺ NA
<i>Access to Specialized Services</i>	75.47% ⁺	82.44% ⁺ NA
<i>Transportation</i>	92.37% ⁺	87.35% ⁺ NA
Individual Item Measures		
<i>Access to Prescription Medicines</i>	96.10% ⁺	93.75% ⁺
<i>Not Felt Treated Unfairly: Race and Ethnicity</i>	100.00% ⁺	98.78% ⁺ NA
<i>Not Felt Treated Unfairly: Health Insurance Type</i>	95.06% ⁺	98.78% ⁺ NA

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating the results.

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.

▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.

No triangle (▲ or ▼) indicates the 2024 score was not statistically significantly higher or lower than the 2023 score.

↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.

↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.

No arrow (↑ or ↓) indicates the 2024 score was not statistically significantly higher or lower than the 2023 national average.

NA Indicates a national average is not available for the measure.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the CAHPS 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: UPP's 2024 top-box scores were statistically significantly higher than the 2023 NCQA child Medicaid national averages for two measures: *Rating of Health Plan* and *Customer Service*.
[Quality]

Weaknesses and Recommendations

Weakness #1: UPP's 2024 top-box scores were not statistically significantly lower than the 2023 NCQA child Medicaid national averages or the 2023 top-box scores for any reportable measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

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

Quality Rating

The 2024 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2024 Michigan Consumer Guide, which is inclusive of UPP's performance.

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

HSAG performed a comprehensive assessment of UPP's aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within UPP that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how UPP's overall performance contributed to the CHCP's progress in achieving the CQS goals and objectives. Table 3-159 displays each MDHHS CQS goal and the EQR activity results that indicate whether the MHP positively (✓), negatively (✗), or minimally (m) impacted the CHCP's progress toward achieving the applicable goals and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to UPP's Medicaid members. Not applicable (NA) was used when EQR activities do not produce data to assess the impact of a quality measure(s) under an objective.

Table 3-159—Overall Performance Impact to CQS and Quality, Timeliness, and Access

Objective	Program	Quality Measure	Overall Performance Impact	Performance Domain
Goal #1: Ensure high quality and high levels of access to care				
1.1	CHCP	Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	✓	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	CHCP	Prenatal and Postpartum Care—Postpartum Care	✓	
	CHCP	Childhood Immunization Status—Combination 3	✗	
	CSHCS	Global Rating of Health Plan	✓	
	CSHCS	Global Rating of Specialist Seen Most Often	✗	
	CSHCS	Global Rating of Health Care	✓	
	CSHCS	Composite Measure for Access to Specialized Services	✓	
	CSHCS	Composite Measure for Transportation	✓	
1.2	CHCP	Asthma Medication Ratio—Total	✓	
	CHCP	Controlling High Blood Pressure	✓	
	CHCP	Comprehensive Diabetes Care (CDC)—Eye Exams ¹	✗	
	CSHCS	Composite Measure for How Well Doctors Communicate	✓	
	CSHCS	Composite Measure for Customer Service	✓	
1.3	CHCP	Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	NA	
	CHCP	Getting Care Quickly Composite (Adult CAHPS)	✓	
	CSHCS	Global Rating of Health Care	✓	
	CSHCS	Composite Measure for Access to Specialized Services	✓	
	CSHCS	Access to Prescription Medicines	✓	
Goal #2: Strengthen person and family-centered approaches				
2.1	CHCP	Rating of Health Plan ²	✓	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	CHCP	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years Old	✓	
	CHCP	Access to Dental Care	✗	
	CHCP	Completion of Annual Health Risk Assessment	NA	
	CSHCS	Composite Measure for How Well Doctors Communicate	✓	
	CSHCS	Global Rating of Health Plan	✓	
	CSHCS	Global Rating of Health Care	✓	
	CSHCS	Global Rating of Specialist Seen Most Often	✗	

Objective	Program	Quality Measure	Overall Performance Impact	Performance Domain
2.2	CHCP	SDOH: Total Member Screening Rate	NA	
	CHCP	SDOH: Total Member Referral Rate	NA	
	CHCP	Social Need Screening and Intervention	NA	
	CSHCS	Composite Measure for Access to Specialized Services	✓	
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)				
3.1	CHCP	Follow-Up After Hospitalization for Mental Illness Within 30 Days (FUH) (Adults)	NA	☒ Quality ☒ Timeliness ☒ Access
	CSHCS	Coordination of Care	NA	
3.2	CHCP	Implementation of Joint Care Management Processes	NA	
	CSHCS	Global Rating of Health Plan	✓	
	CSHCS	Global Rating of Health Care	✓	
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes				
4.1	CSHCS	Chlamydia Screening in Women—Total ³	NA	☒ Quality ☒ Timeliness ☒ Access
	CSHCS	Prenatal and Postpartum Care—Postpartum Care ³	NA	
	CSHCS	Children Immunization Combo 3 ³	NA	
	CSHCS	Lead Screening in Children ³	NA	
	CSHCS	Comprehensive Diabetes Care—Eye Exam ³	NA	
	CSHCS	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years Old ³	NA	
	CSHCS	Not Felt Treated Unfairly: Race and Ethnicity	✓	
Goal #5: Improve quality outcomes through value-based initiatives and payment reform				
5.1	CHCP	Average Percentage of Plan Payments to Providers Who Are in APM Arrangements ("Big Numerator")	NA	☒ Quality ☐ Timeliness ☐ Access
	CHCP	Average Percentage of Plan Payments to Providers That Are Tied to Quality ("Small Numerator")	NA	

✓ = The MHP's rate met the 2026 statewide performance target; or the MHP's rate did not meet the 2026 statewide performance target but demonstrated a statistically significant increase in performance from the prior year.

m = The MHP's rate did not meet the 2026 statewide performance target and while the MHP's rate increased in performance from the prior year, the increase was not statistically significant.

✗ = The MHP's rate did not meet the 2026 statewide performance target and/or the MHP's rate decreased in performance from the prior year.

NA = EQR activities published in this report do not produce data to assess the impact of a quality measure(s) under an objective.

¹ NCQA replaced the *Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed* performance measure with the *Eye Exam for Patients With Diabetes (EED)* performance measure, the overall performance impact was based on the MHP's reported rate for *Eye Exam for Patients With Diabetes (EED)*.

² As the CQS did not identify whether this quality measure applies to the adult or child CAHPS, HSAG assessed performance using the adult rate.

³ While there are reported HEDIS rates that are stratified by race/ethnicity, the EQR deliverables did not include an analysis of these data.

4. Follow-Up on Prior External Quality Review Recommendations for Medicaid Health Plans

From the findings of each MHP’s performance for the SFY 2023 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the CHCP. The recommendations provided to each MHP for the EQR activities in the *State Fiscal Year 2023 External Quality Review Technical Report for Medicaid Health Plans* are summarized in Table 4-1 through Table 4-9. The MHP’s summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation, and as applicable, identified performance improvement, and/or barriers identified are also provided in Table 4-1 through Table 4-9.

Additional performance measures and performance measure results are included in Appendix B. 2024 HEDIS Aggregate Report for Michigan Medicaid. HSAG used this supplemental information to assess the degree to which each MHP addressed the prior year’s recommendations.

Aetna Better Health of Michigan

Table 4-1—Prior Year Recommendations and Responses for AET

1. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Improvement Projects
<p>HSAG recommended the following:</p> <ul style="list-style-type: none"> • AET partially achieved the state-defined goals. The existing disparity was eliminated with the first remeasurement period; however, the comparison population demonstrated a non-statistically significant decline in performance as compared to the baseline. HSAG recommends that AET continue efforts to maintain or improve its performance for the comparison population. The MHP should also determine if any new barriers exist that are decreasing performance for this population.
<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"> • ABHMI has initiated strategic improvements aimed at enhancing maternal health outcomes, particularly in rural areas and for high-risk populations. Key initiatives included expanding access to care by credentialing new obstetrical providers in rural communities, leading to a significant increase in timely care and availability. A partnership with Mae Health introduced a culturally tailored doula program to support African American mothers, offering prenatal and postnatal care, education, and peer support. • Collaboration with the Region 10 Medicaid Health Plans focused on addressing low birth weight (LBW) deliveries through regular workgroup meetings that seek to identify barriers and implement

1. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Improvement Projects

interventions to improve birth outcomes. The Care Management team also improved the referral process for the Centering Pregnancy Program, which enhances birth outcomes through better access to care.

- The Maternity Matters Program targets all pregnant members, with a special emphasis on high-risk individuals, including those with previous pregnancy complications or chronic health conditions. These members receive intensive care management, coordinated with additional medical providers and community resources to ensure comprehensive support throughout pregnancy. These programmatic changes are designed to address both medical and social determinants of health, ultimately improving maternal and neonatal outcomes.
- The BabySmart program is designed to improve prenatal, postpartum, and well-baby visit compliance and health outcomes. This program uses smart technology, member incentives, and engagement combined with virtual doula-trained health coaches. BabySmart provides a high-tech and high-touch solution for members including weekly check-ins with health coaches and incentives for closing maternity-related gaps-in-care. There is a \$10 incentive for each coaching session. The program runs throughout a member's pregnancy and postpartum period.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- As of December 2023, there are a total of 488 Aetna Medicaid contracted obstetrical care providers practicing in rural designated zip codes. This shows an increase in 341 new providers for members living in rural areas. There are 50 doulas, 241 midwives, and 197 OB/GYN providers which include 11 CNMs (Certified Nurse Midwives), one CNP (Certified Nurse Practitioner), 21 DOs (Doctor of Osteopathy), 162 MDs (Medical Doctor), one NP (Nurse Practitioner), and one NP-C (Nurse Practitioner Certified).
- LBW outcomes have improved in consecutive years, observing an improvement of -1.7% in 2023 (10.78%) and -2.08% through July 2024 (8.7%).
- Monthly statistical testing outcomes for timeliness of prenatal care rural to urban are regularly evaluated.
- Through ABH Rewards Program a \$50 incentive for timely completion of prenatal care visit (first trimester or within 42 days of enrollment on the plan) is provided by ABHMI.
- Through ABH Rewards Program a \$50 incentive for timely completion of postpartum care visit (7-84 days after delivery of baby) is provided by ABHMI.
- The Timeliness of Prenatal Care (TOPC) and Postpartum Care (PPC) HEDIS measures increased year over year (YOY) because of initiatives implemented. A 1.21 percentage point rate lift was seen YOY in the TOPC measure and a 4.63 percentage point rate lift was seen YOY in the PPC measure.
 - Prenatal and Postpartum Care YOY 3.16% increase
 - PN 68.86% PP 54.01% MY2020
 - PN 70.07% PP 58.64% MY2021
 - PN 64.48% PP 61.80% MY 2022

c. Identify any barriers to implementing initiatives:

- There are several key barriers affecting the accuracy of prenatal care data. Member mobility, such as not updating addresses, leads to incorrect location data. Pregnancies prior to Medicaid enrollment can result in missing claims, affecting compliance with care measures. Incomplete medical records, due to unresponsive or short-staffed providers, further hinder data accuracy.

1. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Improvement Projects

HSAG Assessment: HSAG has determined that **AET** addressed the prior year's recommendation. The MHP developed intervention strategies impacting both populations and demonstrated improvement as compared to the baseline.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

HSAG recommended the following:

- **AET's** performance for both *Well-Child Visits in the First 30 Months of Life* measure indicators, *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*, ranked below the 25th percentile, indicating children who turned 15 months old during the measurement year were not always having at least six well-child visits with a PCP during their first 15 months of life. Additionally, children who turned 30 months old during the measurement year were not always having at least two well-child visits with a PCP in the last 15 months. Well-care visits provide an opportunity for providers to influence the health and development of a child, and they are a critical opportunity for screening and counseling. While **AET** noted several interventions currently in place to target improvement, such as increased member outreach, member incentives, local community partnerships, in-home service providers, ongoing internal work group meetings, and provider incentives, performance remains low for both *Well-Child Visits in the First 30 Months of Life* measure indicators. Therefore, HSAG recommends that **AET** continue its efforts to improve performance for both *Well-Child Visits in the First 30 Months of Life* measure indicators. Initiatives should be monitored and expanded upon as additional contributing factors are identified. **AET** could consider sharing best practices with PCPs on proper billing.
- **AET's** performance for the *Child and Adolescent Well-Care Visits—Ages 3 to 11 Years, Ages 18 to 21 Years*, and *Total* measure indicators ranked between the 25th and 49th percentiles, and below the 25th percentile for the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* measure indicator, indicating some children were not always receiving one or more well-care visit during the measurement year. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling. While **AET** noted several interventions currently in place to target improvement, such as increased member outreach, ongoing internal work group meetings, and provider incentives, performance remains low for all *Child and Adolescent Well-Care Visits* measure indicators. Therefore, HSAG recommends that **AET** continue its efforts to improve performance for the *Child and Adolescent Well-Care Visits* measure indicators. Initiatives should be monitored and expanded upon as additional contributing factors are identified.
- **AET's** performance for the *Cervical Cancer Screening* measure ranked below the 25th percentile, indicating women were not always being screened for cervical cancer during the specified time frame. Cervical cancer is one of the most common causes of cancer death for American women; effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate. While **AET** noted several interventions currently in place to target improvement, such as member incentives, partnerships with health organizations to increase member engagement, and increased mailings and outreach to members, performance remains low for the *Cervical Cancer Screening* measure. Therefore, HSAG recommends that **AET** continue its efforts to improve performance for the *Cervical Cancer Screening* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified. **AET** could consider the development and deployment of a digital notification system for members needing cervical cancer screening and incorporating screening reminders into current care coordination member touchpoints.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

- **AET's** performance for the *Breast Cancer Screening* measure ranked between the 25th and 49th percentiles, indicating women 50 to 74 years of age were not always being screened for breast cancer. Screening can improve outcomes: Early detection reduces the risk of dying from breast cancer and can lead to a greater range of treatment options and lower healthcare costs. While **AET** noted several interventions currently in place to target improvement, such as mobile mammogram events, member incentives, partnerships with health organization to increase member engagement, and as increased mailings and outreach to members, performance remains low for the *Breast Cancer Screening* measure. Therefore, HSAG recommends that **AET** continue its efforts to improve performance for the *Breast Cancer Screening* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified. **AET** could consider the development and deployment of a digital notification system for members needing breast cancer screening and incorporating screening reminders into current care coordination member touchpoints.
- **AET's** performance for all *Kidney Health Evaluation for Patients With Diabetes* measure indicators ranked below the 25th percentile, except measure indicator *Kidney Health Evaluation for Patients With Diabetes—Ages 65 to 74 Years*, which ranked between the 25th and 49th percentiles, indicating some members with diabetes did not receive kidney health evaluations. Approximately 1 in 3 adults with diabetes has chronic kidney disease. While **AET** noted several interventions currently in place to target improvement, such as provider education on appropriate billing practices and routine medical record review to address identified gaps in care, performance remains low for the *Kidney Health Evaluation for Patients With Diabetes* measure. Therefore, HSAG recommends that **AET** continue its efforts to improve performance for the *Kidney Health Evaluation for Patients With Diabetes* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified.

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*):

Well-Child Visits in the First 30 Months of Life

- The health plan reviews claims/encounters to support medical record review for the analyses of service delivery provided to members. This strategy includes increasing member outreach and engagement efforts, implementation of new healthy behaviors reward platforms with health intelligence solution platforms. These initiatives allow members access to more choices for rewards than just a gift card and member interaction through local community partnerships and in-home service providers.
- ABHMI collaborates with (FQHC) health events, multiple times per year targeting W30.
- Quarterly mailings are sent to non-compliant members encouraging them to visit their PCP for services.
- The ABH Rewards Programs offers incentives in the amount of \$50, for those children/families who complete their qualified WCV-30 within the indicated timeframes. This incentive amount has increased from \$25 in 2023 to \$50 in 2024.
- A targeted outreach program called BabySmart, for new mothers to influence them to bring their children in for vaccines, lead screenings, and well visits has been initiated.
- Healthcare Effectiveness Data and Information Set (HEDIS) Focused, Agile, Solutioning Team (FAST) work group meetings are ongoing with focus on the children's HEDIS measures utilizing

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

specific, measurable, attainable, realist and timely (SMART) goals, and prioritization of disparate populations.

- Non-compliant member lists are distributed monthly to providers and quarterly provider incentives are offered with details regarding what members did not obtain required services.
- Target education programs and resources are shared with PCPs via Joint Operations Committee Meetings and assigned a Quality Practice Liaison (QPL) to help assist with additional resources and closing GIC.
- ABHMI participates in the Pfizer vaccine collaborative, which provides education and reminders to children and families who are due or overdue for vaccine/immunization series.

Child and Adolescent Well-Care Visits—Ages 3 to 11 Years and Ages 18 to 21 Years

- Live outreach calls and notification of screening events children up to age 21 are regularly utilized.
- Target text/digital campaigns through Impulse, sending reminders to those aged Child and Adolescents who are due for WCV and collaboration with their Care Coordinators.
- Quarterly mailings to non-compliant members are sent encouraging them to visit their PCP for services, immunizations, and lead screening, if applicable.
- ABHMI collaborates with (FQHC) health events, multiple times per year targeting W30.
- Ongoing HEDIS FAST work group meetings are utilized with focus on children's HEDIS measures with SMART goals, and prioritization of disparate populations.
- Non-compliant member lists are distributed monthly to providers and quarterly provider incentives with details regarding which members did not obtain required services are sent.
- Target education programs and resources are shared with PCPs via Joint Operations Committee Meetings and assigned a Quality Practice Liaison (QPL) to help assist with additional resources and closing GIC.
- ABHMI participates in the Pfizer vaccine collaborative, which provides education and reminders to children and families who are due or overdue for vaccine/immunization series.

Cervical Cancer Screening

- Ongoing mailings are sent to non-compliant members encouraging them to obtain recommended cervical screenings. More robust and frequent mailings/outreach to those chronically non-compliant have been implemented.
- Continued member incentives of \$50 through the ABH Member Rewards program for women completing timely cervical screenings.
- All women are referred to Health Outreach or Case Management for complex care issues to ensure optimal access to care and coordination.
- Participating and non-participating OB/GYNs are allowed to provide care without prior authorization for continuity of care in women's health initiatives.
- OB/GYNs are partnered with various health organizations and members to increase engagement and meet members in their own community.
- Efforts to improve the network of OB types in rural designated communities are ongoing.
- Improved network capacity of OB/GYN's to improve access and appointment timeliness metrics.

Breast Cancer Screening

- The Quality Team supported Three mobile mammogram events with Ascension Mobile Mammography Unit to improve health outcomes. Specific zip codes were targeted for members chronically non-compliant for mammogram services in regions 9 and 10.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

- Increased Community Events and Collaborations with PCP's offering Breast Cancer Screening events and targeted outreach to members within the geographic area.
- Ongoing mailings are sent to non-compliant members encouraging them to obtain recommended breast health screenings. More robust and frequent mailings/ and live outreach calls to those chronically non-compliant have been implemented.
- Continued member incentives of \$50 through the ABH Member Rewards program for women completing timely Breast Cancer screenings.
- Participating and non-participating OB/GYNs are allowed to provide care without prior authorization for continuity of care in women's health initiatives.
- Multimodal outreach for breast cancer screening is ongoing.

Kidney Health Evaluation for Patients With Diabetes

- Mailers, text messages, and live outreach calls are utilized to encourage members to visit their primary care providers. This targeted outreach is completed via Gaps in Care reporting module in the QNXT system.
- One-time annual Kidney Evaluation Incentive of \$25 through the ABH Rewards Program to promote timely KED screenings.
- Provider education on appropriate billing practices and HEDIS measure review is ongoing.
- PCP Education developed and distributed via email and in-office mailings.
- Medical record review data entry is reviewed regularly to identify and address gaps in care.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Many Significant Performance Improvements have been identified through the MDHHS Annual Performance Measure Reporting Analysis and Certified NCQA HEDIS Outcomes Reports throughout 2024.

Well-Child Visits in the First 30 Months of Life

- W30 (0-15 months) 2.31 % YOY improvement
- W30 (15-30 months) 3.04% YOY improvement

Cervical Cancer Screening

- 3.82% YOY improvement

Breast Cancer Screening

- 1.71% YOY improvement

Kidney Health Evaluation for Patients with Diabetes

- 6.44% YOY improvement

Child and Adolescent Well-Care Visits—Ages 12 to 1 Years, Ages 18 to 21 Years, and Total

- WCV 12-17 years 1.09% YOY improvement
- WCV 18-21 years 1.91% YOY improvement
- WCV Total 0.22% YOY improvement

c. Identify any barriers to implementing initiatives:

Well-Child Visits in the First 30 Months of Life

- For services rendered at practices, health plan does not receive the claim/encounter information (i.e., not the "payer of record," or not billing because "babies don't have insurance for the first 30 days").
- Parents do not adhere to scheduling six visits prior to 15 months of age.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

- Single mothers with multiple children can only schedule two children for well visits at a time (providers do not schedule appointments for more than two children so no-shows do not leave open appointments).
- Providers often miss opportunities to do a well-child visit when they have the child in the office for a sick child visit.
- Incorrect phone numbers are common along with ever-changing demographic info in Medicaid population.
- Use of ED and Urgent Care for non-emergency related care is frequent.
- Overarching transportation issues remain a constant barrier.

Cervical Cancer Screening

- Inaccurate member contact information makes outreach and education difficult for chronically non-compliant members (i.e., 2 years no provider visit).
- There are not enough OB weekend or evening physician appointment dates available.
- There is a high number of 'walk-in' clinics in Wayne County and the wait time can be long versus wait time with scheduled appointments. PCP/OBs are hesitant to schedule appointments due to high no-show rates that result in loss of revenue.
- Cultural differences and religious preferences often prevent some healthcare screenings.
- PCP auto assignment and the member are not appropriately engaged with the provider or office for continuity.
- Overarching transportation issues remain a constant barrier.
- ED/urgent care usage over preventative care is prevalent.
- SDoH often take precedence over health care needs.

Breast Cancer Screening

- Inaccurate member contact information makes outreach and education difficult for chronically non-compliant members (i.e., 2 years no provider visit).
- There are not enough weekend or evening physician appointment dates available.
- There is a high rate of no-show appointments scheduled during outreach events.
- There is a high number of 'walk-in' clinics in Wayne County and the wait time can be long versus wait time with scheduled appointments. PCP/OBs are hesitant to schedule appointments due to high no-show rates that result in loss of revenue.
- Cultural differences and religious preferences often prevent some healthcare screenings.
- PCP auto assignment and the member are not appropriately engaged with the provider or office for continuity.
- Members often fail to follow through with PCP referrals that are scheduled with radiology departments.
- Overarching transportation issues remain a constant barrier.
- ED/urgent care usage over preventative care is prevalent.
- SDoH often take precedence over health care needs.

Kidney Health Evaluation for Patients with Diabetes

- Inaccurate member contact information makes outreach and education difficult for chronically non-compliant members.
- There are not enough weekend or evening physician appointment dates available.
- PCP auto assignment and the member are not appropriately engaged with the provider or office for continuity.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

- Overarching transportation issues remain a constant barrier.
- ED/urgent care usage over preventative care is prevalent.
- SDoH often take precedence over health care needs.
- Providers only complete a urine albumin-creatinine ratio (uACR) without the estimated glomerular filtration rate (eGFR) giving an incomplete assessment of kidney health.
- More robust provider education is needed.

Child and Adolescent Well-Care Visits—Ages 12 to 17 Years, Ages 18 to 21 Years, and Total

- Single mothers with multiple children can only schedule two children for well visits at a time (providers do not schedule appointments for more than two children so no-shows do not leave open appointments).
- Providers often miss opportunities to do a well-child visit when they have the child in the office for a sick child visit.
- Incorrect phone numbers are common along with ever-changing demographic info in Medicaid population.
- Use of ED and Urgent Care for non-emergency related care is frequent.
- Overarching transportation issues remain a constant barrier.

HSAG Assessment: HSAG has determined that **AET** has partially addressed the prior year's recommendations. **AET** has put forth effort to address HSAG's prior year recommendation for the *Well-Child Visits in the First 30 Months of Life (W30)* measure indicators by reviewing claims/encounters to support medical review for analysis, increasing member outreach and engagement efforts, implementing new health behaviors reward platforms, facilitating federally qualified health centers (FQHC) health events, sending quarterly mailings to members encouraging them to schedule a well-child visit with their PCP, giving members and providers incentives for completing well-child visits, facilitating a targeted outreach program called BabySmart for new mothers to encourage PCP engagement and appointment continuance, and strategic development of HEDIS FAST workgroup meetings with an ongoing focus on children's HEDIS measures. However, **AET** continues to demonstrate low performance for the *Well-Child Visits in the First 30 Months of Life (W30)* measure indicators, as the rates continued to rank below the 25th percentile for MY 2023. Barriers noted by **AET** included not receiving some claim or encounter information from service providers, frequent utilization of emergency department or urgent care for non-emergency medical services by parents, transportation issues, incorrect contact information for members, and single mothers with multiple children only being able to schedule two children at a time for well-child visits. HSAG recommends continued efforts by **AET** to further improve the *Well-Child Visits in the First 30 Months of Life (W30)* rates and monitoring of initiatives currently in place to ensure improved performance. **AET** could consider reeducating providers on the importance of well-child visits and utilization of the Quick Reference Guide. Increased provider and member incentives for well-child visits may be another option to consider.

Pertaining to HSAG's prior year recommendation for the *Child and Adolescent Well-Care Visits (WCV)—Ages 3 to 11 Years, Ages 12 to 17 Years, Ages 18 to 21 Years, and Total* measure indicators, **AET** has demonstrated efforts by conducting live outreach calls, issuing notifications of screening events for children up to 21 years of age, quarterly mailings to noncompliant members to encourage scheduling PCP services, collaborating with FQHCs for health events throughout the year, participating in the Pfizer vaccine collaborative, and facilitating targeted education programs for providers. **AET** also demonstrated improved performance for the *Child and Adolescent Well-Care Visits (WCV)—Ages 18 to 21 Years* measure indicator as the rate increased by nearly 2 percentage points from MY 2022 and ranked between the 50th and 74th percentiles for MY 2023. However, **AET** continued to demonstrate low performance for the *Child and Adolescent Well-Care Visits (WCV)—Ages 3*

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

to 11 Years, Ages 12 to 17 Years, and Total measure indicators as the rates ranked between the 25th and 49th percentiles for MY 2023. Several barriers noted by AET included not receiving some claim or encounter information from service providers, frequent utilization of emergency department or urgent care for non-emergency medical services by parents, transportation issues, incorrect contact information for members, and single mothers with multiple children only being able to schedule two children at a time for well-child visits. HSAG therefore recommends that AET continue its efforts on increasing well-care visits for children and adolescents as well as monitor the impact of initiatives currently in place to ensure improved performance.

Related to HSAG's prior year recommendation for the *Cervical Cancer Screening (CCS-E)* measure, AET has demonstrated efforts by sending ongoing mailings to non-compliant members encouraging them to obtain recommended screenings, providing continued member incentives for completed cervical cancer screenings, and allowing participating and non-participating providers to provide care without prior authorization. However, AET continues to demonstrate low performance for the *Cervical Cancer Screening (CCS-E)* measure by ranking below the 25th percentile for MY 2023. Several barriers noted by AET included incorrect member contact information, appointment availability, high rates of no-show appointments, cultural differences or religious preferences, transportation issues, and other SDOH factors. Therefore, HSAG recommends that AET continue its efforts to improve performance for the *Cervical Cancer Screening (CCS-E)* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified. AET could consider the development and deployment of a digital notification system for members needing cervical cancer screening and incorporating screening reminders into current care coordination member touchpoints. Another option to consider would be to develop partnerships with local partners or vendors for transportation services.

Regarding HSAG's prior year recommendation for the *Breast Cancer Screening (BCS-E)* measure, AET has demonstrated efforts by hosting three mobile mammogram events targeting specific ZIP Codes for members with chronic non-compliance for mammogram services, increasing community events and collaboration with PCPs offering screening events, providing continued member incentives for completed breast cancer screenings, allowing participating and non-participating providers to provide care without prior authorization, and conducting multimodal outreach for breast cancer screenings. However, AET continues to demonstrate low performance for the *Breast Cancer Screening (BCS-E)* measure by ranking between the 25th and 49th percentile for MY 2023. Several barriers noted by AET included incorrect member contact information, appointment availability, high rates of no-show appointments, cultural differences or religious preferences, transportation issues, and other SDOH factors. HSAG therefore recommends that AET continue its efforts on increasing breast cancer screenings and monitor the impact of initiatives currently in place to ensure improved performance. AET could consider the development and deployment of a digital notification system for members needing breast cancer screening and incorporating screening reminders into current care coordination member touchpoints. Another option to consider would be partnering with local partners or vendors for transportation services.

Pertaining to HSAG's prior year recommendation for all *Kidney Health Evaluation for Patients With Diabetes (KED)* measure indicators, AET has demonstrated efforts by conducting various methods of targeted outreach based on gaps in care reporting to encourage members to visit their PCPs, providing a one-time annual kidney evaluation member incentive through its rewards program, offering education to providers on appropriate billing practices, and reviewing medical record review data entry to identify and address gaps in care. As a result, AET demonstrated a significant improvement for *Kidney Health Evaluation for Patients With Diabetes (KED)*—Ages 18 to 64 Years, Ages 65 to 74 Years, and Total measure indicators as all rates increased by more

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

than 6 percentage points from MY 2022; however, all measure indicators ranked between the 25th and 49th percentiles for MY 2023 and overall measure performance continues to be low. Several barriers noted by AET included incorrect member contact information, appointment availability, transportation issues, and other SDOH factors. HSAG therefore recommends that AET continue its efforts on increasing breast cancer screenings and monitor the impact of initiatives currently in place to ensure improved performance. HSAG recommends that AET continue its efforts on further improving the *Kidney Health Evaluation for Patients With Diabetes (KED)* measure indicators and monitor the impact of initiatives currently in place to ensure improved performance.

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

HSAG recommended the following:

- While AET demonstrated high performance overall (i.e., 90 percent or greater but less than 100 percent) in the Quality standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for element 4.9 *Performance Monitoring Report (PMR) Review and Response*. AET was required to submit a CAP to address element 4.9, which was approved by MDHHS. As such, HSAG recommends that AET continue to implement action plans and monitoring processes to ensure performance improvement plans are implemented timely when minimum standards are not met.
- While AET demonstrated high performance overall (i.e., 90 percent or greater but less than 100 percent) in the MIS/Financial standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for element 5.11 *Claims Processing (Non-Pharmacy)* and a *Satisfied* score for element 5.15 *Monthly Encounter Record Acceptance Rate in CHAMPS* [Community Health Automated Medicaid Processing System]. AET had a previous CAP and was required to submit another CAP to address element 5.11, which was approved by MDHHS. However, MDHHS did not require a CAP to address element 5.15. As such, HSAG recommends that AET continue to implement action plans and monitoring processes to ensure all claims processing performance standards are consistently met (i.e., *Maintain less than 1% of ending inventory greater than 45 days, Percent of rejected claims must be 12% or less, and Encounter record transmissions must meet or exceed a 95% acceptance rate for encounters loaded into CHAMPS*).

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*):

Element 4.9 Performance Monitoring Report (PMR) Review Response and improvement efforts:

- Aetna Better Health of Michigan submitted 12 of the 16 measures and didn't submit 4 of the unmet performance benchmarks according to the April 2023 Performance Monitoring Reports. Aetna has put together a performance improvement plan that included action items to improve the identified measures. 4 of the measures which were below the performance benchmark were not included in the performance improvement plan. The following are the measures that were excluded:
 - 1. Comprehensive Diabetes Care: Preventive Dental Visit measure
 - 2. Transition out of CFP Status – Cohort 1
 - 3. Transition out of CFP Status – Cohort 2
 - 4. Transition out of CFP Status – Cohort 3
- The 4 measures for which we did not meet the performance benchmark were inadvertently excluded from the performance improvement plan. We have determined that we needed a more robust PMR

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

review, as well as performance improvement plan preparation and quality checks in place to identify each unmet measure and ensure that all unmet measures were included in the performance improvement plan.

The following PMR review, and performance improvement plan preparation and quality checks have been implemented to ensure corrective action and that a complete performance improvement plan is prepared, reviewed, and submitted so that this oversight does not occur in the future:

- Kicked off a monthly internal meeting to review the performance monitoring report and evaluate each measure. The meeting consists of representatives from the Care Management, Engagement Hub Team, and Quality functional areas, and during the meeting all met and unmet measures are discussed.
- Established a documented tiered quality check process to ensure multiple parties are reviewing and validating all content of the performance improvement plan. The quality check process consists of the following:
 - Preparation of the initial draft of the performance improvement plan by the Quality and Care Management/Engagement HUB subject matter experts.
 - Review of the performance improvement plan by the Quality and Care Management Directors for accurate performance evaluation, comprehensive assessment, and appropriate interventions.
 - Validation and sign-off on the completeness of the performance improvement plan content by the Quality Director. Completeness is defined as: At minimum, all unmet measures per the MDHHS PMR are to be included in the performance improvement plan, plus any other measures identified in which improvement would yield better quality care, outcomes and/or service to enrollees.
 - Review and sign-off of the performance improvement plan by the Chief Medical Officer or Chief Executive Officer prior to submission of the performance improvement plan in response to the Compliance Review deliverable.
- Revised the agenda for the quarterly Quality MI Market Strategy meeting to include review of the PMR, including both met and unmet measures, so that all represented functional area leaders understand actual performance compared to established benchmarks and discuss methods to drive better outcomes.

*The 2024 4.9 – Performance Monitoring Report was successfully delivered to MDHHS timely on July 15, 2024, and no CAPS identified.

Element 5.11-Claims Processing:

- Aetna identified a reporting error that caused the report to display that denied/rejected clean claims exceeded 12%. The report was not an accurate reflection of the actual clean-claim rejection rate for the month of August 2022.

The root cause of the error was identified as a change in reporting logic made by the Aetna Informatics Reporting team to the report run for the August 2022 to July 2022 period. The change in the reporting logic erroneously included rejections for non-clean claims that should have been included on lines 3 or 4 of the Claims Processing Report rather than lines 7 and 9.

Activities Completed/ Implemented:

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

To address the inaccurate reporting, Aetna updated internal report creation and submission process document to reflect the following to cure or resolve the deficiency and avoid future non-compliance of the deficiency:

- Transcription errors - Change the transcription methodology, from typing to copy/paste into the MDHHS form.
- Implement a Technical Quality Check to validate the accuracy of the report.
- Conduct training sessions with the report generation informatics team and the report business owners to ensure the new proposals are being properly followed.

Processes in place to ensure continued compliance with all claims processing performance standards include:

- Monitoring pended claims daily to address open items to avoid claims aging beyond 45 days. Our current average number of days between receipt of clean claim and payment or denial is 6 days.
- Ensure alignment of claim disposition logic with definition of MCL 400.11 and OFIS Bulletin 2000-09 so that non-clean claims and clean claims are appropriately identified, and any rejections of non-clean claims are accounted for properly so not to adversely impact the 12% denied claims requirement.
- Utilization of industry-wide/CMS claim editing rules
- Reconciliation of membership eligibility data and benefit configuration to MDHHS reporting, Medicaid Provider manual, Michigan Medicaid fee schedule, MDHHS Policies, Letters and Bulletins and other MDHHS issued guidance to ensure payment in accordance with contractual requirements.

Element 5.15 – Monthly Encounter Record Acceptance Rate:

- Aetna's dental vendor, DentaQuest, went through a system upgrade in the month of August 2022. The low acceptance rate in August was due to a missing piece of logic in DentaQuest's encounter configuration where that logic looks at response data loaded from the 4950-state response file. DentaQuest submitted a file with 71 encounters that were submitted as original encounters instead of adjustments, causing them to fail as duplicates. The problem was corrected effective 9/1/2022.

Activities Completed/ Implemented:

- (1) A system fix ticket was immediately opened to address the configuration issue. The 71 encounters were resubmitted correctly as adjustments.
- (2) DentaQuest disabled the functionality that automatically sends the encounters once the file is generated.
- (3) The DentaQuest team now reviews the files weekly, on Monday mornings, before submission to Aetna to ensure the issues have been addressed.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Stated Monitoring improvements have been implemented triggering improved acceptance rates and a decline in denial rates. ABHMI will continue to observe.

c. Identify any barriers to implementing initiatives:

- No Barriers to completing the above remediation efforts have been identified.

HSAG Assessment: HSAG has determined that **AET** addressed the prior year's recommendation. The SFY 2024 compliance review activity demonstrated that **AET** received a *Met* score for elements 4.9 and 5.11, confirming the MHP's action steps were successful in remediating the deficiencies.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

- Reviewers located only 81.5 percent of the sampled providers in AET's online provider directory. Among the provider categories, 21.2 percent of pediatric providers, 17.9 percent of PCP providers, and 10.3 percent of OB/GYN providers could not be located in the online directory. HSAG recommends that AET use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., inaccurate and/or missing provider information) to address the provider data deficiencies.
- Only 72.7 percent of the sampled provider locations could be reached. HSAG recommends that AET use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies.
- Of the locations reached, only 54.4 percent confirmed affiliation with the sampled provider. Additionally, 46.7 percent confirmed accuracy of the sampled address, 44.8 percent confirmed the services were offered, and 40.0 percent confirmed the requested insurance was accepted. HSAG recommends that AET use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., records with incorrect specialty or provider information) to address the provider data deficiencies.
- Of the cases responding to the survey and accepting the insurance and new patients, only 38.1 percent of locations offered an appointment date. HSAG recommends that AET work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that AET 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)

- 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 ABHMI Provider Network team continues to conduct our own internal audit quarterly of providers to ensure they are compliant with measures. Provider Representatives then complete outreach to any provider office that is non-compliant. They provide them with education regarding our requirements and obtain any demographic updates that may be prohibiting member access. During provider orientations the Provider Network team reviews access requirements in detail, along with State and NCQA benchmark standards. Our provider manual also contains access requirements that providers are able to access through our website. The Provider Network team has also converted to the Quest Cloud application to validate provider data, identify network provider targets and to leverage geo-access plotting of contracted providers to correct gaps in the network. Additionally, ABHMI Provider Network team has continued the 4275 prescreening validation audits to ensure that provider data is transmitted to MDHHS accurately and timely.
- Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - Our internal Q2 2024 Quarterly audit shows 63% accuracy for providers accepting new patients and 72% validated address and phone number which was an improvement over the previous year's results. The ABHMI targets/goals, align with the HSAG threshold of 75% for both accepting new patients and valid location and contact information.
- Identify any barriers to implementing initiatives:
 - There were no significant barriers identified when implementing initiatives.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

HSAG Assessment: HSAG has determined that **AET** has addressed the prior year's recommendations. **AET** implemented initiatives to ensure provider data accuracy (e.g., internal audits, provider education and training) and monitor appointment availability by reviewing gaps in the network. **AET** should also review and address data deficiencies noted in the case-level analytic data files.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

HSAG recommended the following:

- **AET** reported only conducting one quality check for claims/encounters stored in its data warehouses. **AET** should build a comprehensive set of monitoring reports to evaluate encounter data accuracy, completeness, and timeliness for encounters collected by **AET**.
- Although greater than 99.9 percent of provider NPIs identified in the medical/dental data were identified in the provider data, approximately 97 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data. **AET** should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.

MCE's Response: *(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

- a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:
 - Our Encounter Team uses a series of reports to monitor, identify, track, and resolve errors in the encounter management system. These functional reports, allow us to monitor the accuracy, timeliness, and completeness of encounter transactions from entry into the encounter management system to submission and acceptance by the State. A few of our standard reports include:
 - Financial reconciliation encounter dashboard: This report compares actuarial based paid claims data results against our encounters at a distinct claim level and identifies priority categories and areas of focus by provider, age/gender, rate groups, regions, and type of service. This level of detail ensures we maintain high data quality levels by identifying provider completeness rates, which allows our provider relations/network team to perform targeted outreach.
 - Exceptions report: This report provides detail level information by error code and aging status and is used by cross-functional teams to correct internal or external errors related to claim, member, and provider data.
 - Timeliness and accuracy compliance dashboard: This report is used to monitor encounter timeliness and accuracy results by week and month of submission.
 - Encounter File Tracker: This report is used to track all file submissions and all response files including vendors.
 - We promptly review, analyze, and correct any encounter rejected by the State and work to identify the root cause. We use the encounter rejection reason(s) to identify opportunities for improvements in training of staff and providers, encounter processes, protocols and/or operations. Improvements are implemented to address data validity and integrity as appropriate.
 - To improve the accuracy of the provider NPIs in the pharmacy data, Aetna Better Health of Michigan changed the frequency of submission of the state provider file to the PBM. The file is currently being transmitted daily as opposed to weekly.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - Submission of the daily provider file to the PBM has reduced the number of encounter rejections received for invalid NPI.
- c. Identify any barriers to implementing initiatives:
 - No barriers have been identified at this time.

HSAG Assessment: HSAG has determined that **AET** has fully addressed the prior year's recommendations.

Regarding the recommendation to build a comprehensive set of monitoring reports to evaluate encounter data accuracy, completeness, and timeliness, **AET** has fully addressed this by implementing a robust set of tools. These tools include a financial reconciliation dashboard, an exceptions report, a timeliness and accuracy compliance dashboard, and an Encounter File Tracker. Together, these reports allow **AET** to monitor critical aspects of encounter data, such as identifying and resolving errors, tracking file submissions, and analyzing the timeliness and accuracy of data submissions. This comprehensive approach ensures that encounter transactions are reviewed and corrected promptly, contributing to **AET**'s ability to meet quality and compliance requirements.

To address the recommendation to collaborate with MDHHS to ensure both entities maintain an accurate and complete database of contracted providers, **AET** made significant improvements to its processes. Specifically, **AET** increased the frequency of submitting the state provider file to its PBM, transitioning from a weekly to a daily submission schedule. This adjustment has already yielded positive results, significantly reducing the number of encounter rejections for invalid NPIs in the pharmacy data. This initiative demonstrates **AET**'s commitment to enhancing data quality and its ability to implement impactful changes to resolve identified issues.

In conclusion, **AET** has fully addressed the recommendations through thoughtful and well-executed initiatives. **AET**'s proactive approach has demonstrated measurable improvements in encounter data monitoring and provider NPI accuracy. Continued focus enhancement of these solutions will ensure sustained success and alignment with data quality goals.

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis—Adult and Child Medicaid

HSAG recommended the following:

- **AET**'s 2023 top-box scores were not statistically significantly lower than the 2022 NCQA adult and child Medicaid national averages or 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified. HSAG recommends that **AET** monitor the measures to ensure significant decreases in scores over time do not occur.

MCE's Response: *(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

- a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:

Adult and Child Medicaid

- Communicate CAHPS results with Providers/Specialists, and Care Coordinators to increase awareness of opportunities to support members in navigating health care outside of what is shared on our website,

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis—Adult and Child Medicaid

and in our provider newsletters. A more focused approach to ensure understanding of the measurements/metrics and how they are being assessed.

- CHW's and Member Outreach Coordinator's now required to use Health Care Equity assessments to identify and document SDoH and coordinate referrals to CBO's that report results in closed loop platforms (incentivizing CBOs to use specific platforms that offer closed loop functionality) so we can ensure the members needs are being met and refer to the CBOs with successful outcomes.
- Monitor for consistent use of the voluntary post call experience rating survey available to members after each telephone call with their Care Coordinators.
- Expand and leverage telehealth technologies to expand access to care to our members that may not be aware of the ease of use from a smart phone. Also, incentivize providers reluctant to expand use of telemedicine appointments post pandemic to continue doing so.
- Gain member feedback from the Member Advisory Committee (MAC) and other Focus Study groups about areas of improvement with the health plan and network providers.
- A CAHPS supplemental IVR survey will be deployed in Q423 to identify trends in barriers to care. Also, use of QR code will be utilized to improve accessibility.

Children's Special Health Care Services (CSHCS)

- The coordination of care between primary and specialist providers can be a challenge and may affect patient perceptions of their specialist care. Improving the coordination of care and case management can increase patient satisfaction with their specialist. To improve care coordination efficiency and quality to the CSHCS members, AET is putting processes in place to:
- Communicate CAHPS results with Providers/Specialists to increase provider awareness of opportunities to support members in navigating health care outside of what is shared on our website, and in our provider newsletters. A more focused approach to ensure understanding of the measurement and how they are being assessed.
- Ensure referrals and services delivered by the providers/specialists for the CSHCS population are being tracked by the MHP Care Coordinators and follow up occurs to ensure the members needs were met after the referral is given.
- Through Care Coordination and Population Health Management, assist the CSHCS members on how to prepare, and ensure effective communication with their providers such as writing down talking points and questions prior to visits.

Healthy Michigan Plan (HMP)

- Communicate CAHPS results with Providers/Specialists, and Care Coordinators to increase awareness of opportunities to support members in navigating health care outside of what is shared on our website, and in our provider newsletters. A more focused approach to ensure understanding of the measurements/metrics and how they are being assessed.
- CHW's and Member Outreach Coordinator's now required to use Health Care Equity assessments to identify and document SDoH and coordinate referrals to CBO's that report results in closed loop platforms (incentivizing CBOs to use specific platforms that offer closed loop functionality) so we can ensure the members needs are being met and refer to the CBOs with successful outcomes.
- Monitor for consistent use of the voluntary post call experience rating survey available to members after each telephone call with their Care Coordinators.
- Expand and leverage telehealth technologies to expand access to care to our members that may not be aware of the ease of use from a smart phone. Also, incentivize providers reluctant to expand use of telemedicine appointments post pandemic to continue doing so.

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis—Adult and Child Medicaid

- Gain member feedback from the Member Advisory Committee and other Focus Study groups about areas of improvement with the health plan and network providers.
- A CAHPS supplemental IVR survey will be deployed in Q424 to identify trends in barriers to care.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- The ABHMI response rate to CAHPS surveys increased YOY 2022-13.7%, 2023-18.24%-18.76% providing broader insight into member experiences, access to care, and access to providers.
- ABHMI utilized blue envelopes for mailing, so Members could identify the survey when it arrived.
- Getting Care Quickly: Improved 4% (77% to 81%) over previous years result (NCQA: 2 stars to 3 stars)
- Rating of Health Plan: Improved 4% (58% to 62%) over previous years result (NCQA: 2 stars to 3 stars)
- Getting Needed Care maintained strong performance improving .26% (82.6% to 83.0%) (NCQA: 4 stars)

c. Identify any barriers to implementing initiatives:

- When ABHMI supplemental CAHPS campaign in deployed, we are dependent on member responses to IVR surveys.
- Provider responsiveness to ABHMI CAHPS education in sharing our outcomes.
- Low response rates, due to geographic areas and SDOH factors.

HSAG Assessment: HSAG has determined that **AET** has not addressed the prior year's recommendation. The SFY 2024 CAHPS activity confirmed that **AET's** 2024 top-box score for *Coordination of Care* for the adult Medicaid population was statistically significantly lower than the 2023 NCQA adult Medicaid national average. HSAG recommends that **AET** continue to implement performance improvement interventions and evaluate their effectiveness.

7. Prior Year Recommendation from the EQR Technical Report for Performance Results—CSHCS

HSAG recommended the following:

- **AET's** 2024 top-box scores were not statistically significantly lower than the 2023 NCQA child Medicaid national averages or the 2023 top-box scores for any measure; therefore, no substantial weaknesses were identified. HSAG recommends that **AET** monitor the measures to ensure significant decreases in scores over time do not occur.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:

- Changes to our process to streamline complex systems of care where many individuals are supporting our members, such as:
 - Working directly and effectively with the member's case worker and health liaison officers for member in Foster Care to ensure timely bi-directional communication.
 - Working with the member's providers and notifying them of any gaps in care
 - Using predictive modeling for targeted outreach for members with high risk of ED utilization for non-emergency conditions and educating on appropriate ED use

7. Prior Year Recommendation from the EQR Technical Report for Performance Results—CSHCS

- Engaging members in complex case management services with a dedicated Care Manager to ensure appropriate coordination of care.
- Maintaining collaborative agreements with all Local Health Depts (LHDs), Children’s Multidisciplinary Specialty (CMDS) clinics, and Prepaid Inpatient Health Plans (PIHP) and all other appropriate stake holders to improve communication, share data pertaining members’ conditions, support and services, barriers, and health related social needs in an effort to coordinate care for members identified with special health care needs or social determinants of health impacting health outcomes, including but not limited to:
 - Coordinating and facilitation monthly collaborative meetings that allows bi-directional communication on coordinated care planning, sharing member level information, including but not limited to assessments and treatment plans.
 - Ensuring BH integration for members with multiple comorbidities
- Understanding how health related social needs impact health outcomes, which ensued in:
 - Deploying the Community Health Workers (CHW) team who are part of our Peer Workforce to assist members and their families with accessing internal and external resources that improve health outcomes back into our communities 70% as well as embedding them in community-based organizations, provider offices, and Federally Qualified Health Centers (FQHCs)
 - Educating members on the implementation and expansion of over the counter (OTC) benefits to include personal health items.
 - Empowering members to make choices to meet their needs.
- In 2023, Aetna implemented an interdepartmental Youth Taskforce led by our Chief Medical Officer and representatives from Pharmacy, Care Management, Behavioral Health, SDoH, Member Services, Provider Relations, and Quality.
 - Promoting a workgroup focused on mental health improvement for children and young adults.
 - Supporting members and their families as they transition from pediatric services to adult services by identifying interventions to support them as they move into adulthood.
 - Partnering with youth focused Community-Based Organizations (CBOs) to address health related social needs.
 - Collaborating with local foster care agencies to assist with navigating members’ benefits, transition planning, improving access to care, and removal barriers such as, but not limited to access to medications, scheduling appointments, transportation needs, etc.
- Proactively monitoring network adequacy to ensure our in-network providers can support members who are hearing impaired, disabled, or require special support and services.
 - Additionally, Aetna ensures that in our list of network relationships included are children’s hospitals, pediatric sub-specialists, and regional centers to support our culturally diverse membership while prioritizing health equity.
 - Ensuring Aetna’s provider network aligns with Michigan Department of Health and Human Services goals.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Noted performance improvements because of implemented initiatives are as follows:
 - Clinical care managers are consistently maintaining at or above established performance metrics with audits.
 - Implementation of Foster Care Case Rounds due to the overlap of members presenting in other clinical rounds. This also included members with a CSHCS indicator or potentially eligible for CSHCS services based on medical diagnosis.

7. Prior Year Recommendation from the EQR Technical Report for Performance Results—CSHCS

- In 2023, Aetna’s CHW team expanded from 1:5000 to approximately 1:3000 to provide more visibility in the community and to address the social needs of our membership.

c. Identify any barriers to implementing initiatives:

- Aetna did not identify any barriers preventing implementation of the above initiatives. Continuous monitoring of implemented initiatives to determine impact on health outcomes is the collaborative responsibility of multiple departments including Care Management, Member Services, Quality, Provider Relations, and Community Development.

HSAG Assessment: HSAG has determined that **AET** has addressed the prior year’s recommendations. Scores were comparable to national averages and the 2023 top-box scores for all measures for the CSHCS population.

8. Prior Year Recommendation from the EQR Technical Report for Performance Results—HMP

HSAG recommended the following:

- **AET**’s 2023 top-box scores were not statistically significantly lower than the 2022 NCQA adult Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified. HSAG recommends that **AET** monitor the measures to ensure significant decreases in scores over time do not occur.

MCE’s Response: *(Note—the narrative within the MCE’s Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:

Aetna Better Health of Michigan has implemented the following improvement efforts and additional programs, for HMP Metrics/Programs falling below the State specified benchmark targets:

- Diagnostic Dental Services – At or above (30%) – Current Performance (18.41%)
 - Geo-access mailers with offers of appointment and transportation assistance
 - Educational calls, texts, and mailings explaining the importance of regular visits as well as when it’s appropriate to go to ER visits making an appointment directly with a dentist
 - Recommend dental/provider appointments at least busy times of the day accompanied by a friend.
 - Implemented dental vendor broken appointment program to follow up with members to immediately reschedule missed appointments
 - Expand partnerships/collaborations with FQHC’s, providers and community partners to increase number of access opportunities for Members
 - Work with MDHHS on establishing a Provider Directory for Dental Therapist and Dental Hygienist, that can be utilized during community events/mobile units to expand scope of care for members needing more restorative dental services.
 - Other preventative and diagnostic member mailers and newsletters, as shown below:
[redacted embedded document]
- Preventative Dental Services – At or above (17%) – Current Performance (9.52%)
 - Geo-access mailers with offers of appointment and transportation assistance
 - Enrollee Outreach Materials: Educational calls, texts, and mailings explaining the importance of regular visits as well as when it’s appropriate to go to ER visits making an appointment directly with a dentist
 - New Member Welcome Calls: In addition to personal welcome calls, we notify Enrollees of their dental benefit through the Enrollee Welcome Packet, Enrollee Handbook, our website which

8. Prior Year Recommendation from the EQR Technical Report for Performance Results—HMP

- includes a link to the DQ Provider network, and via the Enrollee identification (ID) card, The ID card includes dental coverage and/or dental subcontractor's name and customer service phone number. We mail ID cards according to the timeframes and methods required by MDHHS.
- Transition Efforts to Expanded Dental Benefit: When MDHHS expanded the dental benefit in April 2023, ABH MI successfully transitioned Enrollees to our dental benefit management Plan. We notified Enrollees by mail, updated the Enrollee Handbook and website, and included information in the Enrollee newsletter. We preserved dental continuity of care by honoring prior authorizations in place for newly covered Enrollees for up to one year.
 - Recommend appointments at less busy times of the day accompanied by a friend.
 - Implement dental vendor broken appointment program to follow up with members to immediately reschedule missed appointments.
 - Restorative Dental Filling Services – At or above (14%) – Current Performance (6.59%)
 - Geo-access mailers with offers of appointment and transportation assistance
 - Educational calls, texts, newsletters, and mailings explaining the importance of regular visits to overall health
 - Exploring/Logistics of offering incentives for members who complete preventative, diagnostic and restorative dental services
 - Recommend appointments at less busy times of the day accompanied by a friend.
 - Improved/Expanded Community Partnerships with FQHC's and other community collaboratives/organizations, to meet members where they are in the community and improve access to dental care.
 - Implement dental vendor broken appointment program to follow up with members to immediately reschedule missed appointments
 - Work with MDHHS on establishing a Provider Directory for Dental Therapist and Dental Hygienist, that can be utilized during community events/mobile units to expand scope of care for members needing more restorative dental services
 - Comprehensive Diabetes Care Diagnostic Dental Exam – At or above (30%) – Current Performance (26.33%)
 - Geo-access mailers with offers of
 - appointment and transportation assistance
 - Educational calls, texts, newsletters, and mailings explaining the importance of regular visits to overall health
 - Exploring/Logistics of offering incentives for members who complete preventative, diagnostic and restorative dental services
 - Live outreach calls to those Members with diagnosis of Diabetes and are on our Chronic Dental Non-utilizer report list. The agent provides a personal call to help the Member establish/schedule dental care. Over 900 calls completed in Q3/Q4 of 2023 and 1200 calls completed in Q1/Q2 of 2024.
 - Focus on decreasing dental disparities; Aetna Better Health of Michigan will continue to strategize and implement initiatives focused on sustaining equitable outcomes in our dental utilization as our outcomes show statistically significant disparities between our African American and White populations as well as between our service areas rate of compliance. Based on the outcomes for women completing dental health services enrolled in our Healthy Michigan Plan, women are completing diagnostic, restorative, and preventive dental health services at a much higher rate than men. Our annual work plan will allow us to narrow in objectives and interventions based on these observable disparities and prioritize resources to improve future outcomes.

8. Prior Year Recommendation from the EQR Technical Report for Performance Results—HMP

- Comprehensive Diabetes Care Preventative Dental Visit – At or above (17%) – Current Performance (12.51%)
- Although ABHMI has observed a 2.07% improvement, our target is always to achieve the National/State benchmark of 17% for each PMR measure. Improvement efforts since the last measurement period include:
 - Geo-access mailers with offers of appointment and transportation assistance
 - Educational calls, texts, newsletters, and mailings explaining the importance of regular dental visits to overall health
 - Exploring/Logistics of offering incentives for members who complete preventative, diagnostic and restorative dental services
 - Live outreach calls to those Members with diagnosis of Diabetes and are on our Chronic Dental Non-utilizer report list. The agent provides a personal call to help the Member establish/schedule dental care. Over 900 calls completed in Q3/Q4 of 2023 and 1200 calls completed in Q1/Q2 of 2024.
 - Focus on decreasing dental disparities: Aetna Better Health of Michigan will continue to strategize and implement initiatives focused on sustaining equitable outcomes in our dental utilization as our outcomes show statistically significant disparities between our African American and White populations as well as between our service areas rate of compliance. Our annual work plan will allow us to narrow in objectives and interventions based on these observable disparities and prioritize resources to improve future outcomes.
- Preventive Dental Visits in Pregnant Women – At or Above (17%) - Current Performance (11.37%)
 - Geo-access mailers with offers of appointment and transportation assistance
 - Educational calls, texts, newsletters, and mailings explaining the importance of regular dental visits to overall health3. Exploring/Logistics of offering incentives for members who complete preventative, diagnostic and restorative dental services
 - Live outreach calls to Pregnant Women/Members identified in QNXT-EHR system and ABHMI Baby Smart and Maternity Matters Programs. The agent provides a personal call to help the Member establish/schedule dental care.
 - Incentives available (\$50 value) for mothers who complete Prenatal check-ups within first trimester, or Postpartum Check-up within 7-84 days after delivery.
- Care Continuity – At or above (20%) – Current Performance (5.12%)
 - ABHMI to utilize its Chronic Dental Non Utilizers report to identify HMP members who have not received a dental visit for two consecutive years and provide targeted outreach to those members
 - Targeted Geo-access mailers with offers of appointment and transportation to those members listed on GIC reports as needing a comprehensive or periodic oral health evaluation
 - Educational calls, texts, and mailings explaining the importance of regular dental visits and oral health.
 - Earlier completion of annual Oral Health Evaluation Report, to help identify trends within the qualitative and quantitative analysis regarding members ability to access timely dental care and continuity of dental care policy
 - Working with DentaQuest to establish a dental homes program/process to establish continuity of care with dental provider
- Usual Source of Service – At or above (10%) – Current Performance (7.54%)
 - ABHMI to utilize its Chronic Dental Non Utilizers report to identify HMP members who have not received a dental visit for two consecutive years and provide targeted outreach to those members

8. Prior Year Recommendation from the EQR Technical Report for Performance Results—HMP

- Targeted Geo-access mailers with offers of appointment and transportation to those members listed on GIC reports as needing a comprehensive or periodic oral health evaluation
- Educational calls, texts, and mailings explaining the importance of regular dental visits and importance of oral health.
- Earlier completion of annual Oral Health Evaluation Report, to help identify trends within the qualitative and quantitative analysis regarding members ability to access timely dental care and continuity of dental care policy
- Working with DentaQuest to establish a dental homes program/process to establish continuity of care with dental provider
- Quality, Care Management and Utilization Management Committee review of member dental satisfaction survey feedback and analysis to act on trends and implement performance improvement plans when identified
- Completion of Annual HRA – Informational only – Current Performance (5.76%)
 - Implementation of ABH Rewards Program incentive (\$50 value) for members completing an HRA. Completion of the HRA helps to identify gaps-in-care and SDOH needs. This program also includes member portals to connect members to care and additional resources
 - Member Engagement and re-engagement campaigns: Our Care Management team is working to target specific populations and provide support to complete their healthy behaviors. As part of our re-engagement campaign, we are focusing on increasing our face-to-face visits in the community via CHWs, re-engagement of specialty populations such as maternity, sickle cell, and Special Needs Children.
 - Partnership with Neighborhood Service Organization (NSO) to address the need for community partnerships and boots on the ground. Aetna Better Health of Michigan is partnering with NSO to augment community health workers from the community to support special populations such as members with co-occurring diagnosis, Complex Conditions that requirement intensive Care Management, Maternity and members who are not vaccinated to enroll them in Care Management and connect them with PCP services increasing compliance in Health Behavior and Engagement with PCP.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Improvement in overall respondents for HMP Dental Survey Report
- Improvement of Rating of Regular Dentist Satisfaction
- Improvement in Care from Dentist and Staff Rating
- Improvement in Access to Dental Care Rating
- Improvement in Dental Plan Information and Services

c. Identify any barriers to implementing initiatives:

- Member has not established a dental home with an oral healthcare provider
- Member may not be familiar with dental benefit or ability to cover/pay for dental services
- Member may not be aware that dental disease may be the cause of additional/serious
- Member may not be aware of enhanced/expanded
- Anxiety/fear of the dentist
- Not familiar with dental benefit or ability to cover services
- May not be aware that dental disease may be the cause of additional/serious

8. Prior Year Recommendation from the EQR Technical Report for Performance Results—HMP

- Member may not be aware of enhanced pregnancy benefits and incentives
- Difficulty obtaining Members contact information to schedule initial and follow-up appointments/care

HSAG Assessment: HSAG has determined that **AET** has addressed the prior year’s recommendations as no weaknesses were identified since all 2023 scores were comparable to national averages and the 2022 top-box scores for all measures. HSAG could not verify whether the MHP’s initiatives were successful since HMP CAHPS was not conducted in 2024.

Blue Cross Complete of Michigan

Table 4-2—Prior Year Recommendations and Responses for BCC

1. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Improvement Projects
<p>HSAG recommended the following:</p> <ul style="list-style-type: none"> • BCC did not achieve the state-defined goal of eliminating the existing disparity with the first remeasurement period, and the comparison group demonstrated a non-statistically significant decrease in performance as compared to the baseline. HSAG recommends that BCC revisit its causal/barrier analysis to determine if any new barriers exist for both the disparate and comparison populations that require the development of targeted strategies to improve performance.
<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"> • Based on recommendations, Blue Cross Complete (BCC) completed a Key Driver Analysis to identify barriers to care. The Key Driver Analysis process included review of Member Survey outcomes. In response to the analysis, BCC elected to continue the previous interventions and implemented the following additions: expanded the focus population for stratification and priority outreach and piloted a member incentive. • Expanded stratification and priority outreach from newly pregnant Black women in Wayne County to newly pregnant Black women in all of region 10 (Macomb, Oakland and Wayne Counties) • Piloted a \$50 incentive for Black women in Wayne County who keep a timely prenatal care appointment. • Continued a handoff process from the BCC Case Management team to the BCC Community Outreach team to provide door-to-door outreach for women unreachable by phone. • Continued Community Pregnancy Groups as safe spaces for pregnant Black women to get trusted peer-led education about prenatal care. • Expanded the focus population for the social media campaign with prenatal messaging to Black women in Wayne County, including Detroit. • All interventions except Community Pregnancy Groups are still underway; the pregnancy groups were launched as a pilot and BCC will evaluate successes and explore options in MY 2024 to continue with the same or similar format.
<p>b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):</p> <p>Results of the initiatives include:</p> <ul style="list-style-type: none"> • 100% of pregnant, Black women in region 10 were identified as a high-risk population, receiving expedited high touch and early outreach. • The new incentive process was successfully launched. • BCC Case Management continues to refer unable to reach pregnant women to the BCC Community Outreach team for door-to-door outreach. • Participation in Community Pregnancy groups steadily increased.

1. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Improvement Projects

- The expanded social media campaign launched in 2023 exceeded estimates for number of views and audience reach.
- Performance Improvement Project (PIP) data showed improvement over baseline rate for the disparate subgroup.
- The racial disparity between Black and White women for timeliness of pre-natal care in the focus population decreased from Measurement Year (MY) 2021 (baseline) to MY2023.

c. Identify any barriers to implementing initiatives:

- No barriers identified; all interventions were successfully implemented.

HSAG Assessment: HSAG has determined that **BCC** addressed the prior year's recommendation. The MHP revisited its causal/barrier analysis to identify barriers to care and developed targeted intervention strategies.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

HSAG recommended the following:

- **BCC's** performance for the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* measure indicator ranked between the 25th and 49th percentiles, indicating some children were not always receiving one or more well-care visit during the measurement year. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling. HSAG recommends that **BCC** conduct a root cause analysis to determine why some children did not receive timely well-child visits. **BCC** could also consider working with providers to integrate appointment barrier screening into appointment reminder calls or notifications. Upon identification of a root cause, **BCC** should implement appropriate interventions to improve the performance related to the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* measure indicator.
- **BCC's** performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked between the 25th and 49th percentiles, indicating children who turned 30 months old during the measurement year were not always having at least two well-child visits with a PCP in the last 15 months. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling. While **BCC** noted several interventions currently in place to target improvement, such as facilitating telephonic and community-based member outreach, conducting member texting campaigns, utilizing social media posts, and distributing newsletters to members, performance remains low for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator. Therefore, HSAG recommends that **BCC** continue its efforts to improve performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator. Initiatives should be monitored and expanded upon as additional contributing factors are identified.
- **BCC's** performance for the *Controlling High Blood Pressure* measure ranked between the 25th and 49th percentiles, indicating some members with a diagnosis of hypertension did not have controlled blood pressure. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions. HSAG recommends that **BCC** conduct a root cause analysis or focused study to determine why some members with hypertension did not have controlled blood pressure. Upon identification of a root cause, **BCC** should implement

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

appropriate interventions to improve the performance related to the *Controlling High Blood Pressure* measure indicator.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

- a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:

BCC conducted a root cause analysis to determine why some children did not receive timely well-child visits. All initiatives are still underway:

- Child and Adolescent Well-Care Visits—Ages 12 to 17 Years
 - Provider incentive
 - Telephonic and Door to Door outreach
 - Member texting campaigns
 - Social media posts
 - Member and provider newsletter articles
 - Meetings with providers with emphasis on care gap closures and office outreach to members
 - Providers can access gaps in care reports via Navinet and their EDIFACS mailbox.
 - All member facing associates discuss gaps in care with members.

BCC conducted a root cause analysis to determine why some children did not receive well-child visits. All initiatives are still underway:

- Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30).
 - Telephonic and Door to Door outreach
 - Member texting campaigns and social media posts
 - Member and provider newsletter articles
 - Meetings with Doula providers and reminders to educate parents about need for well-childcare.
 - Meetings with Maternal Infant Health Program providers and reminders to educate parents about need for well-childcare.
 - Meetings with providers with emphasis on care gap closures and office outreach to members
 - All member facing associates discuss gaps in care with members.
 - Birthday cards to members turning 1- and 2-years old emphasizing importance of well-child visits.
 - Providers can access gaps in care reports via Navinet and their EDIFACS mailbox.

BCC conducted a root cause analysis to determine why some members with hypertension did not have controlled blood pressure. All initiatives are still underway:

- Controlling High Blood Pressure
 - Provider incentive
 - Telephonic and Door to Door outreach
 - Social media posts
 - Increased impact from supplemental data sources
 - Promoting use of CPT 2 codes with providers
 - Year-round medical record review
 - Member and provider newsletter articles
 - Providers can access gaps in care reports via Navinet and their EDIFACS mailbox.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

- Targeted Case Management with care plans specific to controlling Blood Pressure
- No cost Mom's Meals delivered to eligible members.
- No cost fitness center membership for eligible members
- No cost Blood Pressure cuffs for eligible members

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- W30 2 or more well-child visits
 - Rate increased 4.22 percentage points from MY 2022 to MY 2023
- Controlling High Blood Pressure
 - Rate increased 5.53 percentage points from MY 2022 to MY 2023

c. Identify any barriers to implementing initiatives:

- No barriers identified.

HSAG Assessment: HSAG has determined that **BCC** partially addressed the prior year's recommendations.

HSAG has determined that **BCC** has addressed the prior year's recommendation for the *Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator. **BCC** facilitated telephonic and door-to-door member outreach, conducted member texting campaigns, distributed newsletters to members and providers, met with doula and maternal information health program providers to educate on need of well-child care visits, met with providers to emphasize care gap closures, distributed birthday cards to members turning 1- and 2-years-old while emphasizing well-child visits, and allowed providers to access gaps in care reports via Navinet. **BCC** also conducted a root cause analysis to determine why some children did not receive timely well-child visits, as recommended by HSAG. As a result of multiple targeted measure interventions, the rate significantly increased from the prior measurement year by over 4 percentage points and ranked between the 50th and 74th percentiles for MY 2023, demonstrating improved performance.

HSAG has determined that **BCC** has addressed the prior year's recommendation for the *Child and Adolescent Well-Care Visits (WCV)—Ages 12 to 17 Years* measure indicator. **BCC** conducted a root cause analysis to determine why some children did not receive timely well-child visits, as recommended by HSAG. **BCC** also implemented initiatives such as provider incentives, member texting campaigns, social media posts, meeting with providers to emphasize importance of care gap closures, and allowing providers to access gaps in care reports via Navinet. As a result of multiple targeted measure interventions, the rate significantly increased from the prior measurement year by over 3 percentage points and ranked between the 50th and 74th percentiles for MY 2023, demonstrating improved performance.

Regarding HSAG's prior year recommendation for the *Controlling High Blood Pressure (CBP)* measure, **BCC** has demonstrated efforts by offering provider incentives, conducting telephonic and door-to-door outreach, utilizing social media posts, conducting year-round medical record review, providing free blood pressure cuffs to members, and providing targeted case management. **BCC** also conducted a root cause analysis to determine why some members with hypertension did not have controlled blood pressure, as recommended by HSAG. While the rate increased slightly from the prior measurement year by over 5 percentage points, **BCC** continues to demonstrate low performance for the measure by ranking between the 25th and 49th percentile for MY 2023. Therefore, the interventions utilized to improve the rate may or may not be directly impacting the unidentified root cause of the measure's low performance. HSAG recommends continued efforts by **BCC** to further improve performance for the *Controlling High Blood Pressure* measure.

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

HSAG recommended the following:

- While **BCC** demonstrated high performance overall (i.e., 90 percent or greater but less than 100 percent) in the MIS/Financial standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for element 5.6 *Pharmacy/MCO Common Formulary* and a *Satisfied* score for element 5.15 *Monthly Encounter Record Acceptance Rate in CHAMPS*. **BCC** was required to submit a CAP to address element 5.6, which was approved by MDHHS. However, MDHHS did not require a CAP to address element 5.15. As such, HSAG recommends that **BCC** continue to implement action plans and monitoring processes to ensure all claims processing performance standards are consistently met (i.e., *Accurate NCPDP 70 Rejections, must have less than 0.1% noncompliant claims for products covered on the Common Formulary, and Encounter record transmissions must meet or exceed a 95% acceptance rate for encounters loaded into CHAMPS*).
- BCC** demonstrated moderate performance overall (i.e., 80 percent or higher but less than 90 percent) in the OIG/Program Integrity standard and scored below the statewide average. The MHP received a *Not Met* score for elements 6.1 *Quarterly Program Integrity Forms – Tips and Grievances – FY22 Q4*, 6.2 *Quarterly Program Integrity Forms – Data Mining – FY22 Q1*, 6.3 *Quarterly Program Integrity Forms – Audits – FY22 Q1*, 6.8 *Quarterly OIG Program Integrity Forms – Encounter Adjustments – FY22 Q1*, and 6.8 *Quarterly OIG Program Integrity Forms – Encounter Adjustments – FY22 Q2*. **BCC** was required to submit a CAP for elements 6.1, 6.2, 6.3, and 6.8, which were approved by MDHHS. As such, HSAG recommends that **BCC** continue to implement action plans and monitoring processes for noncompliant elements under the OIG/Program Integrity standard to ensure that all data reported for program integrity purposes are accurate (i.e., *Tips and Grievances, Date Mining, Audits, and Encounter Adjustments* data).

MCE’s Response: (Note—the narrative within the MCE’s Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

- 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*):
 - Regarding section 5.6, BCC completed a root cause analysis of formulary errors. Additional training was provided to ensure that appropriate coding is utilized along with supplemental messaging that assists the pharmacy with problem solving and adjudication guidance. BCC performed quarterly compliance monitoring until the NCPDP error 70 was performing at a compliant level.
 - Regarding the issues identified in the Quarterly Program Integrity Report, BCC completed all the necessary changes identified at the time of the respective CAPs. Additional corrective action included scheduling educational meetings with business owners involved in report generation. These supplemental review meetings continued to occur whenever changes outside of the Compliance Timeline were received. Additional steps are included in the Quality Assurance process to review the specific issues that were identified in any CAPs received.
- Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - Regarding section 5.6, BCC received a “met” on the same section in 2024.
 - Regarding section 5.15, BCC received a “met” for the same sections in February and May 2024.
 - Regarding the Quarterly Program Integrity Report, BCC received a “met” for the February and August 2024 Quarterly Reports.

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

c. Identify any barriers to implementing initiatives:

- While BCC received a “not met” and corresponding CAP for the May Quarterly Program Integrity Report in 2024, BCC continued to work with the respective areas as referenced above and added additional quality assurance steps to address any identified issues. MDHHS acknowledged that BCC corrected the issues identified and BCC subsequently received a “met” for the August report.

HSAG Assessment: HSAG has determined that **BCC** partially addressed the prior year’s recommendation. The SFY 2024 compliance review activity demonstrated that **BCC** received a *Met* score for elements 5.6 and 6.8, confirming the MHP’s action steps were successful in remediating the deficiencies. However, **BCC** received two *Satisfied* scores for element 5.15 and did not meet the minimum acceptable rate for dental encounters in September 2023 and July 2024. Additionally, the SFY 2024 compliance review activity confirmed that **BCC** had continued data discrepancies on the program integrity reports and received a *Not Met* score for elements 6.1–6.7. MDHHS approved the MHP’s CAP for elements 6.1–6.7 and did not require a CAP for element 5.15. As such, HSAG recommends that **BCC** continue to implement action plans and monitoring processes to improve the encounter acceptance date for dental invoice types and the accuracy of its program integrity reports.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

- Only 55.0 percent of the sampled provider locations could be reached. HSAG recommends that **BCC** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies.
- Of the locations reached, only 53.2 percent confirmed affiliation with the sampled provider. Additionally, 49.5 percent confirmed accuracy of the sampled address, 45.9 percent confirmed the services were offered, and 40.5 percent confirmed the requested insurance was accepted. HSAG recommends that **BCC** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., records with incorrect specialty or provider information) to address the provider data deficiencies.
- Of the cases responding to the survey and accepting the insurance and new patients, only 63.2 percent of locations offered an appointment date. However, pediatric providers had an appointment availability rate of 53.8 percent, while OB/GYN provider locations had an appointment availability rate of 33.3 percent. HSAG recommends that **BCC** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **BCC** 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)*:

- BCC maintains various methods for providers to submit changes to BCC including email, fax, or mail. Demographic updates are processed timely to reflect updated information.
- Blue Cross Complete conducts an annual access and availability study for network providers. Providers who are non-compliant are placed on a corrective action. Blue Cross Complete publishes the access and availability results annually in our provider newsletter that includes best practices for increasing appointment availability to members.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

- Blue Cross Complete conducts quarterly secret shopper calls prior to all joint operating committee meetings. The results of those calls are discussed during the meeting. All providers that are non-compliant are placed on a corrective action.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Based on overall analysis of most recent secret shopper results, BCC has experienced an increase in compliance to date.

c. Identify any barriers to implementing initiatives:

- The main barrier is lack of provider compliance. Providers are not reporting demographic changes or failing to report timely to the Plan.

HSAG Assessment: HSAG has determined that **BCC** has addressed the prior year's recommendations. **BCC** implemented initiatives to ensure provider data accuracy (e.g., secret shopper calls, corrective action for non-compliant providers) and promote appointment availability through provider outreach. **BCC** should also review and address data deficiencies noted in the case-level analytic data files.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

HSAG recommended the following:

- Although greater than 99.9 percent of provider NPIs identified in the medical/dental data were identified in the provider data, approximately 94 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data. **BCC** should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.
- Approximately 37 percent of **BCC** pharmacy encounters had a submit date prior to the payment date. **BCC** should determine the accuracy of the payment and submission date fields and implement quality checks to ensure the submission date is after the payment date field.

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)*:

Pharmacy Data – Provider NPI Identification:

- BCC identified a reporting error that contributed to encounters rejecting for error code 26132 - Prescriber NPI - Not Valid/Active. When a pharmacy provider validates the prescriber enrollment status in CHAMPS, they submit the claim using submission clarification codes 13 or 13 and 55. When these codes are reported in the encounter record, error code 26132 will not be set.
 - SCC 13: Payer-Recognized Emergency/Disaster Assistance Request - The pharmacist is indicating that an override is needed based on an emergency/disaster situation recognized by the payer.
- A coding update has been deployed to the encounters program and the pharmacy submitted submission clarification codes are now being reported in the encounter records. This update deployed to production in December 2023.

Pharmacy Encounters – submit date prior to payment date:

- BCC completed a root cause analysis resulting in submission date prior to paid date.
- The pharmacy encounter submission process was updated to ensure submission dates reported in the encounter record are on or after the payment date.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Pharmacy Data – Provider NPI Identification:
 - Encounter rejections for error 26132 – Prescriber NPI - Not Valid/Active have significantly decreased.
 - Pharmacy Encounters – submit date prior to payment date:
 - Review of encounter data post coding update shows the issue of submit date prior to paid date has been resolved.
- c. Identify any barriers to implementing initiatives:
- Pharmacy Data – Provider NPI Identification:
 - There are still instances of rejections for Prescriber NPI - Not Valid/Active. For these rejections, the Prescriber NPI enrollment status is manually reviewed to determine if the enrollment status has been updated to active on the claim date of service. When the Prescriber has been validated as active, the encounter is resubmitted for processing.
 - Pharmacy Encounters – submit date prior to payment date:
 - No barriers identified.

HSAG Assessment: HSAG has determined that **BCC** has taken steps to fully address the prior year's recommendations.

Regarding the recommendation to collaborate with MDHHS to ensure an accurate and complete database of contracted providers, **BCC** identified and corrected a reporting error that caused encounters to reject due to error code 26132 (Prescriber NPI - Not Valid/Active). This issue was resolved by deploying a coding update in December 2023, which ensures that submission clarification codes provided by pharmacies are now correctly reported in encounter records. While this initiative has significantly reduced the number of rejections, some instances of error code 26132 persist. **BCC** is addressing these remaining cases through manual review and resubmission when prescriber enrollment status is validated as active on the claim date of service.

For the recommendation to ensure the accuracy of payment and submission date fields in pharmacy encounters, **BCC** conducted a root cause analysis and implemented updates to the pharmacy encounter submission process. These updates ensure that the submission dates reported in encounter records are on or after the payment date. Post-implementation reviews have confirmed this issue has been fully resolved, and no barriers to implementation were identified.

BCC's efforts have successfully addressed both recommendations. **BCC** has demonstrated its ability to identify root causes, implement effective solutions, and achieve measurable improvements. However, additional enhancements could include streamlining the manual review process for unresolved errors related to provider NPIs to further reduce rejections. Additionally, automating aspects of this validation process could improve efficiency and accuracy in managing provider data.

In conclusion, **BCC** has fully addressed the issues related to payment and submission date accuracy and has made significant progress in resolving provider NPI identification errors. Continued efforts to refine and optimize processes will further enhance data integrity and operational efficiency. No significant barriers were noted beyond the need for ongoing manual interventions for specific NPI validation cases.

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis—Adult and Child Medicaid

HSAG recommended the following:

- **BCC's** 2023 top-box score was statistically significantly lower than the 2022 NCQA adult Medicaid national average for one measure, *Rating of Personal Doctor*. HSAG recommends that **BCC** include reminders about the importance of improving communication with patients from different cultures, handling challenging patient encounters, and emphasizing patient-centered communication for the MHP members. Patient-centered communication could have a positive impact on patient experience, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of members' perspectives. Physicians could ask questions about members' concerns, priorities, and values and listen to their answers. Also, physicians could check for understanding, while reinforcing key messages, by allowing members to repeat back what they understand about their conditions and the actions they will take to monitor and manage their conditions.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

- a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:

Blue Cross Complete of Michigan developed several surveys to aide in the ongoing collection of member feedback to assist in the identification of trends and recurring issues to enable actions that will improve member experience. Surveys developed:

- Post Appointment survey – completed by member after provider appointment.
- Member Feedback survey – member experience survey accessible on website
- CSHCS survey – targeted member experience survey

BCC utilizes survey results to monitor and trend member satisfaction. Results drive development of actions to improve performance. BCC provider network management shares the Post Appointment Survey results with providers enabling them to assess member experience and performance trends. Data also enables the provider to make adjustments to policies and processes to improve the member experience.

- BCC provider communications share CAHPS performance results at Joint Operating meetings with providers and regularly publishes articles on the promotion of health equity and cultural competency, providing quality and equitable care to members with limited English proficiency, the quality of the members experiences during office visits and other patient centered topics.
- Blue Cross Complete of Michigan meets monthly to monitor measures and develop initiatives in an effort to ensure significant decreases in CAHPS scores do not occur.

- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- BCC saw a 5.39% increase in CAHPs performance for the Rating of Personal Doctor measure in FY2024.

- c. Identify any barriers to implementing initiatives:

- BCC continues to be challenged with making contact with members to obtain feedback. In many instances when contact is made the member is unwilling to dedicate the time to provide feedback. As surveys are submitted with complete anonymity it is difficult to drill down to specific causes for low performance.

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis—Adult and Child Medicaid

HSAG Assessment: HSAG has determined that **BCC** has addressed the prior year's recommendations. The SFY 2024 CAHPS activity confirmed that **BCC**'s 2024 score for *Rating of Personal Doctor* for the adult Medicaid population was comparable to the 2023 top-box score. **BCC** has reported several performance improvement initiatives that continue to be in progress. HSAG recommends that **BCC** continue to implement performance improvement interventions and evaluate their effectiveness.

7. Prior Year Recommendation from the EQR Technical Report for Performance Results—CSHCS

HSAG recommended the following:

- **BCC**'s 2024 top-box scores were not statistically significantly lower than the 2023 NCQA child Medicaid national averages or the 2023 top-box scores for any measure; therefore, no substantial weaknesses were identified. HSAG recommends that **BCC** monitor the measures to ensure significant decreases in scores over time do not occur.

MCE's Response: *(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

- Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:
 - BCC continues to utilize our BCC CAHPs monthly workgroup to develop initiatives to improve the members experience and access to care for all enrollees. BCC conducted internal CSHCS satisfaction survey in Fall 2023.
- Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - BCC reviewed CSHCS survey results and outreached to responders to obtain more specific feedback. Key area of concern was with transportation. BCC collaborated with our transportation provider to improve the process of addressing member complaints and ensuring outreach to the member to provide resolution and expanded methods of transportation scheduling. The plan meets monthly with the NEMT provider and performance is a standing agenda item.
 - BCC recruited a CSHCS member to join the Member Advisory Council to provide input and feedback on new benefits, programs, policies, and initiatives, and any recommendations for improvement.
 - BCC plans to continue to obtain CSHCS member feedback through additional surveys and focus groups.
- Identify any barriers to implementing initiatives:
 - No barriers identified.

HSAG Assessment: HSAG has determined that **BCC** has addressed the prior year's recommendations. The SFY 2024 CAHPS activity confirmed that **BCC**'s score for *Access to Specialized Services* was statistically significantly higher than the 2023 top-box score. Furthermore, scores were comparable to national averages and the 2023 top-box scores for all measures for the CSHCS population.

8. Prior Year Recommendation from the EQR Technical Report for Performance Results—HMP

HSAG recommended the following:

- **BCC**'s 2023 top-box scores were not statistically significantly lower than the 2022 NCQA adult Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial weaknesses were

8. Prior Year Recommendation from the EQR Technical Report for Performance Results—HMP
identified. HSAG recommends that BCC monitor the measures to ensure significant decreases in scores over time do not occur.
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>
b. 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> : <ul style="list-style-type: none"> BCC continues to utilize our BCC CAHPs monthly workgroup to develop initiatives to improve the members experience and access to care for all enrollees.
d. Identify any noted performance improvement as a result of initiatives implemented (if applicable): <ul style="list-style-type: none"> Not applicable.
e. Identify any barriers to implementing initiatives: <ul style="list-style-type: none"> BCC continues to be challenged with making contact with members to obtain feedback.
HSAG Assessment: HSAG has determined that BCC has addressed the prior year's recommendations as no weaknesses were identified since all 2023 scores were comparable to national averages and the 2022 top-box scores for all measures. HSAG could not verify whether the MHP's initiatives were successful since HMP CAHPS was not conducted in 2024.

HAP CareSource

Table 4-3—Prior Year Recommendations and Responses for HCS

1. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Improvement Projects
<p>HSAG recommended the following:</p> <ul style="list-style-type: none"> • HCS did not achieve significant improvement over the baseline performance for the first remeasurement period. HSAG recommends that HCS revisit its causal/barrier analysis to determine if any new barriers exist for the Black/African American population that require the development of targeted strategies to further improve performance.
<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"> • HAP CareSource evaluates each intervention by reviewing Healthcare Effectiveness Data and Information Set (HEDIS®) results and comparing baseline to remeasurement periods. All interventions are tracked to determine if the intervention had an impact on the rate. Interventions include: <ul style="list-style-type: none"> ○ Transitioned members to HAP CareSource Mom and Baby Beginnings (MBB) maternity program effective for MY2024. The MBB makes outreach to 100% of identified pregnant HAP CareSource members regardless of when they are identified during the pregnancy, which includes postpartum members. ○ Continued strategies to engage members and educate on incentive program. ○ Continued Centers for Disease Control (CDC) Hear Her strategies to raise awareness in our Black/African American population. ○ Implemented an enhanced MBB assessment in August 2024 to identify gaps in care such as HIV, syphilis, STI testing, other testing, last dental exam, and last dental exam during pregnancy. ○ Implemented postpartum outreach program by the Quality Improvement (QI) team in August 2024 for any member no longer engaged in the MBB program days 31-59 postpartum who have not completed their postpartum visit. ○ Encouraged and promoted doula services combined with the Michigan Clinical Consultation & Care (MC3) program services starting from August 2024 forward for a holistic approach to perinatal, prenatal, and postpartum care and wellness. <p>b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):</p> <ul style="list-style-type: none"> • Below is a summary of effectiveness of interventions during remeasurement 2: <ul style="list-style-type: none"> ○ Effective October 2023, all eligible HAP CareSource members were enrolled into the Mom and Baby Beginnings (MBB) program. ○ Of members enrolled in the maternity program year to date, 140/404 (34.7%), received timely prenatal care. ○ 69/140 (49.29%) had timely prenatal care and earned the incentive through Q2 2024. ○ 100/245 (40.82%) had timely postpartum care and earned the incentive through Q2 2024.

1. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Improvement Projects

- For 2023, the Member Rewards Program logic for Prenatal Care did not match the HEDIS logic. The HEDIS logic requires that the member must complete a prenatal visit within the first trimester or within 42 days of enrollment with the Plan. To ensure a positive member experience, HAP CareSource allowed any member who obtained a prenatal visit to be rewarded \$50 for that first prenatal visit. This helped ensure that members did not need to wait until after they delivered to receive their reward. Additionally, the goal was promoting the healthy behavior of seeking that preventive care visit. As a result, not all members who received a reward for their prenatal visit positively impacted the HEDIS measure. HAP CareSource rewarded 880 members for completing a prenatal visit in 2023. 43.86% (386 members) fell in the MY 2023 Timeliness of Prenatal Visit denominator, where 72.28% (or 279 members) were compliant for the measure. Additionally, HAP CareSource had a large increase in the number of members who earned a member reward for Timeliness of prenatal visit in MY 2023 when compared to MY 2022 (116 members rewarded). This is due to a manual process that was still being used to identify members eligible for this reward in MY 2022 vs the automated claims process that was implemented for MY 2023.
- For Postpartum Care, HAP CareSource did not follow the HEDIS logic completely. The HEDIS logic limits the measure to members who had a live birth. Again, HAP CareSource decided to reward all members who delivered despite the birthing outcome. This was to promote the member seeking preventive care after delivery. It was also HAP CareSource's recommendation that members who had a non-live birth needed to be evaluated for postpartum depression or other behavioral health needs. In MY 2023, HAP CareSource rewarded 462 members for postpartum visits, this is a large increase from the 279 members who were rewarded in MY 2022.
- The overall HEDIS® MY2023 prenatal care rate is 76.11% which is an increase of 0.31 percentage points compared to the baseline rate of 75.8%. HAP CareSource further compared the study indicator of the Black/African American remeasurement 2 rates to the baseline rate. The Black/African American baseline results are 157 out of 217 (72.35%) members received timely prenatal care compared to 141 out of 200 (70.5%) in remeasurement period 2. Utilizing the Chi-Square to analyze the data, the p value is 0.6759 and indicates the decrease in the rate is not statistically significant. HAP CareSource continues to identify opportunities for improvement and collaborate on plan interventions.

c. Identify any barriers to implementing initiatives:

- Member Outreach/Engagement
 - Unable to reach member (lack of correct contact information/member does not answer call)
- Social Determinants of Health (SDoH)
 - Income/poverty, job status and education as well as psychosocial factors of chronic stress and lack of social support.

HSAG Assessment: HSAG has determined that **HCS** addressed the prior year's recommendation. Within the most recent annual submission the MHP revisited its causal/barrier analysis to identify barriers to care and developed targeted intervention strategies.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

HSAG recommended the following:

- HCS'** performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator ranked between the 25th and 49th percentiles. Additionally, performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for*

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

Age 15 Months to 30 Months—Two or More Well-Child Visits measure indicator ranked below the 25th percentile, indicating children who turned 15 months old during the measurement year were not always having at least six well-child visits with a PCP during their first 15 months of life. Additionally, children who turned 30 months old during the measurement year were not always getting at least two well-child visits with a PCP in the last 15 months. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling. While **HCS** noted several interventions currently in place to target improvement, such as distributing gap-in-care letters to members, revamping its member rewards program, hiring outreach specialists to remind members of preventive care, providing member education, and addressing SDOH, performance remains low for both *Well-Child Visits in the First 30 Months of Life* measure indicators. Therefore, HSAG recommends that **HCS** continue its efforts to improve performance for the *Well-Child Visits in the First 30 Months of Life* measure indicators. Initiatives should be monitored and expanded upon as additional contributing factors are identified.

- **HCS'** performance for the *Child and Adolescent Well-Care Visits—Ages 3 to 11 Years, Ages 12 to 17 Years*, and *Total* measure indicators ranked below the 25th percentile, and performance for the *Child and Adolescent Well-Care Visits—Ages 18 to 21 Years* ranked between the 25th and 49th percentiles, indicating children between the ages 3 and 21 years were not always getting one or more well-care visits during the measurement year. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling. While **HCS** noted several interventions currently in place to target improvement, such as distributing gap-in-care letters to members, revamping its member rewards program, hiring outreach specialists to remind members of preventive care, providing member education, and addressing SDOH, performance remains low for the *Child and Adolescent Well-Care Visits* measures indicators. Therefore, HSAG recommends that **HCS** continue its efforts to improve performance for the *Child and Adolescent Well-Care Visits* measure indicators. Initiatives should be monitored and expanded upon as additional contributing factors are identified. **HCS** could consider working with providers to integrate appointment barrier screening into appointment reminder calls or notifications.
- **HCS's** performance for the *Cervical Cancer Screening* measure ranked between the 25th percentile and 49th percentile, indicating women were not always being screened for cervical cancer. Cervical cancer is one of the most common causes of cancer death for American women; effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate. While **HCS** noted several interventions currently in place to target improvement, such as facilitating women's events to offer needed screenings, strengthening partnerships with providers, and offering a \$50 reward for members who completed an annual doctor visit where screenings could be completed, performance remains low for the *Cervical Cancer Screening* measure. Therefore, HSAG recommends that **HCS** continue its efforts to improve performance for the *Cervical Cancer Screening* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified. **HCS** could consider the development and deployment of a digital notification system for members needing cervical cancer screening and incorporating screening reminders into current care coordination member touchpoints.

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):

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

- Related to the Well-Child Visits in the First 30 Months of Life measure and the Child and Adolescent Well-Care Visits measures:
 - In 2022, HAP CareSource hired two (2) Health Outreach Specialists for gap closure outreach. In 2023, one (1) Health Outreach Specialist focused solely on getting members in for their well-child visit. In this initiative, HAP CareSource conducted telephonic outreach to notify the member's parent/guardian a well-child visit was needed as well as any other gaps the member may be due for (such as child immunizations and lead screenings). During these outreaches, the health outreach specialists reminded members of the preventive care that they were due to complete, provide education around these services, identify, and address social determinants of health (SDoH) barriers, and assist in scheduling doctor's appointments and transportation (as needed). HAP CareSource also reached out to the provider if HAP CareSource was unable to reach the member and mailed reminder letters to both the member and the provider about the gap(s).
 - In 2023, HAP CareSource restructured its Member Rewards Program. In 2022, members would earn a \$50 reward if they completed all six (6) well-child visits within the first 15 months of life, but there was not an incentive for the 2+ Well-Child Visits between 15-30 Months. In 2023, HAP CareSource revised this reward to the following criteria:
 - 6+ Well-Child Visits Within First 15 Months of Life – Member can earn \$50 reward for each well-child visits, (up to 6 rewards), completed within the ages of 0 months through 14 months.
 - 2+ Well-Child Visits Between 15-30 Months – Member can earn \$50 reward for each well-child visit (up to 2 rewards), completed within ages of 15 months through 35 months.
 - In 2024, HAP CareSource:
 - Continues efforts to improve strategies to identify and address SDoH barriers.
 - Continues to assist with scheduling doctor appointments and transportation as needed.
 - Conducts semi-annual mass mailing of Child Wellness postcard to remind members to schedule a well visit with their doctor.
 - Implemented member Trying to Reach Letter when telephonic outreach attempts are unsuccessful.
 - Implemented member Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Letter with every telephonic outreach.
 - Plan Do Study Act (PDSA) cycle with a provider group offering a coordinated outreach and warm handoff appointment scheduling directly with provider Patient Active Liaison.
- Related to the Cervical Cancer Screening (CCS) measure and the Chlamydia Screening in Women (CHL) measure:
 - In MY 2023, HAP CareSource provided select Provider Groups with monthly Healthcare Effectiveness Data and Information Set (HEDIS) Reporting's Package. Multiple reports were included in this Package:
 - HEDIS Comparison Report which showed the Groups HEDIS rate compared to the market.
 - HEDIS Rates by providers within the organization
 - Member level detail report which showed what outstanding HEDIS gaps their members are due for. The group can feed this into their reports and/or Electronic Medical Record (EMR).
 - HAP CareSource continues to implement women's events focused on providing needed screenings while growing partnerships with providers.
- Implemented an enhanced Mom and Baby Beginnings (MBB) assessment in August 2024 to identify gaps in care such as HIV, syphilis, STI testing, other testing, last dental exam, and last dental exam during pregnancy.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Related to the Well-Child Visits in the First 30 Months of Life:
 - (W30) 6+ Visits in the First 15 Months did not have statistically significant improvement, but the performance rate increased by 2.48 percentage points from MY 2022 to MY 2023. Additionally, the denominator increased from 389 to 457 members. The final (W30) 6+ Visits in the First 15 Months MY 2023 rate missed the goal of 55.72% by 3.46 percentage points (17 numerator hits) with a performance rate of 54.92%.
 - (W30) 2+ Visits in between 15-30 Months did not reach the goal, the performance rate increased by 11.78 percentage points from MY 2022 to MY 2023 and had a p-value = 6.6E-05, meaning that this measure had statistically significant improvement. In addition, the (W30) 2+ Visits in between 15-30 Months denominator increased by 509 to 646 members. The final MY 2023 performance rate missed the goal of 66.76% by 7.63 percentage points (52 numerator hits) with a performance rate of 59.13%. However, 52.27% (138) of the non-compliant members completed 1 well-child visit and were only 1 visit away from being compliant, a 10.11% improvement from the prior year.
- HAP CareSource final CCS MY 2022 rate was 56.45% and decreased by approximately 3.36 percentage points in MY 2023 to 53.09%. HAP CareSource had 4.68% increase in the eligible population for CCS from MY 2022 with 8,283 members to MY 2023 with 8,671 members. Additionally, this measure is a hybrid measure, therefore the final rate is reported on a sample. Due to previous years, the sample for MY 2023 was reduced from 411 to 405. HAP CareSource's sample for MY 2023 started at a lower rate with a 42.96% compared to the MY 2022 sample rate of 48.91%. HAP CareSource was able to get the MY 2023 up to a 53.09% through Medical Record Reviews.

c. Identify any barriers to implementing initiatives:

- Missing, incorrect, or incomplete contact information results in unsuccessful member contact during member outreach.
- Preventative screenings such as cervical cancer screening may not be completed during doctor visit.
- Provider confusion on the different timeframes a cervical cancer screening should be completed, as it is dependent on the members' age and whether or not it is completed in conjunction with an HPV test. The provider is very dependent on their EMR system to notify them when members should have these services rendered.
- Members may not recognize the need to have a cervical cancer screening if they are not exhibiting any signs or symptoms that would alert them.
- SDoH barriers include housing and food insecurity, income, type of employment, poverty, and education may present barriers for cervical cancer screenings.
- Identified that members ages 18-21 years are less likely to obtain their annual well-child visits. These members are in a point of transition, either leaving home for college or entering the job market and are not aware that they should be going in for an annual visit. Additionally, their contact information continues to be their parent/guardian. The parent/guardian are often not willing to give the contact information for the member preventing the Plan from conversing with the member directly.

HSAG Assessment: HSAG has determined that **HCS** has partially addressed the prior year's recommendations. **HCS** has put forth effort to address HSAG's prior year recommendation for the *Well-Child Visits in the First 30 Months of Life (W30)* measure indicators by restructuring its member rewards program to include incentives for *Well-Child Visits in the First 15 Months—Two or More Well-Child Visits* measure indicator, hiring outreach specialists solely focused on outreach to members due for well-child visits, sending

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

gaps in care letters to members, assessing SDOH, and by assisting with scheduling doctor appointments and transportation. While both measure indicator rates increased from the prior measurement year, with the *Well-Child Visits in the First 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator demonstrating significant improvement with the rate increasing by more than 11 percentage points, **HCS** continues to demonstrate low performance for both measure indicators. The *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator ranked between the 25th and 49th percentiles and the *Well-Child Visits in the First 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked below the 25th percentile for MY 2023. Therefore, the interventions utilized to improve the rate may or may not be directly impacting the root cause of the measure's low performance. Potential barriers noted by **HCS** include incorrect member contact information for outreach. HSAG recommends that **HCS** continue its efforts to improve performance for the *Well-Child Visits in the First 30 Months of Life (W30)* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified. Increased provider and member incentives for well-child visits may be an option to consider.

Pertaining to HSAG's prior year recommendation for the *Child and Adolescent Well-Care Visits (WCV)* measure indicators, **HCS** has demonstrated efforts by restructuring its member rewards program to provide more incentives, hiring outreach specialists solely focused on outreach to members due for well-child visits, sending gaps in care letters to members, providing education to members, assessing SDOH, assisting with scheduling doctor appointments, and arranging transportation when needed. However, **HCS** continues to demonstrate low performance for *Child and Adolescent Well-Care Visits* measure overall. While the rates for the *Ages 3 to 11 Years* and *Total* measure indicators demonstrated significant improvement from MY 2022 to MY 2023, the rates for the *Child and Adolescent Well-Care Visits (WCV)—Ages 3 to 11 Years* and *Ages 18 to 21 Years* measure indicators ranked between the 25th and 49th percentiles and ranked below the 25th percentile for the *Child and Adolescent Well-Care Visits (WCV)—Ages 12 to 17 Years* and *Total* measure indicators. Potential barriers noted by **HCS** include incorrect member contact information for outreach and members ages 18–21 years being less likely to obtain their annual well-child visits, as the contact information for these members continues to be that of their parent/guardian, thus preventing **HCS** from conversing with and coordinating services for these members. HSAG recommends that **HCS** continue its efforts to improve performance for the *Child and Adolescent Well-Care Visits (WCV)* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified. Increased provider and member incentives for well-child visits may be an option to consider.

Regarding HSAG's prior year recommendation for the *Cervical Cancer Screening (CCS-E)* measure, **HCS** has demonstrated efforts by providing select provider groups with monthly HEDIS reporting packages, implementing women's events focused on providing needed screenings, and evaluating each intervention by reviewing HEDIS results and comparing the baseline to remeasurement periods. However, the rate for the *Cervical Cancer Screening (CCS-E)* measure significantly declined by more than 11 percentage points in comparison with the prior measurement year and ranked below the 25th percentile. Some barriers noted by **HCS** include inaccurate contact information for members, preventive screenings not being completed during doctor visits, provider confusion on what age the screening should be completed and whether the screening should be completed with an HPV test, and members not being aware screening is needed if they are exhibiting any signs or symptoms. Therefore, HSAG recommends that **HCS** continue its efforts to improve performance for the *Cervical Cancer Screening (CCS-E)* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified. **HCS** could consider the development and deployment of a digital

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

notification system for members needing cervical cancer screening and incorporating screening reminders into current care coordination member touchpoints.

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

HSAG recommended the following:

- While **HCS** demonstrated high performance overall (i.e., 90 percent or greater but less than 100 percent) in the Members standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for element 3.1 *Member Material – ID Card and Member Handbook*. **HCS** was required to submit a CAP to address element 3.1, which was approved by MDHHS. As such, HSAG recommends that **HCS** continue to implement action plans and monitoring processes to ensure member ID cards and member handbooks are mailed timely.
- While **HCS** demonstrated high performance overall (i.e., 90 percent or greater but less than 100 percent) in the MIS/Financial standard, the MHP scored below the statewide average. The MHP received a *Satisfied* score for elements 5.14 *Monthly Pharmacy Encounter Timeliness* and 5.15 *Monthly Encounter Record Acceptance Rate in CHAMPS*. MDHHS did not require a CAP for elements 5.14 and 5.15 as **HCS** met the standards in subsequent reporting months. As such, HSAG recommends that **HCS** continue to implement action plans and monitoring processes to ensure that all encounter processing performance standards are consistently met (i.e., *Submitted and accepted records must meet or exceed the minimum volume calculated by MDHHS and Encounter record transmissions must meet or exceed a 95% acceptance rate for encounters loaded into CHAMPS*).

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*):
 - HAP Empowered identified the deficiency in December 2021 when the previous print vendor, (RR Donnelley (RRD) had a ransomware breach and halted the print of both the Welcome Kit and ID Cards. The ID cards were only affected during the ransomware breach from December 2021 through Q1 2022. During the reconciliation process, the team who ensures the mailing of the Welcome Kits/Handbooks updated a process to trigger the documents to mail out within 10 business days of the file receive date versus the effective date of the member. The process to rebuild the mailing with the new print vendor was 100% complete by the end of Q2 2022. Also, HAP Empowered implemented and completed the Welcome Kit/Handbook clean-up during mid Q1 through Q2 to ensure that any members missed throughout the ransomware breach received Welcome Kits/Handbooks. The incident is related to a point in time event that has been remedied. The print vendor use at the time is no longer used for print and fulfillment.
 - In January 2024, HAP and CareSource embarked on a joint venture called HAP CareSource. At that time the print and fulfillment operations were transferred to CareSource's print and fulfillment team. HAP CareSource has been and continues to meet 100% of timely mailing of Member materials.
 - HAP CareSource submissions acceptance rate for the last three service years has been above 99%. HAP CareSource has a monthly check on encounter rejections. The Encounters team partners with internal business teams and vendors to address issues that can either be corrected and resubmitted, or if the claim should be returned to the provider for correction.

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

- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- HAP CareSource has met 100% of Member Service requests in timely delivery of Member materials such as ID Cards and Handbooks.
 - HAP CareSource will continue to monitor its existing process in place to continue to meet 99% and above acceptance rates.

- c. Identify any barriers to implementing initiatives:
- None.

HSAG Assessment: HSAG has determined that **HCS** partially addressed the prior year's recommendation. The SFY 2024 compliance review activity demonstrated that **HCS** received a *Met* score for element 3.1, confirming the MHP's action steps were successful in remediating the deficiencies. However, **HCS** received a *Satisfied* score for element 5.14 and two *Satisfied* scores for element 5.15. **HCS** did not meet timeliness requirements for pharmacy encounters for October 2023; and **HCS** did not meet the minimum encounter acceptance rate for dental invoice types for the submission month of October 2023 and November 2023. MDHHS approved the MHP's CAP for element 5.15 and did not require a CAP for element 5.14. As such, HSAG recommends that **HCS** continue to implement action plans and monitoring processes to improve timeliness of pharmacy encounter submissions and improve the encounter acceptance date for dental invoice types.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

- Only 69.9 percent of the sampled provider locations could be reached. HSAG recommends that **HCS** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies.
- Of the locations reached, only 75.9 percent confirmed affiliation with the sampled provider. Additionally, 70.8 percent confirmed accuracy of the sampled address, 62.0 percent confirmed the services were offered, and 45.4 percent confirmed the requested insurance was accepted. HSAG recommends that **HCS** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., records with incorrect specialty or provider information) to address the provider data deficiencies.
- Of the cases responding to the survey and accepting the insurance and new patients, only 60.9 percent of locations offered an appointment date. However, PCP locations had an appointment availability rate of 86.1 percent. HSAG recommends that **HCS** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **HCS** 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)*:
- Among the challenges HAP CareSource encounters with providers not having sufficient appointment availability is the lack of accurate provider data including provider demographics and reporting of demographic changes to the health plan. When providers do not update the health plan when they have address changes, close an address, or terminate with the health plan, this causes incorrect data reporting

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

for surveys. The survey data will not accurately reflect provider information from a reporting perspective or for members to utilize when seeking appointments with providers. To remedy this issue, HAP CareSource implemented multiple changes to the process whereby providers can update their demographic information with HAP CareSource making it more user friendly and allow HAP CareSource to make provider changes timelier. The details of those efforts are provided below. In addition to the implementation of process changes to update provider data, HAP CareSource has expanded its presence across Michigan's lower peninsula. HAP CareSource's provider network has expanded by thousands of providers in multiple regions to allow for more appointment availability to be offered to our members.

- Establish consistent provider data update rules and processes. Aligned business rules across all teams that have responsibility with provider data: Business Configuration Team, Contracting, Credentialing and Provider Data Management.
- Centralize all inputs for provider data to be managed by a lifecycle team to ensure one team is accountable for managing provider data.
- Stabilize and ensure accuracy for creating, updating, termination of provider data.
- Require NPI and Tax ID for each interaction with providers to confirm updates are being made to the appropriate records.
- Ensure updates are being requested and implemented from approved sources. Only from those able to request changes.
- Proposed implementing a process to collect additional data on provider groups to enable updating data at the highest level, e.g. the group level, allowing the practitioners that roll up to those groups to inherit the demographics. This reduces the ability to have variances in data from one practitioner to another within the same group.
- Educate providers multiple times on the importance of keeping their demographic information updated with HAP CareSource including PCP patient acceptance status, product participation and demographics. This education is done during the initial orientation when the provider is new to the plan, during outreach efforts for appointment availability education and other reasons, and through periodic reminders on the provider portal throughout the year.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Not applicable.

c. Identify any barriers to implementing initiatives:

- None.

HSAG Assessment: HSAG has determined that **HCS** has addressed the prior year's recommendations. **HCS** implemented initiatives to ensure provider data accuracy (e.g., streamline timely data sharing, routine provider outreaches and education) and promote appointment availability through network expansion. **HCS** should also review and address data deficiencies noted in the case-level analytic data files.

5. Prior Year Recommendation From the EQR Technical Report for Encounter Data Validation

HSAG recommended the following:

- **HCS** modified encounters from its subcontractors before submitting them to MDHHS. **HCS** should collaborate with MDHHS to confirm that the identified changes do not require adjustments to be sent back to the subcontractors.

5. Prior Year Recommendation From the EQR Technical Report for Encounter Data Validation

- **HCS** did not indicate any quality checks performed for claims/encounters from its laboratory subcontractor. **HCS** should develop a comprehensive suite of monitoring reports to assess the accuracy, completeness, and timeliness of encounter data received from its subcontractor.
- Approximately 24 percent of **HCS** pharmacy encounters had a submit date prior to the payment date. **HCS** should determine the accuracy of the payment and submission date fields and implement quality checks to ensure the submission date is after the payment date field.

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)*:
 - Modifications were performed on the pass through files from the vendors to update the Interchange Control Number so that our system can collaborate responses and split Encounter Transaction Results Report (ETRR) responses, therefore eliminating the need for adjustments prior to being submitted back to the vendors.
 - HAP CareSource vendors do perform quality checks on 837 encounter files before and after generating and passing to HAP CareSource. For all vendors, HAP CareSource performs an audit of data for completeness from vendor. Joint Venture Hospital Laboratories (JVHL) is called out to illustrate quality validations performed on encounter data. HAP CareSource also validates JVHL invoice line services submitted to encounters reported for completeness of data. Any issue is reported back to JVHL and any change is sent in a subsequent 837 file.
 - Pharmacy: This is due to timing of when the encounters are released, and the check date is processed and added to a claim. At times, the check date from the financial table is run early enough to be added to the encounter that is sent out the door which is why so many claims on the 9/22 file had a check date generated for 9/23. ESI will be delaying 24 hours between the encounters being released and the financial run to ensure that this issue does not happen in the future. This adjustment will ensure the encounters submit date is not prior to the check date.
- Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - HAP CareSource will continue to monitor existing processes in place to ensure continuous quality checks on vendor data. As stated above, no other modification of encounter data is performed on vendor data except for the "Interchange Control Number" which does not require adjustments to be sent back to vendors.
- Identify any barriers to implementing initiatives:
 - None.

HSAG Assessment: HSAG has determined that **HCS** has partially addressed the prior year's recommendations. **HCS** has implemented several initiatives to address the recommendations provided by HSAG, resulting in varying degrees of success.

Regarding the recommendation to collaborate with MDHHS to confirm whether modifications to subcontractor encounters require adjustments to be sent back, **HCS** explained that changes to vendor data are limited to updates of the Interchange Control Number for operational purposes. These changes do not require adjustments to be sent back to subcontractors, and the processes in place ensure accurate tracking and reporting. This recommendation has been fully addressed through clear communication and process refinement.

5. Prior Year Recommendation From the EQR Technical Report for Encounter Data Validation

To address the recommendation for developing a comprehensive suite of monitoring reports to assess encounter data from its laboratory subcontractor, **HCS** indicated that its vendors, including JVHL, perform quality checks on 837 encounter files. Additionally, **HCS** conducts audits and validates data completeness before reporting issues back to vendors for correction. While this demonstrates some level of monitoring, the response primarily focused on vendor-driven quality checks rather than a robust monitoring system led by **HCS** itself. Therefore, this recommendation has been partially addressed, as further development of **HCS**-led monitoring tools could enhance accountability and ensure data integrity.

For the recommendation to resolve issues related to pharmacy encounters where submit dates precede payment dates, **HCS** identified the root cause as a timing misalignment between encounter release and financial check date processing. To mitigate this, **HCS** implemented a 24-hour delay between encounter release and the financial run, ensuring submission dates are correctly aligned. This corrective action has resolved the issue, and the recommendation has been fully addressed. No barriers to implementation were reported.

In conclusion, **HCS** has fully addressed recommendations related to encounter modifications and pharmacy encounter submission dates but has only partially addressed the need for comprehensive monitoring reports for subcontractor data. While initiatives have shown measurable improvements, additional efforts are recommended to ensure long-term success:

- Specifically, **HCS** should develop its own comprehensive suite of monitoring reports to enhance oversight of subcontractor data quality and reduce reliance on vendor-driven quality checks.
- Formalizing feedback loops with subcontractors to periodically review data quality trends and corrective actions could further strengthen the collaboration and ensure sustained improvements.
- Additionally, automating aspects of quality checks and audits could reduce manual interventions, improve efficiency, and provide consistent, high-quality results.

By implementing these enhancements, **HCS** can build a more robust framework to support data integrity and operational excellence.

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis—Adult and Child Medicaid

HSAG recommended the following:

- **HCS'** 2023 top-box scores were not statistically significantly lower than the 2022 NCQA adult and child Medicaid national averages or 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified. HSAG recommends that **HCS** monitor the measures to ensure significant decreases in scores over time do not occur.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

- 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 CareSource regularly reviews performance compared to the prior year and national average for quality compass to determine if any metrics are deficient and high impact to member satisfaction with the health plan. HAP CareSource works with providers in our assigned regions to improve coordination

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis—Adult and Child Medicaid
<p>of care, boosting experience, and for members and providers with their experience of the health system and interacting with the plan.</p>
<p>b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):</p> <ul style="list-style-type: none"> Not applicable.
<p>c. Identify any barriers to implementing initiatives:</p> <ul style="list-style-type: none"> None.
<p>HSAG Assessment: HSAG has determined that HCS has addressed the prior year’s recommendations. The SFY 2024 CAHPS activity confirmed that HCS’ 2024 scores for the adult and child Medicaid populations did not have significant decreases over time. The score for <i>Rating of All Health Care</i> for the adult Medicaid population was also statistically significantly higher than the 2023 NCQA adult Medicaid national average.</p>
7. Prior Year Recommendation from the EQR Technical Report for Performance Results—CSHCS
<p>HSAG recommended the following:</p> <ul style="list-style-type: none"> HCS’ 2024 top-box scores were not statistically significantly lower than the 2023 NCQA child Medicaid national averages or the 2023 top-box scores for any measure; therefore, no substantial weaknesses were identified. HSAG recommends that HCS monitor the measures to ensure significant decreases in scores over time do not occur.
<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"> HAP CareSource regularly reviews performance compared to the prior year and national average for quality compass to determine if any metrics are deficient and high impact to member satisfaction with the health plan. HAP CareSource works with providers in our assigned regions to improve coordination of care, boosting experience, and for members and providers with their experience of the health system and interacting with the plan.
<p>b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):</p> <ul style="list-style-type: none"> Not applicable.
<p>c. Identify any barriers to implementing initiatives:</p> <ul style="list-style-type: none"> None.
<p>HSAG Assessment: HSAG has determined that HCS has addressed the prior year’s recommendations. Scores were comparable to national averages and the 2023 top-box scores for all measures for the CSHCS population.</p>
8. Prior Year Recommendation from the EQR Technical Report for Performance Results—HMP
<p>HSAG recommended the following:</p> <ul style="list-style-type: none"> HCS’s 2023 top-box scores were not statistically significantly lower than the 2022 NCQA child Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified. HSAG recommends that HCS monitor the measures to ensure significant decreases in scores over time do not occur.

8. Prior Year Recommendation from the EQR Technical Report for Performance Results—HMP

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 CareSource regularly reviews performance compared to the prior year and national average for quality compass to determine if any metrics are deficient and high impact to member satisfaction with the health plan. HAP CareSource works with providers in our assigned regions to improve coordination of care, boosting experience, and for members and providers with their experience of the health system and interacting with the plan.
- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - Not applicable.
- c. Identify any barriers to implementing initiatives:
 - None.

HSAG Assessment: HSAG has determined that **HCS** has addressed the prior year's recommendations as no weaknesses were identified since all 2023 scores were comparable to national averages and the 2022 top-box scores for all measures. HSAG could not verify whether the MHP's initiatives were successful since HMP CAHPS was not conducted in 2024.

McLaren Health Plan

Table 4-4—Prior Year Recommendations and Responses for MCL

1. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Improvement Projects
<p>HSAG recommended the following:</p> <ul style="list-style-type: none"> • MCL did not achieve the state-defined goal of eliminating the existing disparity with the first remeasurement period. HSAG recommends that MCL revisit its causal/barrier analysis to determine if any new barriers exist for the disparate population that require the development of targeted strategies to improve performance.
<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"> • McLaren continues to implement a comprehensive text messaging campaign aimed at educating pregnant members on the importance of timely prenatal and postpartum visits and connecting to resources and provider incentives for timely visits. Text campaigns have yielded higher rates of engagement, which is monitored. We have completed a full implementation of a new data repository and HEDIS vendor. McLaren implemented Maven, a free app for members to assist in prenatal and post-partum care concerns/questions including education on the importance of timely appointments late in 2024.
<p>b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):</p> <ul style="list-style-type: none"> • McLaren demonstrated the reduction in the disparity between white pregnant members and black pregnant members by 2.61% in remeasurement period 2 when compared to baseline. This decrease is represented by a 3.67 percentage point increase in timely prenatal visits for the disparate population from baseline to remeasurement period 2, compared to a 1.06 overall percentage point increase in timely prenatal care for white women from baseline to remeasurement period 2.
<p>c. Identify any barriers to implementing initiatives:</p> <ul style="list-style-type: none"> • Known barriers include the loss of our data repository and transition in HEDIS vendors resulting in a lack of access to gap reports and CHW referrals for 7 months in 2023 through this implementation phase.
<p>HSAG Assessment: HSAG has determined that MCL addressed the prior year's recommendation. Within the most recent annual submission the MHP revisited its causal/barrier analysis to identify barriers to care; however, the MHP maintained the same intervention strategies as used in Remeasurement 1.</p>
2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
<p>HSAG recommended the following:</p> <ul style="list-style-type: none"> • MCL's performance for the <i>Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)</i> and <i>HbA1c Control (<8.0%)</i> measure indicators ranked below the 25th percentile, indicating members with diabetes did not always have controlled HbA1c levels. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life. While MCL noted several interventions currently in place to target improvement, such as distributing care gap reports to

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

providers, which highlighted members with lower glycemic control, and offering monetary incentives to members for completed HbA1c testing, performance remains low for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators. Therefore, HSAG recommends that **MCL** continue its efforts to improve performance for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators. Initiatives should be monitored and expanded upon as additional contributing factors are identified.

- **MCL**'s performance for the *Blood Pressure Control for Patients With Diabetes* measure indicator ranked below the 25th percentile, indicating some members with diabetes did not have controlled blood pressure. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death. While **MCL** noted several interventions currently in place to target improvement, such as distributing care gap reports to providers to outline members with blood pressure readings greater than 140/90 mmHg and routine provider reminders on member incentives for accessing diabetes care, performance remains low for the *Blood Pressure Control for Patients With Diabetes* measure. Therefore, HSAG recommends that **MCL** continue its efforts to improve performance for the *Blood Pressure Control for Patients With Diabetes* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified.
- **MCL**'s performance for the *Kidney Health Evaluation for Patients With Diabetes—Ages 65 to 74 Years* measure indicator ranked below the 25th percentile, a significant decline from the prior year. Additionally, performance for the *Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years* and *Total* measure indicators ranked between the 25th and 49th percentiles, indicating some members with a diagnosis of diabetes did not receive kidney health evaluations. Approximately 1 in 3 adults with diabetes has chronic kidney disease. While **MCL** noted several interventions currently in place to target improvement, such as provider education, distributing care gap reports to providers, offering member incentives, partnering with community health workers (CHWs) to address member access to care barriers, and implementing a new texting campaign to assist members with gaps in care and obtaining needed resources, performance remains low for the *Kidney Health Evaluation for Patients With Diabetes* measure. Therefore, HSAG recommends that **MCL** continue its efforts to improve performance for the *Kidney Health Evaluation for Patients With Diabetes* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified.
- **MCL**'s performance for the *Controlling High Blood Pressure* measure ranked below the 25th percentile, indicating some members with a diagnosis of hypertension did not have controlled blood pressure. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions. While **MCL** noted several interventions currently in place to target improvement, such as distributing care gap reports to providers to outline members with blood pressure readings greater than 140/90 mmHg, routine provider reminders, and member outreach through community health partnerships, performance remains low for *Controlling High Blood Pressure* measure. Therefore, HSAG recommends that **MCL** continue its efforts to improve performance for the *Controlling High Blood Pressure* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified.
- **MCL**'s performance for the *Cervical Cancer Screening* measure ranked between the 25th and 49th percentiles, indicating women were not always being screened for cervical cancer. Cervical cancer is one of the most common causes of cancer death for American women; effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate. While **MCL** noted several interventions currently in place to target improvement, such as ensuring providers had reports on member

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

gaps in recommended services, member education on the importance of preventative screenings, provider education, and texting campaigns, performance remains low for the *Cervical Cancer Screening* measure. Therefore, HSAG recommends that **MCL** continue its efforts to improve performance for the *Cervical Cancer Screening* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified. **MCL** could consider the development and deployment of a digital notification system for members needing cervical cancer screening and incorporating screening reminders into current care coordination member touchpoints.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

- a. Describe initiatives implemented based on recommendations (*include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation*):
- McLaren Health Plan (MCL) Implemented activities for *Hemoglobin A1c Control for Patients with Diabetes—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* included the full implementation of a comprehensive text messaging platform that included member reminders, education, and connection to resources to improve diabetes management. Engagement rates are monitored for effectiveness. In addition, providers are educated on importance of and reminded about incentives for elements of diabetes management completed via faxed Quality Quick Tips (QQT) and updated website resources. McLaren also tracks and monitors all measure rates and gap reporting monthly.
 - *Blood Pressure Control for Patients with Diabetes* included the full implementation of a comprehensive text messaging platform that included member reminders, education, and connection to resources to improve all areas of diabetes control and management. McLaren reminded providers on the incentives associated with blood pressure control in diabetes management via fax updates (QQT) including importance of taking a second reading if the first was high (>140/90) in addition to updated website resources. In addition, rates for this measure and gap reporting are monitored monthly.
 - *Kidney Health Evaluation for Patients with Diabetes—Ages 65 to 74 Years* included the full implementation of a comprehensive text messaging platform that included member reminders, education, and connection to resources to improve all areas of diabetes management. McLaren provided education to providers on appropriate kidney testing and associated codes via Provider newsletters and QQT's and reminded about incentives associated with diabetes testing and diabetes management (BP control, Kidney testing) via fax updates (QQT's) and website resources. McLaren also partnered with the National Kidney Foundation and the "Are you the 33%" campaign for members and providers and shared this information link in member/provider newsletters. Rates for this measure and gap reporting are monitored monthly.
 - *Controlling High Blood Pressure- Hypertension* was the focus for two QQT fax to providers educating on importance of blood pressure management and tips to improve compliance in 2023, including the importance of taking a second blood pressure reading if the first was >140/90. Rates and gap reporting are monitored monthly. McLaren is also considering increasing compliance with blood pressure management through a collaboration with McLaren Physician Partners. Rates for this measure and gap reporting are monitored monthly.
 - *Cervical Cancer Screening*- McLaren continues to remind providers about incentives for Cervical Cancer Screenings via fax updates (QQT's) and website resources. We also implemented a text messaging campaign for women's health screenings including Cervical Cancer Screening to remind members of screenings due and their importance. McLaren monitors the engagement rates for each text

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

messaging campaign to assess reach and effectiveness. **McLaren** also has a collaboration with Karmanos Cancer Center, Wayne State University and the Breast Cancer and Cervical Cancer Control Program (BCCCP). Rates for this measure and gap reporting are monitored monthly.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- *Hemoglobin A1c Control for Patients with Diabetes—HbA1c Poor Control (>9.0%)* rate improved by 16.06 percentage points from 58.64% in MY22 to 42.58% in MY23 and *HbA1c Control (<8.0%)* rate improved by 14.6 percentage points from 34.79% in MY22 to 49.39% in MY23.
- *Blood Pressure Control for Patients with Diabetes* rate improved by 4.87 percentage points from 14.84 percentage points in MY22 47.69% to 62.53% in MY23.
- *Kidney Health Evaluation for Patients with Diabetes—Ages 65 to 74 Years* improved by 4.87 percentage points from MY22 30.94% to 35.81% in MY23.
- *Controlling High Blood Pressure* improved by 6.33 percentage points from MY22 46.47% to 52.80% in MY23
- *Cervical Cancer Screening* rates in MY23 improved by 2.43 percentage points from 55.06% in MY22 to 57.49% in MY23.

c. Identify any barriers to implementing initiatives:

- Transition to a new healthcare analytics vendor in MY23 to Cotiviti, Inc. and the loss of data repository PopHealth left McLaren without the ability to utilize or distribute provider gap reports for 7 out of the 12 months of MY23.
- With limited member reports, outreach activities were decreased for the majority of the year.

HSAG Assessment: HSAG has determined that **MCL** partially addressed the prior year's recommendations. **MCL** has put forth effort to address HSAG's prior year recommendation for the *Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators by implementing a comprehensive text messaging platform that included member reminders, connecting to resources to improve diabetes management, facilitating provider education on incentives for elements of diabetes management, and tracking and monitoring all measure rates and gaps reporting monthly. In addition, both measure indicator rates significantly increased by over 14 percentage points; however, **MCL** continues to demonstrate low performance for the *Hemoglobin A1c Control for Patients With Diabetes (HBD)* measure, as both rates ranked between the 25th and 49th percentiles for MY 2023. HSAG therefore recommends that **MCL** continue its efforts on further improving the *Hemoglobin A1c Control for Patients With Diabetes (HBD)* rates and monitor the impact of initiatives currently in place to ensure improved performance.

Pertaining to HSAG's prior year recommendation for the *Blood Pressure Control for Patients With Diabetes (BPD)* measure, **MCL** has demonstrated efforts by implementing a comprehensive text messaging platform that included member reminders, connecting to resources to improve diabetes management, facilitating provider education on incentives for elements of diabetes management, and tracking and monitoring all measure rates and gaps reporting monthly. In addition, the rate significantly increased by over 14 percentage points; however, **MCL** continues to demonstrate low performance for the *Blood Pressure Control for Patients With Diabetes (BPD)* measure, as the rate ranked between the 25th and 49th percentiles for MY 2023. HSAG therefore recommends that **MCL** continue its efforts on further improving the *Blood Pressure Control for Patients With Diabetes (BPD)* rate and monitor the impact of initiatives currently in place to ensure improved performance.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

HSAG has determined that **MCL** addressed the prior year recommendation for the *Kidney Health Evaluation for Patients With Diabetes (KED)—Ages 65 to 74 Years* measure indicator. **MCL** implemented a comprehensive text messaging platform that included member reminders, education, and connection to resources to improve all areas of diabetes control and management, offered provider education on appropriate kidney testing and associated codes, issued provider reminders on incentives associated with blood pressure control in diabetes management, monitored measure rates and gaps monthly, and partnered with the National Kidney Foundation and the “Are you the 33%?” campaign for members and providers. As a result, the rate increased significantly by nearly 23 percentage points from the prior measurement year and ranked between the 50th and 74th percentiles for MY 2023, demonstrating improved performance.

Regarding HSAG’s prior year recommendation for the *Controlling High Blood Pressure (CBP)* measure, **MCL** has demonstrated efforts by faxing quality quick tips to providers on the importance of blood pressure management, conducting monthly monitoring of rates and gap reporting, and exploring further collaboration with physician partners. However, the rate for the *Controlling High Blood Pressure (CBP)* measure ranked below the 25th percentile. Some barriers noted by **MCL** included the transition to a new healthcare analytic vendor, the loss of data repository which left the plan without the ability to utilize or distribute gap reports for a significant portion of the measurement year, and limited member reports leading to a decrease in outreach activities and opportunity to close gaps in care. Therefore, HSAG recommends that **MCL** continue its efforts to improve performance for the *Controlling High Blood Pressure (CBP)* measure. Initiatives should continue to be monitored and expanded upon as additional contributing factors are identified. **MCL** could consider providing education to members on the importance of controlled blood pressure and monitoring. **MCL** could also consider encouraging members to monitor their blood pressure levels at home.

Regarding HSAG’s prior year recommendation for the *Cervical Cancer Screening (CCS-E)* measure, **MCL** has demonstrated efforts by continuing to remind providers of incentives for cervical cancer screenings, implementing a comprehensive text message campaign for women’s health screenings, monitoring engagement rates for each text message campaign, and collaborating with Karmanos Cancer Center, Wayne State University, and the Breast Cancer and Cervical Cancer Control Program. However, **MCL** continues to demonstrate low performance for the *Cervical Cancer Screening (CCS-E)* measure by ranking between the 25th and 49th percentile and demonstrating a rate decrease of nearly 2 percentage points from the prior year. HSAG therefore recommends that **MCL** continue its efforts on further improving the *Cervical Cancer Screening (CCS-E)* measure rate and monitoring of the impact of initiatives currently in place to ensure improved performance. **MCL** could consider the development and deployment of a digital notification system for members needing cervical cancer screening and incorporating screening reminders into current care coordination member touchpoints.

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

HSAG recommended the following:

- While **MCL** demonstrated high performance overall (i.e., 90 percent or greater but less than 100 percent) in the Members standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for elements *3.1 Member Material – ID Card and Member Handbook* and *3.6-A Member Appeals*. **MCL** was required to submit a CAP to address elements 3.1 and 3.6-A, which were approved by MDHHS. As such, HSAG recommends that **MCL** continue to implement action plans and monitoring processes to ensure members are provided access to the member handbook timely and that all appeals are resolved timely.

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

- While **MCL** demonstrated high performance overall (i.e., 90 percent or greater but less than 100 percent) in the MIS/Financial standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for element *5.1 Health Plan Maintains an Information System that Collects, Analyzes, Integrates and Reports Data as Required by MDHHS* and *5.14 Monthly Pharmacy Encounter Timeliness*. **MCL** was required to submit a CAP to address elements 5.1 and 5.14, which were approved by MDHHS. As such, HSAG recommends that **MCL** continue to implement action plans and monitoring processes to ensure adherence to IS and encounter processing requirements (i.e., *Operational plan and screen prints for claims processing, grievance and appeals tracking, and assignment to PCP and Encounter submissions must be submitted by the 15th of the month following the month of payment*).

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*):
 - 3.1 Member Material – ID Card and Member Handbook* – McLaren Health Plan welcome letters inform members of the electronic location of the Member Handbook and the option to receive a paper copy. These letters and notifications of handbook changes are sent to the Member each year with information on how to access the handbook.
 - 3.6-A Member Appeals* - In response to the prior findings related to timely completion of member appeals, the Appeals and Grievance Supervisor completes daily audits on all open appeals regardless of standard or expedited. She communicates those items due or coming due with thin the next day or two with the Appeals Coordinator responsible for resolution and closure. Staff have been trained and retrained related to sorting appeals Member vs Provider. This training is managed annually with the entire team to ensure alignment and understanding. Additionally, the Supervisor completes audits on a monthly basis of items entered and closed by staff to ensure accuracy of handling. Any findings are shared with staff during monthly 1:1 and any retraining is handled individually.
 - 5.1 Health Plan Maintains an Information System that Collects, Analyzes, Integrates and Reports Data as Required by MDHHS* and *5.14 Monthly Pharmacy Encounter Timeliness*. – both items were reviewed by new reviewers at MDHHS who were unfamiliar with our documentation. McLaren Health Plan implemented additional guidance and language in our coversheet to demonstrate compliance for the standard requested.
- Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - 3.1 Member Material – ID Card and Member Handbook* – McLaren Health Plan updated compliance documents to reflect current practice noted above.
 - 3.6-A Member Appeals* - On the following quarter two reports 275 standard appeals were received and all processed within 30 days. 58 expedited appeals were received 57 were resolved in 72 hours and 1 had a documented extension. Quarter three reported 235 standard appeals all processed within 30 days. 49 expedited appeals were received 47 resolved in 72 hours and 2 had documented extensions. The last quarter, quarter four 202 standard appeals were received all processed within 30 days. 54 expedited appeals were received, and all processed within 72 hours.
 - 5.1 Health Plan Maintains an Information System that Collects, Analyzes, Integrates and Reports Data as Required by MDHHS* and *5.14 Monthly Pharmacy Encounter Timeliness*. – both elements passed for FY24 with no concerns.

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

c. Identify any barriers to implementing initiatives:

- 3.1 Member Material – ID Card and Member Handbook – NA
- 3.6-A Member Appeals - Ensuring communication is ongoing within the department and with external departments on the timeframes required under the contract and the impact to the plan for failure to comply. Education is critical for all departments involved in the intake, investigation and resolution of appeals and staff changings can and do occur which will require new training.
- 5.1 Health Plan Maintains an Information System that Collects, Analyzes, Integrates and Reports Data as Required by MDHHS and 5.14 Monthly Pharmacy Encounter Timeliness. - NA

HSAG Assessment: HSAG has determined that **MCL** addressed the prior year's recommendation. The SFY 2024 compliance review activity demonstrated that **MCL** received a *Met* score for elements 3.1, 3.6-A, 5.1, and 5.14, confirming the MHP's action steps were successful in remediating the deficiencies.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

- Only 59.1 percent of the sampled provider locations could be reached. HSAG recommends that **MCL** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies.
- Of the locations reached, only 63.6 percent confirmed affiliation with the sampled provider. Additionally, 60.5 percent confirmed accuracy of the sampled address, 32.7 percent confirmed the services were offered, and 27.2 percent confirmed the requested insurance was accepted. HSAG recommends that **MCL** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., records with incorrect specialty or provider information) to address the provider data deficiencies.

MCE's Response: *(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:

Provider Relations is made aware of provider data conflicts through several different methods. When conflicts arise, they are added to an adds/changes/terms spreadsheet and records are updated according to department procedures. To address identified provider deficiencies, McLaren Health Plan also reviewed case-level data files and took the following actions:

- Updated McLaren Health Plan Provider Relations process and procedure: Audit of Provider Data Accuracy
 - This revised process combined two other similar processes Provider Relations put in place updated in 2024.
- Data decisions and quarterly provider data attestation
 - McLaren Health Plan seeks to obtain attestations from providers at every opportunity and utilizes a three-tiered data attestation and roster validation process to obtain the most up-to-date provider information, including supplemental resources such as the Council for Affordable Quality Healthcare (CAQH), provider roster reviews and Google.
 - McLaren Health Plan developed and implemented attestation functionality within our secure online provider portal to collect provider demographic changes to date. Provider bulletin was

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

distributed informing providers of a requirement to attest to their demographic information quarterly.

- McLaren Health Plan also partnered with Quest Analytics BetterDoctor) in 2023 to capture validations (attestations) from providers via mail/telephonic/fax outreach on our behalf.
 - McLaren Health Plan (MHP) implemented BetterDoctor in Q2. The team finished preparations early and outreach to MHP providers began June 1, 2023. Internal Provider Relations staff were trained on the process and how to access the Quest portal on 5/23/23. A provider bulletin was distributed reminding providers of their requirement to attest quarterly to their demographic information and that BetterDoctor would be contacting their office on McLaren Health Plan's behalf. This information was also included in our Q1 2024 Provider rounding materials. As McLaren Health Plan develops the relationship with BetterDoctor on the quarterly attestation process, we expect to have quarterly reporting indicating providers attested, and number of changes updated in the MIS, this will continue to evolve.
 - Provider Servicing occurs during regularly scheduled Provider Rounding meetings and ad-hoc sessions. High volume PCPs receive rounding quarterly, PCPs with less than 50 members receive rounding at least annually. During rounding, PCP information is validated, including but not limited to address, phone, fax, email, and acceptance status verification. PO/PHOs [physician's offices/physician hospital organizations] are required to provide monthly rosters to verify/validate provider information. When changes are identified, they are submitted to the MIS and flow to the provider directory.
 - In situations where a provider's front office staff states they are not accepting new patients or are unaware of the provider's participation status with McLaren Health Plan, the Provider Relations Representative immediately contacts the provider's office manager to validate the information and remedy any discrepancies. The Provider Relations Representative also takes the time to educate the office manager on the requirements for opening and closing a practice, as outlined in the Provider Manual, and the provider incentives applicable to having an open practice.
 - If McLaren Health Plan receives a member complaint regarding a provider directory discrepancy, it is handled immediately. At a minimum, this requires telephonic outreach to a provider's office to assist the member in getting care, educating offices on participation status and the quarterly attestation requirement, and follow up to ensure the provider's office is adhering to their participation contract. In addition, quarterly analysis of member complaints is reviewed to identify any opportunities for improvement.
 - In cases where there is a change in location, or a provider is no longer at the office; the Provider Relations Representative requests the appropriate documentation for the contract file and makes the system change to accurately reflect the provider's status.
 - Provider Bulletins provide updates and reminders to providers regarding important plan initiatives, changes, and updates - including quarterly attestation.
- Implementation of Salesforce for provider data
 - In 2023 McLaren Health Plan was actively implementing a Salesforce system for Provider Data Management which is currently being configured to function as the source of truth for provider data within the organization. Once fully implemented, Salesforce is expected to reduce data loss and errors, manual data entry and increase provider's self-service capability.
 - Upon implementation of Salesforce, McLaren Health Plan expects most provider data audit processes will require modification (including those identified above) and revisions to existing

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

processes will need to be modified and enhanced. Salesforce is expected to streamline McLaren Health Plan provider data and improve efficiencies across all platforms and business areas. Salesforce will fundamentally improve how McLaren Health Plan enters, monitors, audits, and extracts provider data – including changes.

- McLaren Health Plan has also redesigned its online provider directory with additional enhancements to for members. These enhancements add data that defines practice restrictions and other important information for members when selecting a provider. McLaren Health Plan created custom fields in Salesforce to support the redesigned provider directory includes additional information which is captured in such as:
 - Additional languages to match all available languages as defined within CAQH.
 - Added additional gender selections to allow for providers who identify a gender other than Male and Female as defined within CAQH such as:
 - I Use Another Term
 - Non-Binary Third Gender
 - Other
 - Decline to Specify
 - Added Location Name (name on the door) which identifies the common name of the practice.
 - Added Provider Ethnicity to support members seeking providers who report ethnicities as defined within CAQH. This allows McLaren Health Plan to gather more granular ethnicities as reported by the provider.
 - Added Location Restrictions to provider any specific restrictions for a location. This information was added to support ensuring locations where a member cannot make a direct appointment do not publish to the directory, such as:
 - Urgent Care Location
 - In Home Services
 - Indian Health Services
 - Hospital Based Location
 - School Based Location
 - Added Offers Medication for Opioid Use Disorder
 - Added Gender Restrictions
 - Added Minimum Age Accepted and Maximum Age accepted.
 - McLaren Health Plan continues to educate providers regarding timely submission of demographic changes, quarterly directory attestations, through provider educational materials, Joint Operating Committee (JOC) Meetings and Provider Updates. McLaren is working closely with our large group Physician Organizations and Delegated Groups in obtaining more frequent rosters. Other barriers are the amount of these requests that the providers receive across all payers is time consuming for the providers. In addition to BetterDoctors attestations, McLaren has also sent Provider Surveys through in various formats (including mail, fax, email, electronic survey tools).

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- As McLaren Health Plan moves to full implementation of Salesforce, the organization expects to realize marked improvement to management processes for and accuracy monitoring of its online Provider Directories. Salesforce will consolidate McLaren Health Plan provider data into one location and become the single source of truth, making it easier to access, retrieve and review provider information in full. The current provider directory process is compliant with Medicaid requirements.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

McLaren Health Plan expects to develop and publish provider directories exceeding timeframes required by MDHHS within 6 months of the Salesforce full implementation go-live date.

- In August 2023, the Plan conducted Secret Shopper reviews of their provider network. Upon completion of the analysis McLaren found that eighty-two (82) percent of provider demographic directory data was accurate including open and accepting status. Two (2) percent of provider data sampled were found to have closed panels. Sixteen (16) percent of providers sampled were found to have other demographic inaccuracies.
- Additional examples of provider data audits completed in Q1 and Q2 of 2024 found a four percent (4) percent error rate in addresses which did not meet USPS standards. New functionality was added to Salesforce system which connects to Melissa Data Suites to validate address against USPS standards when addresses are added or updated to the system. McLaren conducted a Provider Role Audit (PCP versus Spec designation) and found an error rate was less than one (1) percent. Q2 2024 Secret Shopper calls found five (5) percent of sample locations with phone/fax number inaccuracies. McLaren has also enhanced Salesforce system to include additional data fields and workflows to minimize human data entry errors.
- McLaren made appropriate changes within their systems for those providers where inaccuracies were identified. New system implementations are underway, including redesigning of the provider directory to ensure compliance with all required data elements.
- McLaren Health Plan started a full audit of all PCPs (Adult and Pediatric) and OB/GYN and other high volume specialties demographic data in August 2024. McLaren is finalizing these results and making appropriate changes in the system as needed.

c. Identify any barriers to implementing initiatives:

- *Although MCL updated its Audit of Provider Data Accuracy process and procedure, resource constraints and system issues have negatively impacted the organization's ability to fully implement. The MCL Provider Relations department experienced multiple staff transitions throughout 2023 and 2024, impacting operational functions at both the staff and leadership levels. As a result, Provider Relations reallocated staffing resources in 2023 and 2024 to perform essential functions and train new staff on the updated process as quickly as possible.*
- Salesforce was initially set to launch in the first quarter of 2023. However, due to unforeseen complexities in the initial roadmap and the multiple data sources required to deliver a robust, multifunctional provider management system, the go-live date was delayed accommodating development of necessary system functions. A soft launch of Salesforce occurred in late August 2023 with full implementation to production set to occur during the first quarter of 2024. Internal implementation of work streams, testing and validation initiated and remain ongoing.

HSAG Assessment: HSAG has determined that **MCL** has addressed the prior year's recommendations. **MCL** addressed the data deficiencies noted in the case-level analytic data files. **MCL** also implemented initiatives to ensure provider data accuracy (e.g., routine outreaches, promote accurate and timely data sharing) and monitor appointment availability.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

HSAG recommended the following:

- **MCL** modified encounters from its subcontractors before submitting them to MDHHS. **MCL** should collaborate with MDHHS to confirm that the identified changes do not require adjustments to be sent back to the subcontractors.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

- **MCL** only indicated it performed encounter claim volume quality checks for claims/encounters from its pharmacy subcontractor. **MCL** should develop a comprehensive suite of monitoring reports to assess the accuracy, completeness, and timeliness of encounter data received from its subcontractor.
- Although greater than 99.9 percent of provider NPIs identified in the medical/dental data were identified in the provider data, approximately 95 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data. **MCL** should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.

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)*:
 - Encounter submission percent went down related to how the subcontractor was submitting the pharmacy encounters and the volume in which they hit for a 5-week month. In addition, due to a MDHHS resubmission project some reversals were incorrectly processed. MCL has weekly meetings with the PBM Encounters team and reviews weekly submissions reporting to ensure volume is appropriate and on track for the month.
- Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - For FY24 all Pharmacy Encounters has shown appropriate for accuracy, completeness, and timeliness of encounter data for the six months following the concerns indicated. Reports are reviewed monthly with MDHHS.
- Identify any barriers to implementing initiatives:
 - No notable barriers to implementing initiatives.

HSAG Assessment: HSAG has determined that **MCL** partially addressed the prior year's recommendations, demonstrating some progress while leaving room for improvement in several areas.

Regarding the recommendation to collaborate with MDHHS to confirm that modifications to subcontractor encounters do not require adjustments to be sent back, **MCL** did not provide a clear response on whether this collaboration occurred. Without evidence of this action, the recommendation remains not addressed. Collaboration with MDHHS would ensure compliance and clarify responsibilities for data adjustments.

To address the recommendation to develop a comprehensive suite of monitoring reports for subcontractor data, **MCL** indicated it conducts weekly meetings with the PBM encounters team to review submissions and ensure data volume accuracy. While this demonstrates some effort toward monitoring, the response focused narrowly on volume checks rather than implementing a robust, comprehensive system to assess accuracy, completeness, and timeliness. Therefore, this recommendation has been partially addressed. Expanding monitoring tools beyond volume checks would ensure better data quality oversight.

The recommendation to collaborate with MDHHS to maintain an accurate and complete database of contracted providers, particularly for pharmacy data, has not been explicitly addressed. Although **MCL** indicated issues with subcontractor submissions, there is no evidence of specific actions taken to align provider databases. This recommendation was not addressed, and stronger collaboration with MDHHS is necessary to resolve discrepancies in provider NPIs.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

Despite noted issues, **MCL** reported performance improvements in FY24, demonstrating accuracy, completeness, and timeliness for pharmacy encounter data over the last six months. While this is a positive development, it does not fully resolve the underlying gaps in monitoring and provider database collaboration.

No significant barriers were identified, suggesting that **MCL** can further enhance its processes with dedicated focus and resources.

In conclusion, **MCL** has made some progress, particularly in addressing pharmacy encounter data concerns, but has not fully addressed critical recommendations such as subcontractor data modification practices and database alignment with MDHHS. To improve, **MCL** should:

- Prioritize developing a comprehensive suite of monitoring reports that assess all aspects of data quality, not just volume.
- Collaborate with MDHHS to align provider databases and clarify subcontractor data adjustment practices would strengthen compliance and data integrity.
- Automate data validation processes and implement periodic audits would further enhance **MCL**'s ability to monitor and maintain high-quality encounter data.

Addressing these gaps will position **MCL** to achieve better alignment with HSAG's recommendations and improve overall data quality.

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis—Adult and Child Medicaid

HSAG recommended the following:

- **MCL**'s 2023 top-box score was statistically significantly lower than the 2022 NCQA child Medicaid national average and the 2022 child Medicaid top-box score for one measure, *Rating of All Health Care*. HSAG recommends that **MCL** continue to explore what may be driving these lower experience scores, develop initiatives designed to improve quality of care, and focus on improving members' overall experiences with their healthcare.
- **MCL**'s 2023 top-box score was statistically significantly lower than the 2022 NCQA adult Medicaid national average for one measure, *Rating of Specialist Seen Most Often*. HSAG recommends that **MCL** determine if there is a shortage of specialists in the area or an unwillingness of the specialists to contract with the plan that could be contributing to a lack of network adequacy and access issues. HSAG further recommends that the MHP continue to explore the option of conducting other MHP-specific member experience surveys that allow the MHP to better understand member-specific experiences and target areas where members express a negative experience.

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*):
 - *Rating of All Health Care*: McLaren (MCL) will plan to implement a patient experience text messaging campaign upon state approval to better identify areas of member satisfaction/dissatisfaction. Our social media presence and improved website usability also strives to engage members and promote the patient

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis—Adult and Child Medicaid

experience. McLaren recognizes that improving communications with members of all cultures, how we handle challenging encounters and resolve conflicts can have a great impact on how members perceive their care. In response, McLaren has hired a Health Equity Officer in 2024 to review our internal policies, website, quality initiatives and employee training to ensure that we are providing accessible and equitable care in all areas. We also have applied this same focus on our provider communications as well. A redesign of our Member and Provider handbooks was recently made to help members make provider selections that they can identify with such as languages offered and race/ethnicity information,

- *Rating of Specialist Seen Most Often*: McLaren monitors the accessibility of specialists within the geographical areas that McLaren serves, however appointment availability is still sometimes an issue causing hardship for members who have transportation issues, especially in our more rural counties. McLaren will plan to implement a patient experience text messaging campaign upon state approval to better identify areas of member satisfaction/dissatisfaction. Our social media presence and improved website usability also strives to engage members and promote the patient experience. McLaren recognizes that improving communications with members of all cultures, how we handle challenging encounters and resolve conflicts can have a great impact on how members perceive their care. In response, McLaren has hired a Health Equity Officer in 2024 to review MCL's internal policies, website, quality initiatives and employee training in an effort to ensure that we are providing accessible and equitable care. We also have applied this same focus on our provider communications as well. A redesign of our Member and Provider handbooks was recently made to help members make provider selections that they can identify with such as languages offered and race/ethnicity information.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- *Rating of Specialist Seen Most Often* showed improvement in MY23 at 74.70% compared to MY22 at 56%.

c. Identify any barriers to implementing initiatives:

- Member response rate is a known barrier.
- Rural members continue to have more shortages of specialists than the more urban counterparts in Michigan, causing hardships on members who have transportation barriers to access specialists outside of their community.

HSAG Assessment: HSAG has determined that **MCL** has addressed the prior year's recommendations. The SFY 2024 CAHPS activity confirmed that **MCL**'s score for *Rating of All Health Care* for the child Medicaid population was statistically significantly higher than the 2023 top-box score. Furthermore, **MCL**'s score for *Rating of Specialist Seen Most Often* for the adult Medicaid population was statistically significantly higher than the 2023 top-box score.

7. Prior Year Recommendation from the EQR Technical Report for Performance Results—CSHCS

HSAG recommended the following:

- **MCL**'s 2024 top-box scores were not statistically significantly lower than the 2023 NCQA child Medicaid national averages or the 2023 top-box scores for any measure; therefore, no substantial weaknesses were identified. HSAG recommends that **MCL** monitor the measures to ensure significant decreases in scores over time do not occur.

7. Prior Year Recommendation from the EQR Technical Report for Performance Results—CSHCS

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)*:
 - Continuing to have a highly trained staff service CSHCS members to assist with questions, issues, and care needs.
 - Implementation of an annual survey of CSHCS members to monitor satisfaction and feedback specific to the CSHCS population in late 2023. MCL is also implementing a twice a year communication to the CSHCS population that includes key information on accessing assistance, authorizations, transportation, and grievance and appeals in late 2024.
 - Greater collaboration and communications with local health departments to have less overlap in activities.
 - Clarification of contacts for all CSHCS communications.
- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - MCL's rating for Specialist Seen Most Often improved from 75.8% to 78.7% in MY2023.
 - MCL's Customer Service scores improved from 87.9% to 96.0% in MY2023.
 - MCL's Transportation score improved from 78.6% to 82.2% in MY2023.
 - MCL's Local health department services score improved from 77.2% to 78.8% in MY2023.
- c. Identify any barriers to implementing initiatives:
 - None identified at this time except potentially the cost of mailings.

HSAG Assessment: HSAG has determined that **MCL** has addressed the prior year's recommendations. The SFY 2024 CAHPS activity confirmed that **MCL**'s score for *Rating of Health Plan* was statistically significantly higher than the 2023 NCQA child Medicaid national average. Furthermore, scores were comparable to national averages and the 2023 top-box scores for all measures for the CSHCS population.

8. Prior Year Recommendation from the EQR Technical Report for Performance Results—HMP

HSAG recommended the following:

- **MCL**'s 2023 top-box score was statistically significantly lower than the 2022 NCQA adult Medicaid national average for one measure, Rating of Personal Doctor. HSAG recommends that **MCL** include reminders about the importance of improving communication with patients from different cultures, handling challenging patient encounters, and emphasizing patient-centered communication for the HMP members. Patient-centered communication could have a positive impact on patient experience, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of members' perspectives. Physicians could ask questions about members' concerns, priorities, and values and listen to their answers. Also, physicians could check for understanding, while reinforcing key messages, by allowing members to repeat back what they understand about their conditions and the actions they will take to monitor and manage their conditions.

8. Prior Year Recommendation from the EQR Technical Report for Performance Results—HMP

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)*:
 - *Rating of Personal Doctor*: McLaren will plan to implement a patient experience text messaging campaign upon state approval to better identify areas of member satisfaction/dissatisfaction. Our social media presence and improved website usability also strives to engage members and promote the patient experience. McLaren recognizes that improving communications with members of all cultures, how we handle challenging encounters and resolve conflicts can have a great impact on Rating of Personal Doctor. In response, McLaren identified a need and hired a Health Equity Officer in 2024 to review our internal policies, website, quality initiatives and employee training to ensure that we are providing accessible and equitable care in all areas. We also have applied this same focus on our provider communications as well. A redesign of our Member and Provider handbooks was recently made to help members make provider selections that they can identify with such as languages offered and race/ethnicity information. McLaren monitors and tracks this and all CAHPS measures to better assess the impact of interventions and determine next courses of action if needed.
- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - While Rating of Personal Doctor did not show improvement in MY2023, Getting Needed Care, Getting Care Quickly, Rating of Health Care, Rating of Specialist and Coordination of Care all showed improvement in MY2023 indicating that McLaren's focus on educating and improving communications with providers has shown to be effective. Increased focus on communications as a result of our newly hired Health Equity Officer will also help ensure that our communications to providers are focused on providing equitable and patient centered care.
- c. Identify any barriers to implementing initiatives:
 - Member response rate is a known barrier.

HSAG Assessment: HSAG has determined that **MCL** has addressed the prior year's recommendations for the *Rating of Personal Doctor* measure. HSAG could not verify whether the MHP's initiatives were successful since HMP CAHPS was not conducted in 2024.

Meridian Health Plan of Michigan

Table 4-5—Prior Year Recommendations and Responses for MER

1. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Improvement Projects
<p>HSAG recommended the following:</p> <ul style="list-style-type: none"> MER did not achieve the state-defined goal of eliminating the existing disparity with the first remeasurement period, with both performance indicators demonstrating a decrease in performance as compared to the baseline. HSAG recommends that MER revisit its causal/barrier analysis to determine if any new barriers exist for both the disparate and comparison populations that require the development of targeted strategies to improve performance. Interventions should be initiated early in the measurement period to have the greatest impact on the performance indicators.
<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"> For another consecutive year, Meridian committed to <i>Addressing Health Disparities in the Timeliness of Prenatal Care Prenatal Care Performance Improvement Project (PIP)</i> in prosperity Region 6. Another comprehensive causal/barrier analysis was conducted to ensure relevance of previously identified barriers and assess for new barriers. PIP interventions are evaluated for effectiveness to ensure successful achievement of PIP objectives. Analysis outcomes were incorporated into existing and newly implemented PIP interventions. Meridian implemented or continued the following interventions: Meridian offers provider incentives for meeting HEDIS® Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care benchmarks. Meridian publishes HEDIS® PPC care gap reports to alert providers of members needing timely prenatal visits. A HEDIS® Quick Reference Guide (QRG) aids providers with meeting PPC measure compliance requirements. Expanded prenatal gift card incentive in region 6 to include Black and White (non-Hispanic) populations to improve overall PPC Timeliness. Biweekly referral lists sent to Meridian's CHW team for outreach to pregnant members within the PPC Timeliness window. CHWs conduct outreach, assessments, and connect members to needed resources. Meridian's My Health Pay Rewards program offers incentives to pregnant members for completing a notification of pregnancy and a timely prenatal visit. Moderate and high-risk pregnant members are enrolled in Meridian's maternity case management program, Start Smart for Baby (SSFB), providing access to nurse care managers, assessments, education, and resource connections. Meridian sends biweekly referral lists of members in Genesee and Lapeer counties to CHW Delegate partner, Greater Flint Health Coalition (GFHC), for outreach, education, transportation, and barrier assessments.

1. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Improvement Projects

- The Maternal Health Equity Pod Pilot Program, active in high-disparity areas (e.g., Tuscola and Genesee counties), aims to improve birth outcomes for African American members by providing comprehensive care teams. The program uses claims, screenings, risk assessments, and SDoH data to stratify members and tailor care.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Meridian's CHW delegate, Greater Flint Health Coalition (GFHC) intervention has proven to be successful with reaching members and ensuring connections to prenatal care. The intervention expanded to include Lapeer County for HEDIS® MY2023. During HEDIS® MY2023, 97 of the 240 non-compliant HEDIS® PPC-Timeliness of Prenatal Care members referred to GFHC successfully completed a timely prenatal care visit achieving a 40.42% success rate for the intervention. For the measurement year (MY) 2023 HEDIS® Timeliness of Prenatal Care measure, 249 members were eligible to receive a gift card. 80 members received a gift card for successfully completing a timely prenatal care visit resulting in a 32.13% success rate.

c. Identify any barriers to implementing initiatives:

- Late notification of pregnancy hinders Meridian's ability to efficiently execute timely prenatal care interventions. In addition to State pregnancy reporting delays, members and providers are slow to complete and submit timely Notification of Pregnancy (NOP) assessment forms. Region 6 faces a shortage of prenatal care providers and birth hospitals, requiring many members to travel outside the county for care. This shortage also results in long wait times for timely prenatal appointments. Members are often unreachable due to incorrect or disconnected phone numbers, limiting Meridian's ability to engage members for timely prenatal care coordination and connect to needed resources.

HSAG Assessment: HSAG has determined that **MER** addressed the prior year's recommendation. Within the most recent annual submission the MHP revisited its causal/barrier analysis to identify barriers to care and developed two additional targeted intervention strategies during Remeasurement 2.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

HSAG recommended the following:

- MER's** performance for the *Well-Child Visits in the First 30 Months of Life* measure indicators, *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*, ranked between the 25th and 49th percentiles and below the 25th percentile, respectively, indicating children who turned 15 months old during the measurement year were not having at least six well-child visits with a PCP during their first 15 months of life. Additionally, that children who turned 30 months old during the measurement year were not having at least two well-child visits with a PCP in the last 15 months. Well-care visits provide an opportunity for providers to influence the health and development of a child, and they are a critical opportunity for screening and counseling. While **MER** noted several interventions currently in place to target improvement, such as interactive text messaging services to provide health education on well-child visits, care gap reminders, collecting barrier assessment data, offering appointment scheduling assistance to members, and member gift card incentives for successful completion of well-child visits, performance remains low for the *Well-Child Visits in the First 30 Months of Life* measure. Therefore, HSAG recommends that **MER** continue its efforts to improve performance for the *Well-Child Visits in the First 30 Months of Life* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

- **MER's** performance for the *Kidney Health Evaluation for Patients with Diabetes—Ages 65 to 74 Years* and *Ages 75 to 85 Years* measure indicators ranked between the 25th and 49th percentiles, indicating some members with diabetes did not receive kidney health evaluations. Approximately 1 in 3 adults with diabetes has chronic kidney disease. While **MER** noted several interventions currently in place to target improvement, such as more diverse member outreach methods, expanded vendor relationships to include in-home screening kits, and text message reminders to members due for kidney evaluation, performance remains low for the *Kidney Health Evaluation for Patients with Diabetes—Ages 65 to 74 Years* and *Ages 75 to 85 Years* measure indicators. Therefore, HSAG recommends that **MER** continue its efforts to improve performance for the *Kidney Health Evaluation for Patients with Diabetes* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified.

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 is committed to implementing effective interventions to improve HEDIS® measure performance. The following interventions were implemented for the *Kidney Health Evaluation for Patients with Diabetes* measure:
 - Meridian offers provider incentives for meeting HEDIS® Kidney Health Evaluation for Patients with Diabetes measure benchmarks.
 - Meridian publishes a HEDIS® Quick Reference Guide (QRG) aimed to support providers' knowledge of KED measure guidelines and requirements.
 - Meridian added the KED measure to the 2024 My Health Pay Rewards member incentive program.
 - Biannually, Meridian sends HEDIS® Passport letters to members due for preventive care services. Kidney Health Evaluation for Patients with Diabetes is a HEDIS® Passport initiative measure.
 - Meridian enhanced its member-focused diabetes booklet to include kidney health education along with KED testing guidance.
 - Meridian leveraged digital communication to promote kidney health evaluation screening education utilizing social media, text, and email campaigns to encourage compliance with annual kidney health screenings.
 - To help address access to care barriers, Meridian mailed in-home test kits to diabetic members to close open KED measure care gaps.
 - In collaboration with the National Kidney Foundation of Michigan (NKFM), Meridian conducted an analysis that identified that members may be receiving the services, but providers are not appropriately billing. Provider education was enhanced to emphasize the HEDIS specifications and billing guidelines.
 - Meridian is working with NKFM to deploy additional education for provider-facing quality staff.
 - Meridian's comprehensive analysis of *Well-Child Visits in the First 30 Months of Life* measure indicators, *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* identified opportunities to enhance measure outcomes:

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

- Incentivized members through the My Health Pays program to encourage completion of preventive services.
- Implemented HEDIS Passport mailings to remind members of all preventive services due and help close care gaps.
- Expanded interactive texting, social media, and email campaigns to enhance members' preventive care education and assess barriers to care.
- Increased well child visit appointment scheduling care coordination efforts.
- Supported community events to improve access to care, close local care gaps, and boost member engagement and education.
- Expanded children's care initiatives, focusing on wellness visits and vaccinations through programs like the Vaccine Confidence Program, home health visits, Reach Out and Read sponsorships, and provider-distributed coloring books.
- Strengthened community partnerships with children's health access programs to increase well visits and immunizations.
- Launched the Pediatric Quality Bonus Program, rewarding providers for closing HEDIS care gaps.
- Offered Pay for Performance (P4P), enabling providers to earn rewards for delivering quality preventive healthcare services.
- Meridian publishes a HEDIS® Quick Reference Guide (QRG) as an educational tool to ensure providers understand HEDIS® PPC measure compliance requirements.
- In 2024 Meridian continues to conduct further disparities analysis to identify pilot programs.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Kidney Health Evaluation for Patients with Diabetes:
- In 2023, Meridian sent KED measure in-home test kits to diabetic members. The in-home test kit program had a completion rate of 8.3%.
- Meridian saw an increase in performance in *Kidney Health Evaluation for Patients with Diabetes* in the two following age ranges 65 to 74 and 75 to 85 from 2022 to 2023. For members ages 65 to 74, the overall rate increased by 3.2%, with a final rate in 2023 of 37.58%. For members ages 75-85, the overall rate increased by 5.49%, with a final rate in 2023 of 34.79%.
- Well Child Visits Within the First 30 Months of Life:
- In a 2021 to 2022 comparison, Meridian detected a 2.64% decrease in *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* rate. Meridian shows an increase in this rate by 8.3% in 2023 with a final 2023 HEDIS rate of 63.67%. As of September 2024, Meridian is reporting continued increase with a current rate of 64.6%.
- In a 2021 to 2022 comparison, Meridian detected a 5.48% decrease in *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* rate. Meridian shows an increase in this rate by 7.1% in 2023 with a final 2023 HEDIS rate of 66.37%. As of September 2024, Meridian is reporting continued increase with a current rate of 67.8%

c. Identify any barriers to implementing initiatives:

- Meridian's comprehensive analysis of the *Kidney Health Evaluation for Patients with Diabetes* measure revealed the following barriers to implementing initiatives:
 - Members opted out of KED initiatives, such as text messaging or in home test kits.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

- Members fail to complete or return in-home tests.
- Members are often unreachable due to incorrect or disconnected phone numbers, limiting Meridian's ability to engage and connect members resources needed to complete KED measure testing.
- Providers miss opportunities to complete timely KED measure testing. Additionally, providers often fail to accurately prescribe or bill KED measure compliant testing.
- Meridian's comprehensive analysis of *Well-Child Visits in the First 30 Months of Life* measure indicators, *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* identified the following barriers to implementing initiatives and increasing measure rates:
 - Medicaid members are often difficult to reach due to changing addresses and phone numbers and failure to provide updated contact information to the plan.
 - Members may not prioritize or be aware of the importance of well child visits.
 - Members face Social Determinant of Health (SDoH) barriers, such as lack of transportation, which prevent members from completing well child visits.
 - Members may associate well child visit with immunizations, and due to immunization hesitancy, do not attend well child visits.
 - Providers often miss opportunities to complete well child visits during sick visits.
 - Providers and office staff may be unaware of implicit biases when treating specific marginalized populations.

HSAG Assessment: HSAG has determined that **MER** has partially addressed the prior year's recommendations. **MER** has put forth effort to address HSAG's prior year recommendation for the *Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicators by implementing HEDIS passport mailings to remind members of all preventive services due, expanding interactive text messaging and email campaigns, assessing barriers to care, increasing well-child visit appointment scheduling care coordination efforts, and offering member incentives through the My Health Pays program. As a result, the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicators demonstrated a significant rate improvement by over 7 percentage points and ranked between the 75th and 89th percentiles and between the 25th and 49th percentiles, respectively, for MY 2023, demonstrating improved performance. However, HSAG recommends continued efforts by **MER** to improve performance for the *Well-Child Visits in the First 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator and monitoring of initiatives currently in place to ensure continued improved performance.

Regarding HSAG's prior year recommendation for the *Kidney Health Evaluation for Patients With Diabetes (KED)—Ages 65 to 74 Years* and *Ages 75 to 85 Years* measure indicators, **MER** has demonstrated efforts by offering provider incentives for meeting measure benchmarks, adding the measure to the 2024 My Health Pay Rewards member incentive program, and utilizing social media and text messaging to encourage member compliance. As a result, the *Kidney Health Evaluation for Patients With Diabetes (KED)—Ages 65 to 74 Years* and *Ages 75 to 85 Years* measure indicators demonstrated a rate increase of over 3 percentage points, with the *Ages 65 to 74 Years* ranking between the 50th and 74th percentile, a significant improvement from the prior year. However, the *Ages 75 to 85 Years* measure indicator ranked between the 25th and 49th percentiles for

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

MY 2023. HSAG therefore recommends that **MER** continue its efforts on further improving the *Kidney Health Evaluation for Patients With Diabetes (KED)—Ages 75 to 85 Years* rate and monitoring the impact of initiatives currently in place to ensure improved performance.

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

HSAG recommended the following:

- While **MER** demonstrated high performance overall (i.e., 90 percent or greater but less than 100 percent) in the Members standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for the element *3.6-A Member Appeals*. **MER** was required to submit a CAP to address element 3.6-A, which was approved by MDHHS. As such, HSAG recommends that **MER** continue to implement action plans and oversight and monitoring processes to ensure that all appeals are resolved timely.
- While **MER** demonstrated high performance overall (i.e., 90 percent or greater but less than 100 percent) in the MIS/Financial standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for element *5.3 Quarterly Financials*, *5.11 Claims Processing (Non-Pharmacy)*, and *5.15 Monthly Encounter Record Acceptance Rate in CHAMPS*. **MER** was required to submit a CAP to address elements 5.3, 5.11, and 5.15, which was approved by MDHHS. As such, HSAG recommends that **MER** continue to implement action plans and monitoring processes to ensure adherence to MDHHS' report submission requirements and encounter data processing requirements (i.e., *Quarterly Financial Statements and Reports that were submitted to DIFS* [Department of Insurance and Financial Services]; *Maintain less than 1% of ending inventory greater than 45 days*; *Percent of rejected claims must be 12% or less*; and *Encounter record transmissions must meet or exceed a 95% acceptance rate for encounters loaded into CHAMPS*).

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

- a. Describe initiatives implemented based on recommendations (*include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation*):
 - In response to the recommendations for Meridian's *Not Met* score for the element *3.6-A Member Appeals*:
 - Meridian has created and maintained a robust inventory of job aids and resources utilized by front end staff to ensure compliance with all regulatory and internal requirements including timeliness and quality of appeal reviews. The library of resources is updated ad hoc when processes are updated/changed, as well as reviewed annually to ensure each process is up to current standards.
 - Meridian has implemented additional oversight of incoming and in-flight appeals by utilizing enhanced system reporting capabilities. The system allows a real-time view of outstanding appeals that is refreshed to current inventory multiple times each day.
 - In response to the recommendations for Meridian's *Not Met* score for element *5.3 Quarterly Financials*, *5.11 Claims Processing (Non-Pharmacy)*, and *5.15 Monthly Encounter Record Acceptance Rate in CHAMPS*:
 - *5.3 Quarterly Financials CAP*: Meridian has implemented a thorough Quality check to ensure error does not occur again. Meridian has added extra validation steps within the review process before Compliance Review submissions are uploaded for MDHHS review. These steps include a three-layer level review from multiple departments before submission. Meridian's Finance team reviews submission providing sign-off confirmation that all reports are present and accurate. The Regulatory Operations team then reviews submission ensuring that all reports are present and

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

meeting all requirements, including confirmation sign-off. Meridian's senior leadership team completes final review confirming all reports are present, accurate, and meeting all criteria requirements before uploaded for MDHHS to review.

- *5.11 Claims Processing (non-pharmacy) CAP:* Meridian has stabilized operations following a claims processing system migration in 2022. All initiatives identified (people, process, and technology) have been completed to address the former finding. This has allowed Meridian to maintain less than 1% of ending inventory greater than 45 days and less than 12% rejected claims.
 - This process includes the following implementation updates to ensure compliance. System configuration errors were corrected. All claim's workflows and inventories are documented, assigned, monitored, and reviewed routinely. Claims processing and reporting logics are accurate and audited. Real time reporting, daily status reporting, and enterprise dashboards are available to allow for dedicated oversight of the MI claims processing. All of Meridian's claims staff are adequately trained, with appropriate levels of leadership oversight. Meridian continues to adhere to MDHHS claims report submission requirements.
- *Monthly Encounter Acceptance CAP:* Meridian has established weekly engagement calls within the plan including key teams to discuss Acceptance Rates, Completeness/Volume, Encounter Rejection errors, Mitigation plans/ Key initiatives, and State Requirements/ Request.
 - In collaboration with engagement calls Meridian has also implemented the following to ensure encounter compliance. Meridian has completed enhancements to upfront processing logic, reviewed/enhanced encounter-built logic per state mapping/ companion guide requirements, and engaged providers to conduct training/education for appropriate billing. Meridian continues to review claims and encounter processing to ensure continued opportunities are identified and future success for Meridian's encounter performance.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- *3.6-A Member Appeals:*

Meridian has not received any Non- Compliance or CAP regarding 3.6A since process has been implemented.

- *5.3 Quarterly Financials, 5.11 Claims Processing (Non-Pharmacy), and 5.15 Monthly Encounter Record Acceptance Rate in CHAMPS:*

- Meridian has not received any Non- Compliance or CAP regarding 5.3 since process has been implemented.
- Meridian has remained in monthly compliance with 5.11 requirements following initiative implementation.
- Meridian has maintained high compliance with 5.15 requirements following key initiative implementation since December 2022.

c. Identify any barriers to implementing initiatives:

- *3.6-A Member Appeals:*

- During this reporting period the Meridian team was still learning and adapting to new systems implemented in April of 2022. Since this time, we have been able to identify how to best utilize our new systems and the reporting capabilities to add additional layers of oversight into our overall process.

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

- 5.3 *Quarterly Financials*, 5.11 *Claims Processing (Non-Pharmacy)*, and 5.15 *Monthly Encounter Record Acceptance Rate in CHAMPS*:
 - Meridian has not experienced or identified any barriers to implementing initiatives for all three issued CAPs, 5.3, 5.11 and 5.15

HSAG Assessment: HSAG has determined that **MER** partially addressed the prior year's recommendation. **MER**'s action steps were successful in remediating the deficiencies for elements 3.6-A, 5.3, and 5.11, as the SFY 2024 compliance review activity confirmed that the MHP received a *Met* score for these elements. However, **MER** received five *Satisfied* scores for element 5.15. **MER** did not meet the minimum encounter acceptance rate on professional encounter invoice types for the month of October 2023; **MER** did not meet the minimum encounter acceptance rate on dental encounter invoice types for the month of November 2023; **MER** did not meet the minimum encounter acceptance rate on professional encounter invoice types for the month of January 2024; MDHHS noted that its data warehouse did not properly load encounters from CHAMPS in February 2024, which affected **MER**'s dental acceptance rate; and **MER** did not meet the minimum acceptance rate for dental encounters submitted in May 2024 due to inadvertently submitted test files which caused an increase in rejections. **MER** was not required to submit a CAP. As such, HSAG recommends that **MER** continue to implement action plans and monitoring processes to improve the accuracy of encounter data submissions and acceptance rates.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

- Only 71.7 percent of the sampled provider locations could be reached. HSAG recommends that **MER** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies.
- Of the locations reached, only 77.7 percent confirmed the services were offered and 61.7 percent confirmed the requested insurance was accepted. HSAG recommends that **MER** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., records with incorrect specialty or provider information) to address the provider data deficiencies.
- Of the cases responding to the survey and accepting the insurance and new patients, only 64.9 percent of locations offered an appointment date. However, OB/GYN providers had an appointment availability rate of 57.1 percent, while PCP locations had an appointment availability rate of 45.8 percent. HSAG recommends that **MER** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **MER** 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)*:
 - In addition to provider education and the criteria listed in the provider manual, contract language, and provider bulletins, Meridian has continued monthly provider directory audits in pursuit of identifying opportunities for improvement, and rectifying provider directory deficiencies.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

- The team overseeing provider data collection and updates has transitioned to a team with more direct leadership support and operational tracking to mitigate prior deficiencies identified with staffing. Along with the transition and increased support, more robust training, and end to end process documentation has also occurred.
- In pursuit of continuous process improvement, Meridian is improving the way in which we intake provider changes, terms and enrollments from our Provider Portal based on the voice of our customer. This is anticipated to result in a simplified process for providers to submit data changes to Meridian timely. This will be supplemented by more real time reporting and inventory oversight of provider data change requests to ensure adherence to SLA and expeditious provider data changes. The revised web form was launched in September 2024 for an enhanced provider experience and internal oversight of real time inventory management reporting.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Meridian has reviewed the case-level analytic files containing provider deficiencies shared by HSAG and 100% of those deficiencies have been corrected as evidenced by follow up audit.
- As of August 2024, Meridian's Monthly Provider Directory Monitoring (secret shopper) results are showing evidence of improvement with 16/17 Key Monitoring Metrics from appendix 16 requirements with results above the target goal of 75% for June, July, and August of 2024. The "accepting new patients" metric is still in need of improvement, at 63.33%.
- As of August 2024, Meridian's Monthly Provider Directory Monitoring (secret shopper) activity has resulted in 100% of prior month deficiencies being corrected/resolved on a rolling monthly basis.

c. Identify any barriers to implementing initiatives:

- The provider directory requirements have historically been a challenge for the Medicaid Health Plans. In response to all three HSAG recommendations listed, Meridian continues to identify barriers with:
 - Timely notice of changes that would prompt directory updates from providers. For example, the data the health plan has is only as good as what the providers communicate.
 - Gaps in personal knowledge of requirements/adherence to availability requirements of staff within provider offices.

HSAG Assessment: HSAG has determined that **MER** has addressed the prior year's recommendations. **MER** has addressed data deficiencies noted in the case-level analytic data files. Also, **MER** implemented initiatives to ensure provider data accuracy (e.g., routine audits, provider education and training, process improvements for timely data sharing) and monitor appointment availability.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

HSAG recommended the following:

- **MER** indicated that it did not store any of its subcontractor data. To support the **MER**'s overall capabilities, it should consider storing its subcontractor encounter data within its claims systems, ensuring accessibility for various purposes.
- **MER** did not indicate any quality checks performed for claims/encounters from its vision subcontractor. **MER** should develop a comprehensive suite of monitoring reports to assess the accuracy, completeness, and timeliness of encounter data received from its subcontractor.
- Although **MER** submitted dental and pharmacy encounters in a timely manner, **MER** did not submit professional or institutional encounters timely. About 98 percent of professional encounters were submitted

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

within 210 days of payment, and 98 percent of institutional encounters were submitted within 330 days from payment. **MER** should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment.

- Although greater than 99.9 percent of provider NPIs identified in the medical/dental data were identified in the provider data, approximately 94 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data. **MER** should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.
- Although payment dates and detail payment amounts were submitted 100 percent of the time in professional data, **MER** submitted these fields 93.4 percent of the time in institutional data. **MER** should continue to evaluate its data for accuracy and completeness for all key data elements, including these fields.

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 recognizes the benefits of storing our subcontractor encounter data within our encounter's system and is currently working through the development of a business case and seeking funding in order to initiate a project to build out this capability.
 - Meridian currently does not have a subcontractor for vision. However, if ever contracted Meridian will include all subcontractor data within our encounters system once funding is available.
 - Meridian has a weekly submission process in place. This weekly submission process has run consistently over the past couple of years. Meridian has identified 99% + of weekly submissions are within 30 days of the paid date. Monthly reporting takes place on timeliness metric for Meridian lines of business, Medicaid and MMP. Over the years process changes and new implementations have taken place on a large scale. This leads to encounters being voided, replaced, and/or resubmitted which may impact timeliness scoring. Continued monitoring and process improvements continue to be investigated as needed.
 - Meridian has changed PBMs effective as of March 2023. Based on our current acceptance rates we are not experiencing rejected encounters based on non-rostered NPIs. Meridian continues to work with the pharmacy network team to get any pharmacies identified as missing added to the roster, should it be deemed necessary.
 - Meridian reviewed feedback regarding the 93.4 % for institutional data for further review. Based on recent reviews, Meridian has submitted pay dates consistently on both professional and institutional encounters. However, institutional encounters that have the paid date and payment details may be submitted at header level or line level based on processing.
- Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - Meridian Health Plan retains encounter data files and has a system available to view data fields as needed. In addition, Meridian Health Plan has stood up regular reporting from each subcontracted vendor for key data points while working toward long term storage of all subcontractor data.
 - N/A
 - Meridian submissions are currently meeting timeliness benchmarks. Continued monitoring will take place to support continued process improvement efforts and highlight mitigation activities if necessary.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

- Meridian is currently tracking Pharmacy acceptance rate at or around 99.9%. The identified issue is not adversely impacting pharmacy performance metrics.
- Meridian will continue to monitor data accuracy and completeness.

c. Identify any barriers to implementing initiatives:

- Meridian foresees no future barriers currently, as business case and funding are still pending.
- N/A
- Meridian foresees no future barriers implementing recommendation.
- To fully address the 6% missing pharmacy data, it would be helpful for **Meridian** to be provided a detailed listing of NPIs that were not identified in the HSAG database.
- Meridian foresees no future barriers implementing recommendation.

HSAG Assessment: HSAG has determined that **MER** has partially addressed the prior year's recommendations, demonstrating some progress while leaving specific areas unresolved.

For the recommendation to store subcontractor encounter data within its claims system, **MER** acknowledges the importance of this action and is in the process of developing a business case and seeking funding to initiate the project. While this demonstrates awareness and intent, the recommendation has not yet been implemented and is therefore partially addressed. Implementing this capability would enhance data accessibility and support overall operational efficiency.

Regarding the recommendation to develop a comprehensive suite of monitoring reports for subcontractor data, **MER** noted that it currently has no subcontractor for vision but plans to include subcontractor data in its system if applicable in the future. Although this response clarifies the current situation, it does not address the broader need for comprehensive monitoring tools. This recommendation was not addressed, as proactive measures are required to improve data quality oversight for all subcontractors.

For encounter submission timeliness, **MER** highlighted that 99 percent of weekly submissions occur within 30 days of the paid date, supported by regular monitoring and process changes. However, **MER**'s explanation regarding voided, replaced, or resubmitted encounters impacting timeliness scores suggests that further refinements may be necessary. This recommendation was partially addressed, as **MER** demonstrates consistency in submissions but should strive for enhanced timeliness tracking and mitigation strategies.

In response to the recommendation to collaborate with MDHHS to maintain an accurate provider database, **MER** changed its PBM as of March 2023, resulting in high pharmacy acceptance rates. While **MER** mentioned resolving non-rostered NPI issues with its pharmacy network team, it requests more detailed feedback from HSAG to address the remaining 6 percent of missing pharmacy data. This recommendation was partially addressed, as efforts are ongoing but not yet fully resolved.

Lastly, **MER** reviewed institutional data accuracy and stated that paid dates and payment details are consistently submitted. However, it acknowledged potential discrepancies due to submission variations at the header or line level. This recommendation was partially addressed, as continued monitoring and standardization efforts are required to ensure data consistency.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

In conclusion, **MER** has made some progress in addressing HSAG’s recommendations but has not fully resolved critical issues. While efforts such as developing a business case for data storage, improving timeliness metrics, and resolving pharmacy acceptance issues demonstrate commitment, more structured actions are necessary. **MER** should:

- Expedite the implementation of subcontractor data storage.
- Develop comprehensive monitoring tools for all subcontractor data.
- Refine processes to improve timeliness and data accuracy.
- Collaborate closely with MDHHS to resolve provider NPI discrepancies and standardize institutional data submissions, which would further enhance compliance and data quality.

No significant barriers were identified, indicating that focused efforts and resource allocation could achieve full resolution of the recommendations.

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis—Adult and Child Medicaid

HSAG recommended the following:

- **MER**’s 2023 top-box scores were not statistically significantly lower than the 2022 NCQA adult and child Medicaid national averages or 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified. HSAG recommends that **MER** monitor the measures to ensure significant decreases in scores over time do not occur.

MCE’s Response: (Note—the narrative within the MCE’s Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:

- Meridian continues to monitor and track CAHPS® results. Though no substantial weaknesses were identified, Meridian has implemented the following interventions to support sustained performance:
 - CAHPS® Staff Training: Beginning in 2023 and continued into 2024 the Quality department facilitated enhanced annual CAHPS® training for all member- and provider-facing staff. The specialized training emphasizes the crucial role exemplary service plays in survey outcomes.
 - Consumer Advisory Council (CAC) Meetings: Quarterly meetings with members, including CSHCS members, and State and health plan representatives, help Meridian understand member preferences, experiences, and barriers. These meetings focus on improving access to care and addressing issues like transportation barriers.
 - CAHPS® Best Practices: Leveraged Centene Corporate resources to incorporate CAHPS® best practices to improve Meridian’s CAHPS® outcomes.
 - Providing-Facing Staff Presentations: Meridian holds monthly meetings with high-volume provider groups to discuss various quality initiatives with a prioritized focus on Coordination of Care measures.
 - Member Impact Team: Expanded the Quality department’s member-facing team to increase member outreach and to maximize positive outcomes of prioritized quality initiatives.

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis—Adult and Child Medicaid

- CAHPS® Survey Pre-Conditioning: In January 2024, reminders were sent to members proactively reinforcing positive health plan aspects, reminding members to contact the health plan with any questions or issues, and encouraging members to complete the CAHPS® survey, if received.
- Access and Availability Audits: Bi-annual audits are conducted by an external vendor, Faneuil, to ensure the provider network efficiency and meets member needs. This also ensures providers are following recommended appointment scheduling guidelines.
- Meridian is working to increase its CAHPS® survey response rates by sending out pre-survey notification materials and continuing online survey completion options in 2024.
- Member-facing teams provided care coordination assistance aimed to enhance access to needed care barriers.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Meridian analyzed the adult and child CAHPS® results year over year:
 - Meridian's adult Medicaid 2023 top-box score shows an increase from 2022 to 2023 in all measures with a statistically significantly higher rate for one measure, Coordination of Care. Increasing from 72.73% in 2022 to 87.37% in 2023.
 - Meridian's Child Medicaid 2023 top-box score shows an increase from 2022 to 2023 in seven measures with a statistically significantly higher rate than the 2022 child Medicaid national averages for two measures, Customer Service and Coordination of Care.

c. Identify any barriers to implementing initiatives:

- Limited responses on CAHPS® surveys present difficulty with gaining granular insight of members' health care and health plan experiences, which is necessary to make informed improvements.

HSAG Assessment: HSAG has determined that **MER** has not addressed the prior year's recommendations. The SFY 2024 CAHPS activity confirmed that **MER**'s 2024 scores for *Rating of Health Care* for the child Medicaid population was statistically significantly lower than the 2023 NCQA child Medicaid national average. Furthermore, **MER**'s 2024 scores for *Customer Service* for the child Medicaid population was statistically significantly lower than the 2023 top-box score. **MER** has reported several performance improvement initiatives that continue to be in progress. HSAG recommends that **MER** continue to implement performance improvement interventions and evaluate their effectiveness and service.

7. Prior Year Recommendation from the EQR Technical Report for Performance Results—CSHCS

HSAG recommended the following:

- **MER**'s 2023 top-box score was statistically significantly lower than the 2022 top-box score for one measure, *Rating of CMDs Clinic*. HSAG recommends that **MER** explore drivers of this lower experience score and develop initiatives designed to improve quality of care. In addition, **MER** should consider obtaining direct patient feedback from members to drill down into areas that need improvement.

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 following interventions have been implemented to enhance MER's Children's Special Health Care Services (CSHCS) CAHPS ratings:

7. Prior Year Recommendation from the EQR Technical Report for Performance Results—CSHCS

- Consumer Advisory Council (CAC) Meetings: Quarterly meetings with members, including CSHCS members, and State and health plan representatives, help Meridian understand member preferences, experiences, and barriers. These meetings focus on improving access to care and addressing issues like transportation barriers.
- Member-facing teams provide care coordination, appointment scheduling, and assistance aimed to enhance access to needed care barriers.
- MER works collaboratively with Local Health Departments (LHD) and Children's Multidisciplinary Specialty (CMDS) clinics to support appropriate coordination for CSHCS enrollees. To best serve these enrollees, relationships with LHDs and CMDS clinics are maintained through regular communication and collaboration in creating and updating an enrollee's individualized plan of care via phone, fax, and portal. To enhance collaboration, MER's Care Management department is working to optimize coordination with CMDS Clinics and LHDs to remove duplicative services and bridge the gap to ensure collaboration for mutual CSHCS enrollees is occurring in a meaningful manner. MER is investigating ways to enhance monitoring and tracking of CMDS coordination for shared CSHCS enrollees through documentation processes and operational workflows, as it may result in timely coordination and follow up between areas.
- MER's Population Health & Clinical Operations department developed a dedicated Pediatric Pod that focuses on offering wrap around care management services to our CSHCS population through a variety of methods. For CSHCS enrollees, dedicated Care Management staff coordinate member centric care to CSHCS enrollees through assessment completion, care plan development, connecting to providers, scheduling appointments, educating on available benefits, coordinating transportation, supporting through transition to adulthood, Social Determinants of Health (SDoH), medication and durable medical equipment needs, emergency department diversion, prior authorization (PA) processes and safe Transitions of Care (TOC) post inpatient discharges. Our Pediatric Pod provides ongoing care management to medically complex CSHCS enrollees by sharing applicable education and best practices on how to effectively manage their conditions independently long-term.
 - Within the Pediatric Pod, Care Management staff focus on targeted outreach to members who may have an increased cost of care due to several inpatient admissions, avoidable frequent emergency department utilization, and severe medical conditions to ensure the appropriate access and delivery of care is occurring.
 - Within the Pediatric Pod, Care Management staff support CSHCS enrollees with an Asthma diagnosis maintain adherence to their asthma medications. Care Management staff complete medication assessments to address compliance and Registered Nurses are consulted to provide medication guidance, when needed. Through the Pediatric Pod, CSHCS enrollees are receiving appropriate referrals to the appropriate disease state specialist to effectively manage their condition(s).

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- MER's 2023 CSHCS CAHPS top-box scores global ratings for Rating of CMDS Clinic measure statistically significantly decreased from 77.78% in 2022 to 56.41% in 2023. Although MER experienced a decline in the global rating for Rating of CMDS Clinic, a positive increase was reported for the 2023 individual item measure, CMDS Clinics which assesses for how often a member was able to get an appointment as soon as they needed at a CMDS clinic. This increased from 77.14% in 2022 to

7. Prior Year Recommendation from the EQR Technical Report for Performance Results—CSHCS

80.95% in 2023. As the number of survey respondents was under 100, caution should be used when interpreting the results.

c. Identify any barriers to implementing initiatives:

- Responses on CAHPS® surveys present difficulty with gaining granular insight of members' health care and health plan experiences, necessary to make informed improvements due to a wide range in response rates year over year. Provider access has shown to have an impact member experience. Barriers getting connected to in network providers, scheduling visits, or regarding provider availability has been shared by members. Population Health Clinical Operations (PHCO) staff offer members assistance with contacting providers to confirm they are in network accepting MER patients and assist with appointment scheduling.

HSAG Assessment: HSAG has determined that **MER** has addressed the prior year's recommendations. However, the SFY 2024 CAHPS activity confirmed that **MER**'s score for *Rating of Specialist Seen Most Often* was statistically significantly lower than the 2023 top-box score. **MER** has reported several performance improvement initiatives that continue to be in progress. Therefore, HSAG recommends **MER** continue to implement performance improvement interventions and evaluate their effectiveness.

8. Prior Year Recommendation from the EQR Technical Report for Performance Results—HMP

HSAG recommended the following:

- **MER**'s 2023 top-box score was statistically significantly lower than the 2022 NCQA adult Medicaid national average and the 2022 top-box score for one measure, Rating of Health Plan. HSAG recommends that **MER** explore the drivers of this lower experience score and develop initiatives designed to improve members' quality of care, including a focus on improving members' overall experiences with their health plan.

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 following interventions were implemented to enhance Meridian's CAHPS rankings:

- **CAHPS Training for Staff:** New member-facing staff training module designed to remind teams of their crucial role and impact upon CAHPS outcomes. The training also reiterates the importance of always providing excellent service to our members.
- **Consumer Advisory Council (CAC) Meetings:** Quarterly meetings are held with members including members from the Healthy Michigan Plan population, various State and health plan representatives to increase Meridian's understanding of member preferences, experiences, barriers, and to encourage suggested recommendations for improvement. CAC meetings specifically addressed access to care issues such as transportation barriers and alleviation methods.
- **CAHPS Best Practices:** Leveraged Centene Corporate resources to acquire and incorporate CAHPS best practices to improve Meridian's CAHPS® outcomes.
- **Providing-Facing Staff Presentations:** Meridian holds monthly meetings with high-volume provider groups to discuss various quality initiatives with a prioritized focus on improving CAHPS measures including Rating of Health Plan.
- **Member Impact Team:** Expanded the Quality department's member-facing team to increase member outreach and to maximize positive outcomes of prioritized quality initiatives.

8. Prior Year Recommendation from the EQR Technical Report for Performance Results—HMP

- Meridian is working to increase its CAHPS survey response rates by sending out pre-survey notification materials that encourage members to complete the survey. While the Healthy Michigan Plan (HMP) survey is not administered by the health plan, Meridian is hopeful that messaging that Meridian seeks and values their feedback will reinforce member completion of the survey.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Meridian is awaiting the 2024 HMP CAHPS results to assess year over year improvement for the Rating of Health Plan measure.

c. Identify any barriers to implementing initiatives:

- Limited responses on CAHPS surveys present difficulty with gaining granular insight of members' healthcare and health plan experiences, necessary to make informed improvements. Provider access has shown to have an impact member experience. Barriers getting connected to in network providers, scheduling visits, or regarding provider availability has been shared by members. PHCO staff offer members assistance with contacting providers to confirm they are in network accepting Meridian patients and assist with appointment scheduling.

HSAG Assessment: HSAG has determined that **MER** has addressed the prior year's recommendations for the *Rating of Health Plan* measure. HSAG could not verify whether the MHP's initiatives were successful since HMP CAHPS was not conducted in 2024.

Molina Healthcare of Michigan

Table 4-6—Prior Year Recommendations and Responses for MOL

1. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Improvement Projects
<p>HSAG recommended the following:</p> <ul style="list-style-type: none"> • MOL partially achieved the state-defined goals, and the existing disparity was eliminated with the first remeasurement period. However, the comparison population demonstrated a very slight decline in performance as compared to the baseline. HSAG recommends that MOL continue efforts to maintain or improve its performance for the comparison population. The MHP should also determine if any new barriers exist that are decreasing performance for this population.
<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"> • Based on analysis and findings MOL implement four new interventions in 2023 and continued two successful interventions from 2022 to improve overall rates and disparities found in the Timeliness of Prenatal Care measure. Below is a summary of each: <ul style="list-style-type: none"> ○ Starting in 2022, Molina utilized monthly claims reports to identify pregnant members quicker so outreach can be conducted, and members can be encouraged to obtain prenatal care. To increase the number of Black members identified at the earliest point in their pregnancies, Molina utilizes a vendor called Lucina, which employs a pregnancy-specific algorithm daily to all submitted claims. The reports are available on demand and allow for timely outreach, ensuring members relate to pregnancy care and resources earlier in the pregnancy. In 2023 Lucina was able to help identify 6,092 pregnancies, with 5,983 (98.2%) meeting the denominator criteria for Timeliness of Prenatal care. ○ Molina found that many members delay the initiation of prenatal care. This can be for multiple reasons such as the member is not educated on the importance of Timeliness of Prenatal Care, the member may have had a pregnancy before and does not feel the need for early care, or the member may lack resources to obtain care. To address these barriers, starting in 2022 Molina members of childbearing age are emailed information about the importance of the initiation of prenatal care as soon as they are aware of the pregnancy, along with information on available services to support a healthy pregnancy and who to contact for more information and resources. ○ In 2023, Michigan Department of Health and Human Services (MDHHS) implemented a new doula benefit for Medicaid members allowing members to have visits during their pregnancy and the doula to be present at the birth. Molina found that many Black pregnant members were not engaged in doula program after this benefit was implemented. To increase the member engagement Molina partnered with Mae, a culturally competent, Black-owned Doula organization to support Black pregnant members in Molina's service area to improve successful prenatal and post-partum pregnancy management. Molina launched a pilot targeting up to 600 Black members who were pregnant and had been flagged as potentially at-risk. The pilot leverages Mae's contracted doulas and lactation consulting network (in-home and virtual visits) in support of pregnant Black members across Molina's service area.

1. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Improvement Projects

- In 2023, Molina found that many pregnant members do not engage with an OB/GYN in the first trimester therefore are not meeting the Timeliness of Prenatal Care metric. To address this barrier Molina partnered with Ouma Health to collaboratively outreach to pregnant members to provide access to early prenatal care through Ouma's platform. Ouma's "Total Maternal Telehealth" solution assists with outreach and early prenatal visits to members in first trimester and have not had a prenatal visit. Ouma Health reaches out to all members identified as pregnant who have not engaged in prenatal care. Outreach occurs within 48 hours (or 24 hours if identified as high-risk) from the time of pregnancy identification in all of Molina service regions. Molina also offers a car seat for all members completing a prenatal visit with Ouma, and a gift card incentive to all members who complete their prenatal visit within the Timeliness of Prenatal Care period.
- In early 2023, Molina began to proactively refer Black members in region 10 who were identified as pregnant to the Detroit-based Women-Inspired Neighborhood (WIN) Network. WIN Network is a Centering Pregnancy® model clinic providing Group Prenatal Care led by Certified Nurse Midwives (CNMs) for expectant mothers with a focus on improving birth outcomes for Black pregnant members and their babies. With group prenatal care, participants experience no wait time for appointments and have more time to address questions and concerns about pregnancy, birth, infant care, and more. WIN Network's model of group prenatal care is enhanced with extra support from a Community Health Worker (CHW) and a focus on members' Social Determinants of Health (SDoH) needs. Referrals are sent to WIN monthly for CHW outreach and education on the benefits of Centering Pregnancy® group prenatal care.
- Throughout 2024, Molina began to develop an intervention to target health related social needs associated with food insecurity. Molina has partnered with Instacart to develop an innovative home-delivered meals/nutrition supports initiative, targeting Molina's prenatal/postpartum members with food insecurity throughout Molina's service area. Molina is launching a pilot targeting up to 600 pregnant members who are experiencing food insecurity. Qualifying members will receive a monthly \$100 Fresh Fun stipend through Instacart. This program will go live in quarter one of 2025.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Molina continues to see improvements in the Timeliness of Prenatal care measure. Molina's plan rate for reporting year (RY) 2024 is 84.50%, a 3.48% increase from RY 2023 (81.02%). Previously RY 2023 Molina saw a 2.67% increase in Timeliness of Prenatal Care from RY2022. A review of the RY 2023 HEDIS® performance rates by race/ethnicity revealed the rate for Black members, reported at 68.04%, which is 1.84 percentage points above the HEDIS® RY2021 rate of 66.20%, but it is lower than the rate for White members 72.53%.
- Below is a high-level summary of the six interventions carried out through 2023 to address disparities within the Timeliness of Prenatal Care metric.
 - After implementation with Lucina, there was a 55% increase in the number of early identification of pregnancies from Jan – May 2023 (3,556) compared to the same time in 2022 (1,610). From May 2023- Dec 2023 there were 6,092 early pregnancies identified. Of those early pregnancies identified in 2023, 5,983 (98.2%) met the denominator criteria for the measure.
 - Results from the Email Campaign are as follows. In 2022 sent 29,577 emails with 11,339 (39.80%) being opened. In 2023, Molina saw an increase in the opening rate with 5,087 sent and 2,136 (41.99%) being opened. Molina plans to restart this email campaign in September 2024. Although direct correlation with an increase in the Timeliness of Prenatal Care cannot be drawn, Molina is

1. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Improvement Projects

seeing an increase in member engagement and will continue to utilize best practices in future campaigns.

- After implementing the partnership with Mae, Molina found that Mae served 87 Black members in CY23 enrolled as of January 2024. Currently Mae has 222 members enrolled, as of August 2024. Molina will continue to monitor members served and determine if engaged members complete their Timeliness to Prenatal Care metric.
- In 2023, Ouma completed 261 Prenatal Visits. As of August 2024, Ouma completed 134 Prenatal Visits. In CY23, there were 113 members that received a \$100 gift card for completing their prenatal visit under the specified time. There have been 66 members that have received a gift card in CY24 as of August 2024.
- To date, Molina has referred over 400 Black pregnant members to WIN Network with a 5% engagement rate with the Group Prenatal Care model.
- There is no data for this pilot, as the Instacart program has not gone live yet. Molina is in its final steps to launch the pilot.

c. Identify any barriers to implementing initiatives:

- Below is a summary of barriers Molina faced implementing interventions:
 - Molina's partnership with Mae has generated a large engagement among our Black members. This will help reduce disparities within this population. However, Molina is not seeing the same sort of engagement for other racial/ethnic groups, and it remains an area of opportunity for Molina to address.
 - While Molina can identify approximately 85% of all first trimester pregnancies while the members can still become compliant with Timeliness of Prenatal Care, Molina and Ouma have experienced barriers in reaching and connecting with members due to incorrect contact information. Molina and Ouma are working to identify better ways to connect and engage members throughout the remainder of 2024.
 - Molina has experienced delays with the Instacart partnership. Molina started the contract negotiation with Instacart nearly two years ago, and the contract process was not completed until July 2024. Molina Healthcare of Michigan will now be able to go live with this intervention and will monitor success for the next HSAG PIP resubmission.

HSAG Assessment: HSAG has determined that **MOL** addressed the prior year's recommendation. Within the most recent annual submission the MHP revisited its causal/barrier analysis to identify barriers to care and developed targeted intervention strategies.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

HSAG recommended the following:

- **MOL**'s performance for the *Kidney Health Evaluation for Patients with Diabetes—Ages 18 to 64 Years*, *Ages 65 to 74 Years*, and *Total* measure indicators ranked between the 25th and 49th percentiles. Additionally, performance for the *Kidney Health Evaluation for Patients with Diabetes—Ages 75 to 85 Years* measure indicator ranked below the 25th percentile, indicating some members with diabetes did not receive kidney health evaluations. Approximately 1 in 3 adults with diabetes has chronic kidney disease. While **MOL** noted several interventions currently in place to target improvement, such as on-site or virtual visits with providers to explain the tests needed for measure compliance and provider incentives, performance for the *Kidney Health Evaluation for Patients with Diabetes* remained low. Therefore, HSAG

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

recommends that **MOL** continue its efforts to improve performance for the *Kidney Health Evaluation for Patients with Diabetes* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified.

- **MOL**'s performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked between the 25th and 49th percentiles, indicating children who turned 30 months old during the measurement year were not always getting at least two well-child visits with a PCP in the last 15 months. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling. While **MOL** noted several interventions currently in place to target improvement, such as using various methods of outreach to members, providing member education, sending reminders within a month after the members' birth to serve as a reference for parents regarding scheduling of all well-child visits, and providing outreach materials in multiple languages, performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator remains low. Therefore, HSAG recommends that **MOL** continue its efforts to improve performance for the *Well-Child Visits in the First 30 Months of Life* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified.
- **MOL**'s performance for the *Hemoglobin A1c Control for Patients with Diabetes—HbA1c Poor Control (>9.0%)* measure indicator ranked between the 25th and 49th percentiles, indicating members with diabetes did not always have controlled HbA1c levels. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life. HSAG recommends that **MOL** conduct a root cause analysis or focused study to determine why some members with diabetes did not have controlled HbA1c levels. Upon identification of a root cause, **MOL** should implement appropriate interventions to improve the performance related to the *Hemoglobin A1c Control for Patients with Diabetes—HbA1c Poor Control (>9.0%)* measure indicator.

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 *Kidney Health Evaluation for Patients with Diabetes (KED) – All Denominators*: Molina has partnered with Sprinter, an in-home phlebotomy service, to collect specimens from members who have not completed the two laboratory test components of the KED measure in the measurement year. Additionally, Molina has collaborated with the National Kidney Foundation of Michigan (NKFM) to develop biannual communications to members with a diagnosis of diabetes and/or hypertension to raise awareness of the increased risk for chronic kidney disease or failure. To further support diabetes self-management and routine monitoring, Molina developed a “stoplight” magnet and mailer, which is distributed annually to all members with a diagnosis of diabetes. The magnet includes important information on routine maintenance of diabetes, as well as guidance and appropriate site of care for acute, urgent, or emergent care. Molina further instituted both member and provider incentives for the KED measure in MY2024 to increase awareness and completion rates of the screenings in diabetic members.
 - For *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*: As part of the Quality Improvement team, Molina has created a specific staff role for outreach to the parents/guardians of infant and toddler-aged Molina members.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

The Early Periodic Screening Diagnosis and Treatment (EPSDT) Coordinators are responsible for engaging telephonically with parents/guardians on a cadence which aligns with the American Academy of Pediatrics' (AAP) Periodicity Schedule for EPSDT visits and screenings. The EPSDT Coordinator serves to remind parents/guardians about upcoming wellness visits, needed blood lead screening, and immunizations. Molina's Provider Engagement Team also shares monthly gaps in care lists with large-volume providers to assist practices in identifying needed services for their patient population.

- For *Hemoglobin A1c Control for Patients with Diabetes—HbA1c Poor Control (>9.0%)*: Molina has partnered with Sprinter Health, an in-home phlebotomy service, to collect specimens from members who have not completed a hemoglobin A1c (HbA1c) test in the measurement year. Similar to the interventions outlined in the KED measure, diabetic Molina members receive a number of communications regarding diabetes self-management and routine monitoring, all which contain evidence-based interventions to maintain a healthy blood glucose level. Molina's Provider Engagement Team also shares monthly gaps in care lists with large-volume providers to assist practices in identifying needed services for their patient population, including members with elevated HbA1c levels in need of retesting or changes to the medical management of the member's diabetes.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- For *Kidney Health Evaluation for Patients with Diabetes (KED) – All Denominators*: Molina has seen a marked increase in the performance of the KED – Total measure year-over-year (MY2023 to MY2024). In MY2023, Molina achieved a rate of 36.46% for the KED – Total measure, which exceeded the NCQA's Quality Compass® 50th percentile. Currently for MY2024, Molina's rate is 5.42 percentage points ahead of same time last year, with a projected final rate of 41.88%, which is above the 75th percentile. The addition of Sprinter Health's in-home phlebotomy services produced a total of 603 completed KED screenings in quarter three and quarter four of 2023, which substantially increased the numerator compliance for Molina.
- For *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30B)*: With the initiation of the EPSDT Coordinator position in MY2023, Molina has seen a significant increase in the W30B rate, year over year. By providing regular, consistent outreach with a familiar member of the Molina team, parent/guardian engagement has increased as well in MY2024, as the EPSDT Coordinators' reach rate averages greater than 40% each month. This rate of engagement is substantially higher than previous telephonic outreach campaigns, which typically averaged engagement rates around 20%. As a result, Molina currently has a rate of 66.82%, an increase of 3.9 percentage points over the same time last year, and above the Quality Compass® threshold for the 50th percentile. In MY2023, Molina failed to achieve the Quality Compass® 50th percentile, ending with a rate of 65.56%.
- For *Hemoglobin A1c Control for Patients with Diabetes—HbA1c Poor Control (>9.0%) (HBD Poor Control)*: Molina has seen a marked increase in the performance of the HBD Poor Control measure year-over-year (MY2023 to MY2024). In MY2023, Molina achieved a rate of 37.47% for the HBD Poor Control measure, which failed to achieve the NCQA's Quality Compass® 50th percentile. Currently for MY2024, Molina's rate is 7.83 percentage points ahead of same time last year, with a projected final rate of 32.47%, in which is above the 75th percentile. The addition of Sprinter in-home phlebotomy services produced a total of 632 completed HbA1c screenings in quarter three and quarter four of 2023, which substantially increased the numerator compliance for Molina.

c. Identify any barriers to implementing initiatives:

- For *Kidney Health Evaluation for Patients with Diabetes (KED) – All Denominators*: Molina has experienced a lack of awareness of the laboratory test components necessary for compliance for the

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

KED measure among both providers and members. Molina has implemented educational resources and communications for both audiences, to raise awareness of the need for both the blood and urine components for accurate testing of renal function. In the collection of patient specimens in the home with Sprinter Health, one of the largest barriers encountered is the member's inability to void at the time of the appointment, which results in the Estimated Glomerular Filtration Rate (eGFR) being drawn without the accompanying Urine Albumin Creatinine Ratio (uACR). Due to the short window of opportunity to collect the urine specimen within four days of the eGFR, a second Sprinter Health appointment is most often not able to be scheduled, and the KED measure gap persists.

- For *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30B)*: The completion of the childhood immunization series at the 18-month milestone typically creates the barrier seen most frequently with the W30B measure. Once a child has completed the final round of immunizations at 18 months, including the Hepatitis B, Diphtheria, Tetanus, and acellular Pertussis (DTaP), and the Inactivated Polio Virus (IPV) vaccines, parents and guardians may feel that the child no longer needs to be seen as frequently and can be seen on an “as needed” or annual basis. Parents and guardians need to be educated on the importance of the 24-month visit, despite having completed the vaccination series. Molina has produced and disseminates “The Path to a Healthy Childhood” magnet to all newborn member to serve as a reminder of the cadence and services needed from birth to adulthood. This magnet is available in English, Spanish, and Arabic, and has been widely distributed at community events with positive feedback.
- For *Hemoglobin A1c Control for Patients with Diabetes—HbA1c Poor Control (>9.0%) (HBD Poor Control)*: Molina has noted a sizeable increase in members who are identified as diabetic in the HBD Poor Control measure in the last several years. When an analysis of this issue was completed, it was determined that a significant portion of the increase could be attributed to members who are taking GLP-1 diabetes medications (e.g., Ozempic/Semaglutide) but who have no current or prior history of diabetes. Based on the HEDIS® MY2023 technical specifications, members taking these medications had been added to the HBD Poor Control measure denominator but do not meet the criteria for an official diagnosis of diabetes. Although the inclusion of members who use GLP-1 medications for off-label use has been removed from the measure for MY2024, a small portion of the downward trend in performance of this measure may be attributable to the addition of these non-diabetic members to the denominator. Furthermore, the values derived from continuous glucose monitoring (CGM) devices were not considered numerator compliant until MY2024, despite widespread use across the Molina network. With this change to the HEDIS® technical specifications to address both of these barriers, Molina anticipates seeing an accompanying rise in the performance of the new Glycemic Status Assessment for Patients with Diabetes (GSD) measure for MY2024 and beyond.
- Additionally, Molina identified some data issues with certain provider groups, where providers are reporting higher rates for the HbA1c measure within their systems that do not align with Molina's rates for those providers. Molina suspects that this data discrepancy issue is due to Current Procedural Terminology (CPT) coding and data submission delays or omissions. Molina plans to continue to investigate the cause of these data discrepancies with the identified provider groups and provide guidance and support to reconcile these.

HSAG Assessment: HSAG has determined that **MOL** has partially addressed the prior year's recommendations. **MOL** has put forth effort to address HSAG's prior year recommendation for the *Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator by incorporating additional staff for outreach to parents/guardians of infant and toddler-aged members and sharing monthly gaps in care lists with large-volume providers to assist

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

practices in identifying needed services for their patient populations. While the measure indicator rate significantly improved from the prior year by over 3 percentage points, **MOL** continues to demonstrate low performance for the measure indicator, with the *Well-Child Visits in the First 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranking between the 25th and 49th percentile for MY 2023. HSAG recommends continued efforts by **MOL** to improve performance for the *Well-Child Visits in the First 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator and monitoring of initiatives currently in place to ensure continued improved performance.

HSAG has determined that **MOL** addressed the prior year recommendation for the *Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Poor Control (>9.0%)* measure indicator. **MOL** partnered with an in-home phlebotomy service to collect specimens from members who did not complete an HbA1c test in the measurement year, issued communication to members diagnosed with diabetes with resources on self-management and routine monitoring, and shared monthly gaps in care lists with large-volume providers to assist practices in identifying needed services for their patient populations. As a result, the rate decreased from the prior measurement year by over 4 percentage points and ranked between the 50th and 74th percentiles for MY 2023, demonstrating improved performance.

Regarding HSAG’s prior year recommendation for the *Kidney Health Evaluation for Patients With Diabetes (KED)* measure indicators, **MOL** has demonstrated efforts by partnering with an in-home phlebotomy service to collect specimens from members who did complete laboratory test components of the measure, collaborating with NKFM to develop biannual communications to members with a diagnosis of diabetes, developing and distributing a “stoplight” magnet and mailer to all members with a diagnosis of diabetes, and adding member and provider incentives to improve the performance measure rates. All measure indicator rates significantly increased from the prior year by over 3 percentage points and the *Ages 18 to 64 Years* and *Total* measure indicators ranked between the 50th and 74th percentiles for MY 2023. However, **MOL** continues to demonstrate low performance for the *Ages 65 to 74 Years* and *Ages 75 to 85 Years* measure indicators as both ranked between the 25th and 49th percentiles for MY 2023. HSAG therefore recommends that **MOL** continue its efforts on further improving the *Kidney Health Evaluation for Patients With Diabetes (KED)—Ages 65 to 74 Years* and *Ages 75 to 85 Years* measure indicator rates and monitoring the impact of initiatives currently in place to ensure improved performance.

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

HSAG recommended the following:

- HSAG did not identify any substantial weaknesses for **MOL** through the compliance review activity.

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)*:

- N/A

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- N/A

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

c. Identify any barriers to implementing initiatives:

- N/A

HSAG Assessment: NA

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

- Of the 79.4 percent of locations reached, only 73.6 percent confirmed affiliation with the sampled provider. Additionally, 71.4 percent confirmed accuracy of the sampled address, 59.5 percent confirmed the services were offered, and 51.1 percent confirmed the requested insurance was accepted. HSAG recommends that **MOL** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., records with incorrect specialty or provider information) to address the provider data deficiencies.
- Of the cases responding to the survey and accepting the insurance and new patients, only 63.6 percent of locations offered an appointment date. However, pediatric providers had an appointment availability rate of 74.4 percent, PCP locations had an appointment availability rate of 63.1 percent, while OB/GYN provider locations had an appointment availability rate of 0.0 percent. HSAG recommends that **MOL** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **MOL** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

MCE's Response: *(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:

- Molina continues to work through identified inconsistencies with receiving provider information, ongoing review of its internal process including roster reconciliation practices, provider audits/secret shopper calls, and validation of the provider data received. Molina implemented and maintained several initiatives to improve the provider data issue, starting with:
- Molina leverages data verifications completed by a third-party vendor HiLab, using Artificial Intelligence (AI). HiLab's AI verifies provider data elements, such as: demographic and service location details; this data validation identifies address standardization as an improvement intervention. When inconsistent provider data is identified, the results are reviewed and used to update provider database.
- During the Summer 2024 Molina launched a Provider Network Management Portal, this tool is designed to streamline the onboarding and ongoing maintenance process of provider data management.
- Ongoing Quarterly updates from providers through roster submissions and periodic data validations done monthly through provider attestations.
- Regular monitoring continues to include regular audits and secret shopper calls to provider offices, which are tracked in our Provider Visit Log. Provider Services Reps also include requests for updated information and staffing changes in their monthly rounding calls.

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):
- Molina is still evaluating the results of the above-mentioned initiatives through ongoing auditing and monitoring working to identify trends and insights on our provider data management process, specifically focusing on HiLabs and the Provider Network Management Portal.
- c. Identify any barriers to implementing initiatives:
- The most significant barrier impacting the implementation of accurate provider data is the human component from provider compliance (i.e., CAQH and CHAMPS) to practice/provider staff bandwidth & priorities to report changes timely.

HSAG Assessment: HSAG has determined that **MOL** has addressed the prior year's recommendations. **MOL** has implemented initiatives to ensure provider data accuracy such as routine audits, provider outreach, and streamlining timely data sharing.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

HSAG recommended the following:

- MOL** modified encounters from its subcontractors before submitting them to MDHHS. **MOL** should collaborate with MDHHS to confirm that the identified changes do not require adjustments to be sent back to the subcontractors.
- MOL** indicated that it did not store its pharmacy subcontractor data. To support the **MOL**'s overall capabilities, it should consider storing its subcontractor encounter data within its claims systems, ensuring accessibility for various purposes.
- Although **MOL** submitted institutional and pharmacy encounters in a timely manner, **MOL** did not submit professional or dental encounters timely. About 95 percent of professional encounters were submitted within 300 days from payment, and 64 percent of institutional encounters were submitted within 360 days from payment. **MOL** should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment.
- Although greater than 99.9 percent of provider NPIs identified in the medical/dental data were identified in the provider data, approximately 90 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data. **MOL** should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.

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)*:
- Effective June 2023, Molina is storing data from its pharmacy subcontractor.
 - Molina makes no modifications from its subcontractor's data before submitting to MDHHS.
 - Molina tracks timeliness quality via reports received from all vendors. In addition, Molina has monthly meetings with subcontractors to review all encounter performance measures including timeliness quality checks.
 - Molina implemented a code logic to fix the way Molina was reporting COB on claims / encounters to ensure full compliance and accuracy with state metrics. This included a large resubmission of claims / encounters. Molina is now up to date in submitting all encounters after payment.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

- Molina has implemented use of the MDHHS CHAMPS provider file when validating providers NPI. For Pharmacy, the difference was due to Covid tests being dispensed under the pharmacy NPI as opposed to the pharmacists' NPI. MDHHS policy MSA 21-50 required MHP's to allow pharmacists to be the prescriber for Covid tests, but due to MI being a roster state, applying NPI restrictions would not be possible unless every single pharmacist were to register in CHAMPS. This is no longer an issue due to MDHHS discontinuing coverage of COVID tests.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Molina has higher acceptance metrics at MDHHS due to new initiatives, including a reduction of provider validation rejections.

c. Identify any barriers to implementing initiatives:

- NA

HSAG Assessment: HSAG has determined that **MOL** has partially addressed the prior year's recommendations, demonstrating progress in key areas while leaving room for further improvement.

For the recommendation to store subcontractor encounter data, **MOL** has made significant progress by beginning to store data from its pharmacy subcontractor as of June 2023. This ensures better accessibility and supports overall operational capabilities. This recommendation was fully addressed, as the initiative aligns with HSAG's guidance.

In response to the recommendation to collaborate with MDHHS to confirm that modifications to subcontractor data are not necessary, **MOL** stated that no modifications are made to subcontractor data before submission to MDHHS. While this addresses the immediate concern, ongoing collaboration with MDHHS could provide additional clarity and validation. This recommendation was partially addressed, as proactive engagement with MDHHS would ensure sustained compliance.

Regarding the timeliness of professional and dental encounter submissions, **MOL** has implemented monthly meetings with subcontractors and developed reports to monitor timeliness. Although **MOL** acknowledges prior delays, it has updated its processes and is now current with encounter submissions after payment. This recommendation was fully addressed, provided the timeliness metrics continue to meet expectations.

For the recommendation to collaborate with MDHHS to ensure an accurate and complete provider database, **MOL** implemented the use of the MDHHS CHAMPS provider file for NPI validation. However, issues related to pharmacy NPIs during the COVID-19 pandemic affected accuracy, which **MOL** attributes to state-specific policies that have since been resolved. While **MOL** has addressed the root cause and improved its metrics, ongoing collaboration with MDHHS is needed to ensure sustained accuracy. This recommendation was partially addressed.

In conclusion, **MOL** has made notable progress in addressing HSAG's recommendations, particularly in data storage and encounter submission timeliness. While **MOL** has implemented effective solutions, such as leveraging CHAMPS for NPI validation and improving vendor oversight, further proactive collaboration with MDHHS is recommended to ensure sustained improvements and compliance. **MOL** should continue enhancing its monitoring processes and engaging with MDHHS to validate its practices and maintain data quality. No

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

barriers to implementation were identified, indicating that **MOL** is well-positioned to address any remaining gaps.

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis—Adult and Child Medicaid

HSAG recommended the following:

- **MOL**'s 2023 top-box score was statistically significantly lower than the 2022 adult Medicaid top-box score for one measure, *Customer Service*. HSAG recommends that **MOL** conduct an evaluation of current MHP call center hours and practices to determine if the hours and resources meet members' needs. **MOL** could further promote the use of existing after-hours customer service to improve customer service results. Furthermore, **MOL** could appoint workgroups from call center staff members to discuss and refine existing service standards to enhance staff interactions with members.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

- a. Describe initiatives implemented based on recommendations (*include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation*):
 - Below is a summary of initiatives and actions that took place within 2023 to address the *Customer Service* top-box score for the Adult Medicaid members:
 - In 2023 Molina implemented a Net Promoter Score (NPS) survey to help assess customer service perception and experience. The goal of this survey is to identify both proactive and reactive responses. Molina deployed this survey through email and SMS, which allows Molina to analyze member perception throughout the year.
 - In 2023 Molina implemented more monitoring within the Member Services area. This monitoring allowed for call metrics to be reviewed thoroughly throughout the year. This monitoring also helps assess the reason for the call. This analysis can be used to increase member education, staff education, resources, etc.
- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - Below is a summary of the initiatives results:
 - In 2023 a total of 6,486 NPS surveys were completed. Results of the survey showed majority of callers had a positive experience with 5,113 callers being identified as promoters, 793 detractors, and 580 neutral (66.6 NPS score). Analysis showed that the Molina Medicaid program scored a 96% in courtesy, indicating positive customer service perceptions. To date in 2024 4,296 NPS surveys have been completed with 3,382 callers being promoters, 511 being detractors and 403 neutral (NPS score 66.83). Molina analyzed the call reasons to determine what topics most commonly led to a negative perception. Molina plans to continue the NPS survey to help identify positive and negative perceptions and member experiences.
 - As stated above, Molina has implemented heavier monitoring of the Member Service department. Overall Molina has met all call metrics and determined that the call center is appropriately staffed. Throughout 2024 the average service level has been 93.3%, average handle time 8.1 minutes, average answer time 10 seconds. This is a significant improvement from 2023 where Molina's service level average was 89.6%. Throughout 2024 Molina saw that the most common call reasons were demographic changes and eligibility checks.

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis—Adult and Child Medicaid

c. Identify any barriers to implementing initiatives:

- At the beginning of the year Molina saw a service level 89.1% and answer times of 16 seconds, these metrics are above Molina's goals and targets for the Member Services teams. Since quarter one Molina's call metrics have improved significantly with the average being 97.6%. This continues to be achieved and should impact future customer experience perceptions.
- Through analyzing the call reasons, Molina identified that the most common call reasons were demographic changes, benefit inquiries and eligibility checks. This type of information can be updated or verified through other methods outside the call center. Higher call volume could be attributed from redetermination activities taking place, like asking members to update demographic or changing members' eligibility. Molina would expect that this volume will be significantly lower through the last half of 2024 and throughout 2025 with redetermination activities winding down. During each member interaction Molina also asks if the member would like to opt in to receiving text and/or emails communication. Members can also order ID cards, change PCPs, view benefit information, etc. via the member portal.

HSAG Assessment: HSAG has determined that **MOL** has addressed the prior year's recommendations. The SFY 2024 CAHPS activity confirmed that **MOL**'s score for *Customer Service* for the adult Medicaid population increased from 2023, although not statistically significantly. **MOL** has reported several performance improvement initiatives that continue to be in progress. HSAG recommends that **MOL** continue to implement performance improvement interventions and evaluate their effectiveness.

7. Prior Year Recommendation from the EQR Technical Report for Performance Results—CSHCS

HSAG recommended the following:

- MOL**'s 2023 top-box score was statistically significantly lower than the 2022 top-box score for one measure, *Not Felt Treated Unfairly: Health Insurance Type*. HSAG recommends that **MOL** explore the drivers of this lower experience score and develop initiatives designed to improve quality of care. In addition, **MOL** should consider obtaining direct patient feedback from members to drill down into areas that need improvement.

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*):

- Below is a summary of the member and provider initiatives that took place to assess why members may feel they are not being treated fairly.
 - Throughout 2024, MOL Case Managers surveyed CSHCS members/guardians during case management calls to gauge members perception of MOL as a health plan and its providers. If members feel that they are being treated unfairly by their provider their Case Manager can assist in finding a new provider or filing a complaint. MOL also hired more Case Management staff to support CSHCS members in the beginning of 2024. This allows for staff to dedicate more time to the CSHCS member/guardian. In addition to the aforementioned, MOL completed a prior authorization relaxation within the Utilization Management department. This relaxation increases access and reduces provider and member barriers.

7. Prior Year Recommendation from the EQR Technical Report for Performance Results—CSHCS

- MOL works to ensure that providers are educated and aware of CSHCS benefits. Throughout 2023 and 2024 the health plan used monthly General Orientation sessions and publishes articles in our monthly provider bulletins to educate and promote all facets of the CAHPS survey including being treated fairly. MOL also has a series of Cultural Competency trainings published on our website molinahealthcare.com for providers and their staff to complete, this is promoted through our orientation sessions and monthly provider bulletins. During July 2024 MOL launched a Practice Health Care Transition provider survey to assess availability for special populations of transition-aged youth and young adults, CSHCS Enrollees and those with chronic conditions; the information is/will be used to develop provider and staff training.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Results of the Case Management survey of CSHCS members/guardian showed that members have not reported being treated unfairly to MOL staff.
- Preliminary results of the provider survey indicated that 86% of MOL providers allocate time alone with their patients; however, need further education and support in providing patient/caregiver educational material (Yes-49%; No-51%) and ensuring readiness assessments are regularly updated (Yes-43%; No-57%).

c. Identify any barriers to implementing initiatives:

- Due to the results of the internal survey MOL did not identify any barriers to members perceiving being treated unfairly. Through review MOL believes that wording of the question assessing members perception is leading to the result. The wording of the question is confusing and unclear.

HSAG Assessment: HSAG has determined that **MOL** has addressed the prior year's recommendations. The SFY 2024 CAHPS activity confirmed that **MOL**'s scores for *Not Felt Treated Unfairly: Health Insurance Type* was comparable to the 2023 top-box score. Additionally, **MOL**'s score for *Access to Prescription Medicines* was statistically significantly higher than the 2023 NCQA child Medicaid national average. Furthermore, scores were comparable to the national average and the 2023 top-box scores for all measures for the CSHCS population.

8. Prior Year Recommendation from the EQR Technical Report for Performance Results—HMP

HSAG recommended the following:

- **MOL**'s 2023 top-box scores were not statistically significantly lower than the 2022 NCQA adult Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified. HSAG recommends that **MOL** monitor the measures to ensure significant decreases in scores over time do not occur.

MCE's Response: *(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

a. Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- Molina will continuously track and analyze HMP top-box scores and trend data to ensure we are proactively addressing areas for improvement and delivering the best possible healthcare experience to our members.

8. Prior Year Recommendation from the EQR Technical Report for Performance Results—HMP

- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Molina did not have lower rates than the 2022 NCQA adult Medicaid national averages or show any statistically significant declines in top-box measures from the previous year. Molina achieved statistically significant improvement in two measures: Rating of All Healthcare and Getting Needed Care. Additionally, Molina saw improvements in three other measures—Getting Care Quickly, How Well Doctors Communicate, and Coordination of Care—though these gains were not statistically significant.
- c. Identify any barriers to implementing initiatives:
- At this time, Molina has not identified any specific barriers that may be impacting the tracking and monitoring performance for the MHP CAHPS top-box measures.

HSAG Assessment: HSAG has determined that **MOL** has addressed the prior year’s recommendations as no weaknesses were identified since all 2023 scores were comparable to national averages and the 2022 top-box scores for all measures. HSAG could not verify whether the MHP’s initiatives were successful since HMP CAHPS was not conducted in 2024.

Priority Health Choice

Table 4-7—Prior Year Recommendations and Responses for PRI

1. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Improvement Projects
<p>HSAG recommended the following:</p> <ul style="list-style-type: none"> • PRI did not achieve the state-defined goal for the PIP, and both performance indicators demonstrated non-statistically significant declines in performance as compared to the baseline. HSAG recommends that PRI revisit its causal/barrier analysis to determine if any new barriers exist for both the disparate and comparison populations that require the development of targeted strategies to improve performance.
<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"> • The Quality Improvement team met with our internal Maternal Health workgroup made up of key stakeholders such as: the Population Health & Health Equity team, Quality Clinical Specialist, Care Management and Product Owners to review our causal/barrier from an interdisciplinary perspective using the fish-bone causal analysis. These revised barriers were reviewed by the maternal workgroup to ensure that targeted interventions were highlighted to improve performance for both the disparate and comparison populations. Findings from the workgroup were then disseminated to staff and team members. • Priority Health leads a Consumer Advisory Council (CAC) aimed at receiving feedback from our members regarding our maternal programs and how we can better prioritize their prenatal journey. This feedback is then channeled into the quality improvement process to increase performance and the overall healthcare quality of our members. A doula has been added as a Council member to provide additional insight. • After a thorough maternal health assessment, Priority Health identified that a targeted outreach by our quality Clinical Specialist will help our African American (disparate) prenatal population by getting them connected with maternal programs and resources available, both internally and through some community-based organizations. Outreach to our pregnant members is done bi-weekly to enhance early detection and resolution of any existing Social Determinants of Health (SDoH) need. • Priority Health observed higher Low Birth Weight (LBW) rates in the Detroit area hence we are connecting with our birthing persons in this area with certified Doulas who will educate and closely support these birthing persons through their prenatal journey. <p>b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):</p> <ul style="list-style-type: none"> • Due to the strategies implemented in section 1.a above and those included in the PIP, Priority Health has seen an increase in prenatal care visits. There has been a 4.62 percentage points increase in our overall rate for prenatal care: comparing Measurement Year (MY) 2023 to Measurement Year 2022. <ul style="list-style-type: none"> ○ MY 2021: 79.56%. ○ MY 2022: 80.78%. ○ MY 2023: 85.40%.

1. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Improvement Projects

- Data was also stratified by race, and we observed an 11.81 percentage points increase for African American birthing persons as well as a 2.83 percentage points increase for Caucasian birthing persons: comparing MY 2023 to MY 2022.
- Please see Priority Health's data broken down by race:
 - African American Rate for MY 2022: 65.7%.
 - African American Rate for MY 2023: 77.60% (11.81% increase).
 - Caucasian Rate for MY 2022: 85.43%.
 - Caucasian Rate for MY 2023: 88.26% (2.83% increase).

c. Identify any barriers to implementing initiatives:

- Member may have behavioral health or substance abuse issues that impacts their ability to receive prenatal care.
- Low member engagement in Priority Health programs aimed at increasing prenatal care compliance.
- Limited community resources, low engagement in community programs.
- Lack of childcare since member may not be able to bring additional children to doctor visits.
- Inflexible work schedule of members may inhibit them from getting prenatal care.
- Limited obstetrics provider ratio to members.

HSAG Assessment: HSAG has determined that **PRI** addressed the prior year's recommendation. Within the most recent annual submission the MHP revisited its causal/barrier analysis to identify barriers to care and developed two additional targeted intervention strategies during Remeasurement 2.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

HSAG recommended the following:

- **PRI**'s performance for *Well-Child Visits in the First 30 Months of Life* measure indicators, *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*, ranked between the 25th and 49th percentiles and below the 25th percentile, respectively, indicating children who turned 15 months old during the measurement year were not having at least six well-child visits with a PCP during their first 15 months of life. Additionally, that children who turned 30 months old during the measurement year were not having at least two well-child visits with a PCP in the last 15 months. Well-care visits provide an opportunity for providers to influence the health and development of a child, and they are a critical opportunity for screening and counseling. While **PRI** noted several interventions currently in place to target improvement, such as member outreach via email or letter, distributing a provider newsletter that includes preventive screening requirements, and developing partnerships with various community agencies, performance for the *Well-Child Visits in the First 30 Months of Life* measure remains low. Therefore, HSAG recommends that **PRI** continue its efforts to improve performance for the *Well-Child Visits in the First 30 Months of Life* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified.

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):

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

Well-child visits continue to be an area of focus and of great importance to **Priority Health**. Initiatives include the following:

Member

- Pfizer partnership: Continue to send out mailings and conduct phone calls to members.
- Targeted telephonic outreach: Members due for their well-child visit, lead screening and immunizations receive targeted outreach.
- New- Priority Baby: Created and implemented program to help families navigate through the first two years of a child's life. Well-child education and reminders are provided to the family.
- Member newsletter: Continue to provide reminders to families via the newsletter.

Provider

- Provider Newsletter: Continue to share education on well-child.
- Provider Meeting (Virtual Office Advisory (VOA)): Live or recorded quality program updates shared with providers.
- ACN Meetings: Conducted to go over quality performance.
- Provider HEDIS Guide: Guide is available to ensure they understand the requirements of the measure.

Community

- Continue to attend community events to share education on well-child visits and connect family with needed resources.
- Health Net: Partnership continues in Kent County focuses on pediatric preventative screening reminders for members, family support, and provider engagement.
- Health Families of America-Wayne: Partnership was established to conduct direct referrals for pregnant members that will be followed until the child is 36 months. They help with scheduling appointments, track vaccinations from birth, conduct home visits to ensure well-child visits and vaccinations are completed.
- Brilliant Detroit: Focused on building healthy neighborhoods for families and children. Priority Health participates in their baby showers as well as community talks to bring awareness to preventative screenings.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- From Measurement Year (MY) 2022 to MY 2023, Priority Health saw improvement in both well-child rates. Rate one (1) 0 to 15 months, saw an increase of 13.24 percentage points, rate two (2) also saw an increase of 10.0 percentage points.
 - Well-Child (0 to 15 Months).
 - MY2022: 53.15%.
 - MY2023: 66.39%.
 - Well-Child (15 to 30 Months).
 - MY2022: 59.86%.
 - MY2023: 69.86%.
- Priority Health will continue to focus on pediatric measures to attempt to increase compliance with lead screenings, immunizations and well-child visits.

c. Identify any barriers to implementing initiatives:

- Low member engagement- Unable to reach member, incorrect demographic information.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

- Low member enrollment- Priority Health programs or external.
- Social needs such as childcare, transportation, food, or other social needs.

HSAG Assessment: HSAG has determined that **PRI** addressed the prior year's recommendation for the *Well-Child Visits in the First 30 Months of Life (W30)* measure indicators. **PRI** implemented initiatives such as creating a program to help families navigate through the first two years of a child's life, conducting ongoing telephonic outreach to members due for well-child visits, distributing a provider newsletter, conducting provider meetings to review quality performance, partnering with various community agencies that focus on pediatric preventive screenings, and promoting awareness of preventive screenings. Additionally, the *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator rates significantly increased from the prior measurement year by over 10 percentage points and ranked between the 75th and 89th percentiles and between the 50th and 74th percentiles, respectively, for MY 2023, demonstrating improved performance.

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

HSAG recommended the following:

- While **PRI** demonstrated high performance overall (i.e., 90 percent or high but less than 100 percent) in the Members standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for element 3.6 – *A Member Appeals*. **PRI** was required to submit a CAP to address element 3.6, which was approved by MDHHS. As such, HSAG recommends that **PRI** continue to implement action plans and monitoring processes to ensure all appeals are resolved timely.
- **PRI** demonstrated poorer performance overall (i.e., less than 80 percent) in the OIG/Program Integrity standard and scored below the statewide average. The MHP received a *Not Met* score for elements 6.1 *Quarterly Program Integrity Forms – Tips and Grievances – FY22 Q3*, 6.2 *Quarterly Program Integrity Forms – Data Mining – FY22 Q2*, 6.2 *Quarterly Program Integrity Forms – Data Mining – FY22 Q3*, 6.3 *Quarterly Program Integrity Forms – Audits – FY22 Q2*, 6.3 *Quarterly Program Integrity Forms – Audits – FY22 Q3*, 6.8 – *Quarterly OIG Program Integrity Forms – Encounter Adjustments – FY21 Q4*, 6.8 – *Quarterly OIG Program Integrity Forms – Encounter Adjustments – FY22 Q1*, and 6.8 – *Quarterly OIG Program Integrity Forms – Encounter Adjustments – FY22 Q2*. **PRI** was required to submit CAPs to address elements 6.1, 6.2, 6.3, and 6.8, which were approved by MDHHS. As such, HSAG recommends that **PRI** continue to implement action plans and monitoring processes for noncompliant elements under the OIG/Program Integrity standard to ensure all data reported for program integrity purposes are accurate (i.e., *Tips and Grievances*, *Date Mining*, *Audits*, and *Encounter Adjustments* data).

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

- 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):
 - Member Appeals: Activities implemented include updating the reporting parameters to include member detail for any instance of request for an extension up to 14 days, conducted training for all responsible team members, and changed the internal procedure with future Appeals and Grievances log reporting to include additional auditing for report preparation and submission.
 - Quarterly Program Integrity Forms: Special Investigation Unit (SIU) provided training to all employees/vendors who contribute to the report. The training included the specific errors, as well as review of the guidance document, report examples, and validation steps. Additionally, **Priority Health**

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

encounter data tables have now been populated, allowing full time to prepare and complete the data validations step prior to the submission.

- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - Member Appeals: Priority Health received a Met score for the November 2023 submission.
 - Quarterly Program Integrity Forms: After changes and education, we received a passing score for the next quarterly report.
- c. Identify any barriers to implementing initiatives:
 - Member Appeals: We saw success after training and internal changes to our policies and procedures.
 - Quarterly Program Integrity Forms: We saw success after training and guidance.

HSAG Assessment: HSAG has determined that **PRI** partially addressed the prior year's recommendation. The SFY 2024 compliance review activity demonstrated that **PRI** received a *Met* score for elements 3.6-A and 6.1-6.7 confirming the MHP's action steps were successful in remediating the deficiencies. However, **PRI** received a *Not Met* score for element 6.8. **PRI** did not meet the minimum match requirements for the January 2024 encounter adjustment submission. MDHHS approved **PRI**'s CAP for element 6.8. As such, HSAG recommends that **PRI** continue to implement action plans and monitoring processes to improve encounter adjustment submission match rates.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

- Only 55.8 percent of the sampled provider locations could be reached. HSAG recommends that **PRI** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies.
- Of the locations reached, only 78.5 percent confirmed affiliation with the sampled provider. Additionally, 76.0 percent confirmed accuracy of the sampled address, 61.2 percent confirmed the services were offered, and 45.5 percent confirmed the requested insurance was accepted. HSAG recommends that **PRI** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., records with incorrect specialty or provider information) to address the provider data deficiencies.
- Of the cases responding to the survey and accepting the insurance and new patients, only 57.1 percent of locations offered an appointment date. However, PCPs had an appointment availability rate of 66.7 percent, pediatric providers had an appointment availability rate of 50.0 percent, while OB/GYN provider locations had an appointment availability rate of 28.6 percent. HSAG recommends that **PRI** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **PRI** 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)*:
 - Initiatives implemented by Priority Health included partnering with Quest Analytics Better Doctor Exchange to outreach to providers to validate provider data, increase provider education, and improve the data in the 4275 reports. Additionally, Priority Health monitors Council for Affordable Quality

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

Healthcare (CAQH) Proview and Direct Assure for research and resolve on retired and deceased providers and providers who have opted out of CAQH.

- Quest Analytics Better Doctor Exchange: The validated data are then reviewed and exported back to Priority Health to update our source systems and provider directory.
- Provider Education: Hosted Virtual Office Advisory (VOA) sessions on Prism, a new tool for providers.
- 4275 Report: Updated the data crosswalks between Priority Health systems and created an internal audit dashboard to monitor any data gaps, using a program called Ultrix to better manage the data.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- With the monitoring of the Council for Affordable Quality Healthcare (CAQH) Proview and Direct Assure, we termed several providers who were deceased, retired, or left their group.

c. Identify any barriers to implementing initiatives:

- We did identify a barrier with CAQH Direct Assure with it having limited offerings. As a result, we partnered with a different vendor for the direct consumption of data for accepting new Medicaid patients. For improvement with the 4275 files, the largest challenge we faced was the volume of initial clean-up/corrections identified.
- Providers not notifying Priority Health of data updates/changes.

HSAG Assessment: HSAG has determined that **PRI** has addressed the prior year's recommendations. **PRI** implemented initiatives to ensure provider data accuracy (e.g., routine audits, provider education, process improvements for timely data sharing and monitor any gaps in data).

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

HSAG recommended the following:

- **PRI** did not indicate encounter completeness checks performed for claims/encounters stored in its data warehouses. **PRI** should build a comprehensive set of monitoring reports at the encounter level to evaluate encounter data accuracy, completeness, and timeliness for encounters collected by **PRI**.
- Approximately 81 percent of **PRI** pharmacy encounters had a submit date prior to the payment date. **PRI** should determine the accuracy of the payment and submission date fields and implement quality checks to ensure the submission date is after the payment date field.
- Although greater than 99.9 percent of provider NPIs identified in the medical/dental data were identified in the provider data, approximately 96 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data. **PRI** should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.

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)*:

- Dashboard was created to allow Priority Health to have better oversight of vendor encounters and errors. The dashboard has allowed Priority Health to streamline our vendor monitoring process. Priority Health can review vendor encounters and timeliness of submission. For Pharmacy encounters,

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

extensive reporting is available and monitored by Pharmacy, data are shared with internal partners each week. Pharmacy collaborates with internal partners on trending issues and works on clarifying edits with MDHHS and Express Scripts (ESI).

- In April of 2024, the Priority Health Pharmacy Benefits Manager (PBM), Express Scripts, switched to a “Prompt payment plan” which will shorten the timeframe a pharmacy is paid to 14 days after receipt of the claim. This will allow ESI to ‘hold’ the encounter until after the pharmacy paid date/check date but still meet the minimum volume requirements each month.
- Not all Medicaid-enrolled providers are prescribers of medication. This statistic is expected, and our plan feels that no action is required.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- The dashboard has allowed us to track vendor performance, this has allowed us to be more proactive and ensure volume submission has met compliance. This has led to improved communication and relationships with our vendors. Can be more proactive when identifying issues and notify MDHHS is needed.

c. Identify any barriers to implementing initiatives:

- No current barriers identified at the moment.

HSAG Assessment: HSAG has determined that **PRI** has partially addressed the prior year’s recommendations, but certain areas remain partially unresolved or require additional efforts.

Regarding the recommendation to build a comprehensive set of monitoring reports to evaluate encounter data accuracy, completeness, and timeliness, **PRI** developed a dashboard to enhance oversight of vendor encounters and errors. This tool enables monitoring of timeliness and submission compliance, which has improved vendor performance tracking and communication. However, the response does not provide detailed evidence that the monitoring reports comprehensively address encounter-level accuracy and completeness. This recommendation was partially addressed, as the dashboard shows promise but could be expanded to include more robust encounter-level analyses.

For the recommendation to address pharmacy encounters with a submit date prior to the payment date, **PRI** implemented a new "Prompt Payment Plan" with its PBM, Express Scripts, in April 2024. This plan ensures that payment and submission dates are aligned, effectively resolving this issue. This recommendation was fully addressed, as the corrective action aligns with the recommendation and improves compliance.

In response to the recommendation to collaborate with MDHHS to ensure an accurate and complete database of contracted providers, **PRI** stated that not all Medicaid-enrolled providers are prescribers, which it views as an explanation rather than an issue requiring resolution. However, the response does not include evidence of collaboration with MDHHS to address potential data discrepancies. This recommendation was not addressed, as greater collaboration is essential to maintaining accurate provider data.

In conclusion, **PRI** has made meaningful progress in addressing timeliness issues for pharmacy encounters, demonstrating effective use of a payment plan to align submission processes. The dashboard developed for monitoring vendor performance shows promise but could benefit from enhancements to provide encounter-level accuracy and completeness checks. Collaboration with MDHHS to ensure an accurate provider database remains a gap that requires focused attention. **PRI** should consider expanding its dashboard functionality,

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

engaging in proactive collaboration with MDHHS, and maintaining regular audits to ensure sustained data quality and compliance. No significant barriers to implementation were identified, indicating **PRI**'s readiness to address remaining gaps with appropriate resource allocation.

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis—Adult and Child Medicaid

HSAG recommended the following:

- **PRI**'s 2023 top-box score was statistically significantly lower than the 2022 adult Medicaid top-box score for one measure, *Rating of Specialist Seen Most Often*. HSAG recommends that **PRI** continue to explore what may be driving the lower experience score, develop initiatives designed to improve quality of care, and focus on improving members' overall experiences with their specialist. **PRI** should determine if there is a shortage of specialists in the area or an unwillingness of the specialists to contract with the MHP that could be contributing to a lack of network adequacy and access issues.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

- Describe initiatives implemented based on recommendations (*include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation*):
 - Priority Health shared the 2022 adult Medicaid reports with our providers through different avenues for awareness and transparency, highlighting the scores for the measure, *Rating of Specialist Seen Most Often*. The reports were shared using the Provider Newsletter and Provider Virtual Office Advisory (VOA). This initiative is aimed at increasing the awareness of our specialist providers and deepening their understanding on how our members feel and view the care they receive.
 - Priority Health also led an interdisciplinary brainstorming activity in our CAHPS workgroup to determine strategies to improve the quality of care and our member's overall satisfaction, with intentional focus on the rating of specialist measure.
 - Additionally, Priority Health interacted with our members through the Consumer Advisory Council (CAC) to identify member's priorities for their overall quality of care, with emphasis on the Rating of Specialist measure.
 - Priority Health started a CAHPS team comprised of Subject Matter Experts (SME), to discuss strategies for improving member experience and satisfaction. Meetings are held monthly to review internal Customer Experience Scores (CES) and stakeholders from Customer Experience (CX), Member Communications and Advance Analytics are invited to share insights on how our member's overall health care experience can be enhanced.
 - County level data is reviewed and used to understand the populations served and prescribe targeted interventions for the different counties served.
 - Diverse forms of member communications have been adopted to prepare members ahead of their appointments, this will help members maximize the limited time they have with the specialist, get their concerns addressed, thereby enhancing the member's experience.
- Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - Based on the aforementioned strategies and interventions Priority Health has seen a 5.8 percentage points increase in our 2023 Adult Medicaid CAHPS scores.
 - 2023 Rating of Specialist Seen – 60.2%.
 - 2024 Rating of Specialist Seen – 66.0% (5.8% increase).

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis—Adult and Child Medicaid

- For the child survey, Priority Health did identify a decrease in performance when comparing 2023 to 2024. Priority Health will continue to find innovative strategies to maintain a steady increase of our members' experience and overall healthcare quality.

c. Identify any barriers to implementing initiatives:

- Limited specialists in rural areas impacting availability of providers and longer wait times for members.
- The survey is anonymous, and we have no visibility into how to assist members who have recorded negative experience through the survey.
- The surveys can be overwhelming and quite lengthy for some members.

HSAG Assessment: HSAG has determined that **PRI** has addressed the prior year's recommendation. The SFY 2024 CAHPS activity confirmed that **PRI**'s score for *Rating of Specialist Seen Most Often* for the adult Medicaid population increased from 2023, although not statistically significantly. HSAG recommends that **PRI** continue to implement performance improvement interventions and evaluate their effectiveness.

7. Prior Year Recommendation from the EQR Technical Report for Performance Results—CSHCS

HSAG recommended the following:

- PRI**'s 2023 top-box score was statistically significantly lower than the 2022 NCQA child Medicaid national average for one measure, *Customer Service*. HSAG recommends that **PRI** conduct an evaluation of current MHP call center hours and practices to determine if the hours and resources meet members' needs. **PRI** could further promote the use of existing after-hours customer service to improve customer service results. Furthermore, **PRI** could appoint workgroups from call center staff members to discuss and refine existing service standards to enhance staff interactions with members.

MCE's Response: *(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:

- Review of Grievances and Appeals: PRI reviews our grievances and appeals report with the CAHPS workgroup. In reviewing the grievances and appeals data we highlight the key themes of member dissatisfaction and initiate resolution as well as process improvement, if needed.
- Quality Call Audits: PRI conducts call audits to enhance our customer service interactions with members.
- Customer Satisfaction Surveys: PRI conducts Customer Satisfaction surveys year-round to understand how our members feel and view the health plan and identify trends to barriers they might be experiencing. Meetings are held monthly to review internal Customer Experience Scores (CES) and stakeholders from Customer Experience (CX), Member Communications and Advance Analytics are invited to share insights on how our member's overall health care experience can be enhanced.
- Report Sharing: CSHCS reports are reviewed in the CAHPS workgroup where stakeholders like the Customer Services team and Care Management brainstorm on improvement strategies, based on the data received.
- Ensuring the Customer Service center is appropriately trained and staffed to answer calls.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- PRI continues to track performance for various call center metrics to help increase member satisfaction.

7. Prior Year Recommendation from the EQR Technical Report for Performance Results—CSHCS

c. Identify any barriers to implementing initiatives:

- Poor communication: Miscommunication between departments or with customers can lead to errors, misunderstandings, or dissatisfaction.
- Limited post-call feedback from members.

HSAG Assessment: HSAG has determined that **PRI** has addressed the prior year's recommendations. The SFY 2024 CAHPS activity confirmed that **PRI**'s score for *Customer Service* was comparable to the 2023 top-box score. Additionally, **PRI**'s score for *Rating of Health Plan* was statistically significantly higher than the 2023 NCQA child Medicaid national average. Furthermore, scores were comparable to the national average and the 2023 top-box scores for all measures for the CSHCS population.

8. Prior Year Recommendation from the EQR Technical Report for Performance Results—HMP

HSAG recommended the following:

- **PRI**'s 2023 top-box scores were not statistically significantly lower than the 2022 NCQA adult Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified. HSAG recommends that **PRI** monitor the measures to ensure significant decreases in scores over time do not occur.

MCE's Response: *(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:

- Priority Health continues to discuss improvement tactics in the CAHPS workgroup with key stakeholders to steadily increase our performance on all measures.
- HEDIS Workgroup: Priority Health meets on a monthly basis with the HEDIS workgroup to develop improvement strategies which impacts the overall quality of care our members receive.
- CAHPS Team: The CAHPS team led by various Subject Matter Experts (SMEs) meet monthly to address all aspects and processes for enhancing our members' experience. This team revises and leads strategies to ensure continuous improvement in how we serve our members.
- CAHPS Reports: The Quality Improvement team shares all CAHPS reports with stakeholders and member-facing teams to increase visibility for all measures and drive quality improvement.
- Customer Experience Survey (CES) Comments: After each phone interaction with our members, a brief CES survey is sent as a follow-up to have a better understanding of how our members view and feel about their overall healthcare. The scores are then evaluated, and key recurring themes are extracted to serve as a guide to quality improvement.
- Consumer Advisory Council (CAC): The CAC meetings are held quarterly with our members to receive direct feedback on our programs. Feedback from this forum helps Priority Health to revise or enhance our different ongoing programs.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- In effect of Priority Health's continuous improvement efforts, we have seen an increase for measures such as Getting Needed Care (1.69% increase), Rating of Health plan (3.89% increase), Getting Care Quickly (2.56% increase), and How Well Doctor communicate (2.04% increase), just to mention a few.

8. Prior Year Recommendation from the EQR Technical Report for Performance Results—HMP

c. Identify any barriers to implementing initiatives:

- Survey Anonymity: Due to the anonymity of these CAHPS survey, Priority Health is unable to identify those members that were dissatisfied with the services they received to attempt to eliminate barriers for these members.
- Length of survey: The length of the surveys can be intimidating and overwhelming for members to complete, leading to lower response rates.

HSAG Assessment: HSAG has determined that **PRI** has addressed the prior year’s recommendations as no weaknesses were identified since all 2023 scores were comparable to national averages and the 2022 top-box scores for all measures. HSAG could not verify whether the MHP’s initiatives were successful since HMP CAHPS was not conducted in 2024.

UnitedHealthcare Community Plan

Table 4-8—Prior Year Recommendations and Responses for UNI

1. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Improvement Projects
<p>HSAG recommended the following:</p> <ul style="list-style-type: none"> UNI did not demonstrate significant improvement over the baseline performance for the first remeasurement period, with the results demonstrating a non-statistically significant decrease in performance. HSAG recommends that UNI revisit its causal/barrier analysis to determine if any new barriers exist for selected population that require the development of targeted strategies to improve performance.
<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"> UNI reviews and updates its causal/barrier analysis annually. Activities still underway include: Referring all members to maternal infant health program (MIHP) services, referrals to the Perinatal Community Health Worker program, promoting Babyscripts, and referrals to the Healthy First Steps program. We continue cultural competency training for providers, offer provider incentives, support doula services, and continue are Member Advisory Group. <p>Additional activities implemented were:</p> <ul style="list-style-type: none"> Mom's Meals allowing pregnant members in high-risk regions to receive two nutritious meals a day for up to 27 weeks of their pregnancy. Educating MIHP providers about the significance of prenatal appointments for their members. We are emphasizing the importance of ensuring that pregnant individuals attend their medical appointments during and after pregnancy, and that MIHP care does not replace these appointments. Providing free pregnancy tests to our members to promote early detection of pregnancy and engagement in prenatal care.
<p>b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):</p> <ul style="list-style-type: none"> UNI increased the use of the Babyscript application among our members. This improved engagement shows more members attending their prenatal care appointments and earning more rewards compared to previous measurement periods. The Health First Steps program successfully increased outreach to pregnant members. This initiative improved access to timely care, ensuring more pregnant women receive essential education and assessments. Doula claims continue to increase for our members, helping to promote the importance of timeliness of care.
<p>c. Identify any barriers to implementing initiatives:</p> <ul style="list-style-type: none"> Members may be difficult to contact for outreach which can limit engagement in educational initiatives.

1. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Improvement Projects

HSAG Assessment: HSAG has determined that **UNI** addressed the prior year's recommendation. Within the most recent annual submission, the MHP revisited its causal/barrier analysis to identify barriers to care; however, the MHP maintained the same intervention strategies as used in Remeasurement 1.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

HSAG recommended the following:

- **UNI's** performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked between the 25th and 49th percentiles, indicating children who turned 30 months old during the measurement year were not always getting at least two well-child visits with a PCP in the last 15 months. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling. While **UNI** noted several interventions currently in place to target improvement, such as provider incentives for meeting the recommended visits, providing additional support for low-performing providers, and offering transportation assistance to address identified SDOH needs, performance remained low for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator. Therefore, HSAG recommends that **UNI** continue its efforts to improve performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified.
- **UNI's** performance for the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* measure indicator ranked between the 25th and 49th percentiles, indicating some children were not always receiving one or more well-care visits during the measurement year. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling. HSAG recommends that **UNI** conduct a root cause analysis or focused study to determine why some children ages 12 to 17 years did not receive timely well-care visits. Upon identification of a root cause, **UNI** should implement appropriate interventions to improve the performance related to the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* measure.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

- 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):
 - Measure #1 - Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months - Two or More Well-Child. UNI monitors and expands upon existing initiatives as contributing factors are identified. Live agents conduct member outreach to offer appointment scheduling assistance with reminder calls and rescheduling, if necessary. Provider communication includes newsletters, fax blasts, and direct quality staff contact with gaps in care reports stressing the importance of well-child visits. Co-branded letters to members also highlight the importance of well-child visits, encourage appointment scheduling, and offer transportation assistance.
 - Measure #2 - Child and Adolescent Well-Care Visits—Ages 12 to 17 Years. A root cause analysis was conducted for well-care visits (WCVs), age 12 to 17 years. Member communications with provider cobranding letter campaigns are ongoing. In 2023 and 2024, UNI partnered with provider groups to

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

conduct WCV focused events. UNI has ongoing provider education regarding WCVs via provider meetings, emails, and fax blasts. Community health workers outreach to families due for WCVs to help with scheduling, locating a new PCP, and arranging transportation, if needed. Provider and member incentives are also available for completing well-care visits – age 12 to 17 years.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Measure #1- Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months - Two or More Well-Child improved by 3.08 percent from 60.54 percent in 2022 to 63.62 percent in 2023. UNI will continue to implement continuous quality improvement initiatives and incorporate interventions into our processes.
- Measure #2 - Child and Adolescent Well-Care Visits—Ages 12 to 17 Years improved by 2.61 percent from 50.53 percent in 2022 to 53.14 percent in 2023. UNI is now ranked between the 50th and 66.67th percentile.

c. Identify any barriers to implementing initiatives:

- Measure #1 - Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child – No barriers identified.
- Measure #2 Child and Adolescent Well-Care Visits—Ages 12 to 17 Years – Access in rural locations and evening and weekend access.

HSAG Assessment: HSAG has determined that **UNI** has partially addressed the prior year’s recommendations. **UNI** implemented initiatives in response to HSAG’s prior year recommendation for the *Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator by monitoring and expanding upon existing initiatives, conducting live member outreach to offer appointment scheduling assistance with reminder calls, issuing provider communication which included newsletters, and facilitating gaps in care report reviews with a focus on well-child visits. Additionally, co-branded letters with PCPs were distributed to members highlighting the importance of well-child visits while offering transportation assistance. However, although the rate demonstrated a statistically significant increase by over 3 percentage points, **UNI** continues to demonstrate low performance for the measure indicator as the rate ranked between the 25th to 49th percentiles for MY 2023. HSAG therefore recommends that **UNI** continue its efforts on further improving the *Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator rate and monitoring the impact of initiatives currently in place to ensure improved performance.

HSAG has determined that **UNI** addressed the prior year’s recommendation for the *Child and Adolescent Well-Care Visits (WCV)—Ages 12 to 17 Years* measure indicator. **UNI** conducted a root cause analysis for measure indicator performance and implemented member communications with provider cobranded letters, partnered with provider groups to conduct well-care visit focused events, conducted provider education regarding measure benchmarks, assigned community health workers to outreach families due for well-care visits and to assist or arrange transportation if needed, and offered provider and member incentives for completing well-care visits for members age 12 to 17 years. Additionally, the rate increased significantly from the prior measurement year by over 2 percentage points and ranked between the 50th and 74th percentiles for MY 2023, demonstrating improved performance.

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

HSAG recommended the following:

- **UNI** demonstrated poorer performance overall (i.e., less than 80 percent) in the OIG/Program Integrity standard and scored below the statewide average. The MHP received a *Not Met* score for elements 6.1 *Quarterly Program Integrity Forms – Tips and Grievances – FY21 Q4*, 6.1 *Quarterly Program Integrity Forms – Tips and Grievances – FY22 Q2*, 6.2 *Quarterly Program Integrity Forms – Data Mining – FY21 Q4*, 6.2 *Quarterly Program Integrity Forms – Data Mining – FY22 Q2*, 6.2 *Quarterly Program Integrity Forms – Data Mining – FY22 Q3*, 6.3 *Quarterly Program Integrity Forms – Audits – FY21 Q4*, 6.3 *Quarterly Program Integrity Forms – Audits – FY22 Q2*, 6.3 *Quarterly Program Integrity Forms – Audits – FY22 Q3*, 6.4 *Quarterly Program Integrity Forms – Provider Disenrollments – FY21 Q4*, and 6.8 – *Quarterly OIG Program Integrity Forms – Encounter Adjustments FY22 Q2*. **UNI** was required to submit CAPs to address elements 6.1, 6.2, 6.3, 6.4, and 6.8, which were approved by MDHHS. HSAG recommends that **UNI** continue to implement action plans and monitoring processes for noncompliant elements under the OIG/Program Integrity standard to ensure all data reported for program integrity purposes are accurate (i.e., *Tips and Grievances*, *Data Mining*, *Audits*, *Provider Disenrollments*, and *Encounter Adjustments* data).

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

- Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):
 - UNI updated our report generation standard operating procedure (SOP) as well as created a quality review guidance document. The Program Integrity Manager and Compliance Officer use the quality review document when completing their final quality review prior to report submission. In addition, UNI updated the report generation timeline which allows additional time for quality review prior to the submission due date.
- Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - UNI received a score of MET in FY24 Q1 and Q3 for all elements of the 6.1-6.8 Quarterly Program Integrity Report. UNI also received a score of MET for FY24 Q2 for components 6.1-6.7.
- Identify any barriers to implementing initiatives:
 - No barriers were identified. Additional corrections to the internal SOP and guidance documents were completed in April 2024 and in August 2024 to address newly identified areas of opportunity.

HSAG Assessment: HSAG has determined that **UNI** partially addressed the prior year's recommendation. While **UNI** addressed the prior recommendations based on the reported initiatives, the SFY 2024 compliance review activity confirmed that **UNI** had continued data discrepancies on the program integrity reports and did not meet the minimum match requirements for the April 2024 encounter adjustment submission and received *Not Met* scores for elements 6.1-6.7 and 6.8. MDHHS approved **UNI**'s CAP for elements 6.1-6.7 and 6.8. As such, HSAG recommends that **UNI** continue to implement action plans and monitoring processes to improve the accuracy of its program integrity reports and encounter adjustment submission match rates.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

- Only 58.7 percent of the sampled provider locations could be reached. HSAG recommends that **UNI** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies.
- Of the locations reached, only 54.9 percent confirmed affiliation with the sampled provider. Additionally, 51.4 percent confirmed accuracy of the sampled address, 29.6 percent confirmed the services were offered, and 24.6 percent confirmed the requested insurance was accepted. HSAG recommends that **UNI** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., records with incorrect specialty or provider information) to address the provider data deficiencies.
- Of the cases responding to the survey and accepting the insurance and new patients, only 50.0 percent of locations offered an appointment date. However, pediatric providers had an appointment availability rate of 54.5 percent, while PCPs had an appointment availability rate of 25.0 percent. HSAG recommends that **UNI** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **UNI** 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)*:

- UNI utilized the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to update provider data. To partner with providers, UNI offers several options for practices to validate data including online and by fax. Additionally, UNI incorporates other opportunities to improve data accuracy including, but not limited to:
 - Synaptic Health Alliance which allows sharing of demographics between health plans and providers, identifies demographic variances, shares attestation data obtained by other alliance members, and potentially reduces provider abrasion and increases directory quality.
 - Google API an externally published website which drives demographic comparisons for both facility and professional providers.
 - Trust Evaluator which compiles and assesses demographic information across multiple external resources, e.g., NPPES, CAQH, LexisNexis, roster, etc.
- Established data controls and proactive business rule detections allow for updates to be made to identified defects within 30 days. UNI initiatives have shifted over time to increase data accuracy in direct relation to realized improvements - for what has been determined to be problematic data within the healthcare industry. Initiatives are carefully reviewed monthly and maintained or changed as evidenced by results. Data controls and proactive business rule detections include, but are not limited to:
 - Proactive defect detection rules triggered during demographic loading, alerting the data loader of potential issues to review and opportunity to remediate before the error is introduced into production.
 - Provider demographic information is compared against USPS standardization rules to ensure accuracy.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

- Enhanced roster certification and maintenance processes with dedicated loaders for improved quality and turnaround time for large groups.
- Continuous review of policies and loading instructions to improve and simplify processes.
- UNI utilizes provider advocate outreach to educate provider office staff on their participation as well as their contractual obligation regarding appointment time frames.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- UNI improved the number of provider locations that could be reached from 2022 to 2023 by 13.2 percent.

c. Identify any barriers to implementing initiatives:

- Multiple attempts to contact providers to validate data.

HSAG Assessment: HSAG has determined that **UNI** has addressed the prior year's recommendations. **UNI** has addressed data deficiencies noted in the case-level analytic data files. Also, **UNI** implemented initiatives to ensure provider data accuracy (e.g., data validation, provider outreach, process improvements for timely data sharing) and promote appointment availability by educating office staff on their contractual obligation regarding appointment time frames.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

HSAG recommended the following:

- **UNI** modified encounters from its subcontractors before submitting them to MDHHS. **UNI** should collaborate with MDHHS to confirm that the identified changes do not require adjustments to be sent back to the subcontractors.
- Approximately 99 percent of **UNI** pharmacy encounters had a submit date prior to the payment date. **UNI** should determine the accuracy of the payment and submission date fields and implement quality checks to ensure the submission date is after the payment date field.
- Although **UNI** submitted professional and institutional encounters in a timely manner, **UNI** did not submit dental encounters timely. About 91 percent of dental encounters were submitted within 360 days of payment. **UNI** should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment.
- Although greater than 99.9 percent of provider NPIs identified in the medical/dental data were identified in the provider data, approximately 95 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data. **UNI** should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.

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)*:

- Recommendation #1 – UNI confirmed that the identified changes do not require adjustments to be sent back to the subcontractors. UNI's response to the encounter data validation questionnaire Section D, question one, erroneously indicated that we modified encounters from subcontractors. To clarify, UNI ingests subcontractor data into our encounter system and translates it into the appropriate 837 and NCPDP file layouts but does not modify claim data elements.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

- Recommendation #2 – UNI determined the accuracy of the payment and submission data fields. UNI batches claim every three days to begin the payment cycle. This batch process allows UNI to set check dates and numbers which are posted to the claim and subsequently reported on encounter files. This process ensures prompt provider payment and ensures providers receive funded payment within 14 days of claim submission.
- Recommendation #3 – UNI monitors dental encounter data submissions to Michigan Department of Health and Human Services (MDHHS). Due to cost settlement, MDHHS recommended UNI resubmit a subset of dental claims. UNI created an encounter file with the requested adjustments to avoid provider abrasion. As a result of this requested adjustment, historical encounters were included in the rate of 91 percent reported.
- Recommendation #4 - UNI collaborates with MDHHS regarding provider NPI mismatches between the encounter data and the state's provider file on a consistent basis. UNI compares encounters manually against MDHHS' provider files and any discrepancies found are communicated to ensure resolution.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Recommendation #3 - When UNI excluded the impacted encounters, our internal reporting shows that 98.6 percent of dental encounters were submitted within 360 days of payment.

c. Identify any barriers to implementing initiatives:

- Recommendation #4 - A barrier to improving provider data and encounter data NPI matches is the inability to receive retro-terminations before we pay claims.

HSAG Assessment: HSAG has determined that **UNI** has partially addressed the prior year's recommendations.

For the recommendation to collaborate with MDHHS to confirm that modifications to subcontractor data do not require adjustments to be sent back, **UNI** clarified that it does not modify subcontractor claim data but only translates it into appropriate file formats. This clarification addresses the issue, and the recommendation was fully addressed.

Regarding the recommendation to address pharmacy encounters with a submit date prior to the payment date, **UNI** implemented a batch process that aligns submission and payment dates by setting check dates and numbers during the batching cycle. This ensures timely payments and accurate reporting on encounter files. This recommendation was fully addressed, as the described process aligns with HSAG's requirements.

In response to the recommendation to improve the timeliness of dental encounter submissions, **UNI** attributed the lower percentage to a cost settlement request from MDHHS, which required the resubmission of historical claims. Excluding the affected encounters, **UNI** reported that 98.6 percent of dental encounters met timeliness requirements. While the corrective actions address the issue, maintaining consistent timeliness metrics is essential. This recommendation was partially addressed.

For the recommendation to collaborate with MDHHS to ensure an accurate and complete database of contracted providers, **UNI** manually compares encounter data with MDHHS's provider file and communicates discrepancies for resolution. While this shows active collaboration, a more automated or scalable approach could improve efficiency. This recommendation was partially addressed.

In conclusion, **UNI** has effectively resolved recommendations related to subcontractor data modifications and pharmacy encounter submission timelines. While efforts to improve dental encounter timeliness and provider

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

NPI accuracy are ongoing, additional measures, such as automating data comparison processes, could enhance results. A noted barrier is **UNI**'s inability to receive retro-terminations for provider data before claims are paid, which impacts **UNI**'s accuracy. Addressing these barriers and further strengthening collaboration with MDHHS will help **UNI** fully meet HSAG's expectations. Overall, **UNI** has demonstrated progress, but some recommendations require continued focus for full resolution.

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis—Adult and Child Medicaid

HSAG recommended the following:

- **UNI**'s 2023 top-box scores were not statistically significantly lower than the 2022 NCQA adult and child Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified. HSAG recommends that **UNI** monitor the measures to ensure significant decreases in scores over time do not occur.

MCE's Response: *(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

- Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:
 - **UNI** continues to address opportunities for performance improvement and monitor the measures to ensure significant decreases in scores over time do not occur.
 - **UNI** partners with Press Ganey, an industry leader in patient experience. Through this partnership, providers have access to interactive modules and downloadable guides to assist them with improving the patient experience. Each module focuses on a specific element of the member experience including *Rating of Personal Doctor* and *Getting Care Quickly*.
- Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - From 2023 to 2024, **UNI**'s adult member experience in *Rating of Personal Doctor* improved by 6.70 percent and *Getting Care Quickly* improved by 3.4 percent. **UNI** will continue to implement continuous quality improvement initiatives.
- Identify any barriers to implementing initiatives:
 - Annually available data makes it challenging to monitor the impact of performance improvement activities.

HSAG Assessment: HSAG has determined that **UNI** has partially addressed the prior year's recommendations. The SFY 2024 CAHPS activity confirmed that **UNI**'s score for *Rating of Health Plan* for the child Medicaid population was statistically significantly lower than the 2023 NCQA child national average. However, **UNI** has reported several performance improvement initiatives that continue to be in progress. HSAG recommends that **UNI** continue to implement performance improvement interventions and evaluate their effectiveness.

7. Prior Year Recommendation from the EQR Technical Report for Performance Results—CSHCS

HSAG recommended the following:

- **UNI**'s 2023 top-box scores were statistically significantly lower than the 2022 top-box score for two measures, *How Well Doctors Communicate* and *Not Felt Treated Unfairly: Health Insurance Type*. HSAG recommends that **UNI** provide literature to doctors and other health providers containing guidelines for how they can ensure they explain things in a way that is easy for the member to understand and that they spend enough time with the member. The literature also could furnish advice concerning the importance of

7. Prior Year Recommendation from the EQR Technical Report for Performance Results—CSHCS

listening carefully to members and how clinicians can show respect for what the member has to say. Providers may not be communicating well with parents/caregivers of child members or spending adequate time with the member to provide the quality of care the member anticipates or expects to meet their or their child's healthcare needs.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:

- UNI encourages providers to participate in a series of educational guides that support their efforts to improve the patient experience. The educational series offers continuing medical education (CME) credits, encompass provider resources, articles, tools, and training sessions which include a focus on effective communication.
- UNI incorporated the availability of interpretative services into provider meetings with a goal to improve provider-patient communication, member engagement and understanding.
- UNI reviews CAHPS survey results during our provider advisory committee with emphasis on recognized areas for improvement.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- UNI's 2024 top-box score for *How Well Doctors Communicate* improved and is now above the 2023 NCQA national average.

c. Identify any barriers to implementing initiatives:

- Annually available data makes it challenging to monitor the impact of performance improvement activities.

HSAG Assessment: HSAG has determined that **UNI** has partially addressed the prior year's recommendations. **UNI**'s scores for *How Well Doctors Communicate* and *Not Felt Treated Unfairly: Health Insurance Type* were comparable to the 2023 top-box scores. However, the SFY 2024 CAHPS activity confirmed that **UNI**'s score for *Customer Service* was statistically significantly lower than the 2023 NCQA child Medicaid national average. However, **UNI** has reported several performance improvement initiatives that continue to be in progress. HSAG recommends **UNI** continue to implement performance improvement interventions and evaluate their effectiveness.

8. Prior Year Recommendation from the EQR Technical Report for Performance Results—HMP

HSAG recommended the following:

- **UNI**'s 2023 top-box score was statistically significantly lower than the 2022 top-box score for one measure, Getting Needed Care. HSAG recommends that **UNI** conduct root cause analyses or focus studies to determine why its members are not getting the quality of care they need, or do not have access to care. **UNI** could consider if there are disparities within its populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, **UNI** should implement appropriate interventions to improve the performance related to the care members need.

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)*:

8. Prior Year Recommendation from the EQR Technical Report for Performance Results—HMP

- UNI conducted a root cause analysis to identify factors that likely play a role in survey responses for Getting Needed Care.
- There was not a disparity found between Caucasian and Black members in 2023 for Getting Needed Care.
- UNI conducted direct member communication to improve awareness of how to access needed care and other benefits.
- UNI encourages providers to participate in a series of educational guides that support their efforts to improve the patient experience. The educational series offers continuing medical education (CME) credits, encompass provider resources, articles, tools, and training sessions which includes a focus on Promoting Access to Care, Virtual Care and Ease of Getting Care.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- In 2024, there was a reverse disparity of 6.2 percent between Caucasians and Black members. Initiatives are ongoing and performance improvement will be evaluated.

c. Identify any barriers to implementing initiatives:

- Annually available data makes it challenging to monitor the impact of performance improvement activities.

HSAG Assessment: HSAG has determined that **UNI** has addressed the prior year’s recommendations for the *Getting Needed Care* measure. HSAG could not verify whether the MHP’s initiatives were successful since HMP CAHPS was not conducted in 2024.

Upper Peninsula Health Plan

Table 4-9—Prior Year Recommendations and Responses for UPP

1. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Improvement Projects
<p>HSAG recommended the following:</p> <ul style="list-style-type: none"> • UPP did not achieve the state-defined goal of eliminating the existing disparity with the first remeasurement period, and the comparison group demonstrated a statistically significant decrease in performance as compared to the baseline. HSAG recommends that UPP revisit its causal/barrier analysis to determine if any new barriers exist for both the disparate and comparison populations that require the development of targeted strategies to improve performance.
<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 Clinical Coordinator conducted targeted outreach to Black members within the cohort who were unmet for AAP. Outreach was attempted three times; two different attempts via telephone and one attempt via letter for those unable to reach via telephone. • UPHP has a close relationship with our Prepaid Inpatient Health Plan (PIHP), Northcare Network (NCN). Through this partnership, UPHP distributes care gap lists for shared membership for specific measures on an ongoing basis. UPHP expanded the care gap list to include AAP. <p>b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):</p> <ul style="list-style-type: none"> • CY 2023 PIP outreach and mailing was evaluated in Q1 and Q2 of 2024. UPHP Clinical Coordinator successfully reached by telephone 13.8% (18/130) of members. Of the members reached, 16.6% (3/18) did go on to complete care. Outreach planned again for October 2024. <p>c. Identify any barriers to implementing initiatives:</p> <ul style="list-style-type: none"> • Inability to reach members due to invalid phone number or mailing address. Analysis indicated that 86.1% (112/130) of outreach was unsuccessful (unable to reach member).
<p>HSAG Assessment: HSAG has determined that UPP addressed the prior year's recommendation. Within the most recent annual submission the MHP revisited its causal/barrier analysis to identify barriers to care; however, the MHP maintained the same intervention strategies as used in Remeasurement 1.</p>
2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation
<p>HSAG recommended the following:</p> <ul style="list-style-type: none"> • UPP's performance for all <i>Chlamydia Screening in Women</i> measure indicators ranked below the 25th percentile, indicating that women identified as sexually active were not always receiving at least one test for chlamydia during the measurement year. Screening is important, as approximately 75 percent of chlamydia infections in women are asymptomatic. While UPP noted several interventions currently in place to target improvement, such as including the measure in the 2023 HEDIS Value-Based Payment Alternative Payment Model and distributing educational letters to members ages 16 to 24 years on the importance of chlamydia screenings, performance for the <i>Chlamydia Screening in Women</i> measure indicators remains

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

low. Therefore, HSAG recommends that **UPP** continue its efforts to improve performance for the *Chlamydia Screening in Women* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified.

- **UPP's** performance for the *Child and Adolescent Well-Care Visits—Ages 12 to 17, Ages 18 to 21 Years*, and *Total* measure indicators ranked between the 25th and 49th percentiles, indicating some children ages 3 to 21 years were not always receiving one or more well-care visit during the measurement year. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling. While **UPP** noted several interventions currently in place to target improvement, such as assisting members ages 18 to 21 years with establishing a new PCP, providing member education on the importance of well-care visits, and mailing a Transition to Adulthood care letter for members turning 18 years old, performance remains low for the *Child and Adolescent Well-Care Visits—Ages 12 to 17, Ages 18 to 21 Years*, and *Total* measure indicators. Therefore, HSAG recommends that **UPP** continue its efforts to improve performance for the *Child and Adolescent Well-Care Visits* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified.
- **UPP's** performance for the *Kidney Health Evaluation for Patients with Diabetes—Ages 75 to 85 Years* measure indicator ranked between the 25th and 49th percentiles, indicating that some members ages 75 to 85 years with a diagnosis of diabetes did not receive kidney health evaluations. Approximately 1 in 3 adults with diabetes has chronic kidney disease. HSAG recommends that **UPP** conduct a root cause analysis or focused study to identify potential provider barriers, such as challenges in standardizing the inclusion of needed lab testing in treatment or appointment availability and to determine why some members with diabetes were not receiving kidney health evaluations. Upon identification of root causes, **UPP** should then implement appropriate member- and provider-focused interventions to improve the performance related to the *Kidney Health Evaluation for Patients with Diabetes* measure.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

- 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*):
 - *Chlamydia Screening in Women*: UPHP text message campaign to all eligible members with education on importance of screening. Chlamydia article included in the provider newsletter on education and screening tips. Chlamydia screening highlighted in UPHP's annual collaborative Healthy Kids Healthy Futures campaign toolkits (provider and member). New in 2024, UPHP developed a member report card to those with gaps in care, chlamydia recommended screening is included, this report card is mailed to members. New in 2025, UPHP plans to implement a sexual health campaign encompassing all Sexual Transmitted Infection's, recommended screening, preventative care and benefits, and locations to obtain care. This campaign will include radio, billboard, provider and member toolkits, and social media.
 - *Child and Adolescent Well-Care Visits—Ages 12 to 17, Ages 18 to 21 Years and Child and Adolescent Well-Care Visits*: UPHP's annual collaborative Healthy Kids, Healthy Futures (HKHF) campaign is aimed at increasing annual well-care visits, lead screening, and immunizations. In Summer 2024, a record 25 primary care clinics took part, covering 10 of the 15 counties in Region 1. Participating clinics received promotional campaign materials including posters, magnets, and window clings. UPHP provides clinic specific care gap lists for targeted outreach during the campaign. Additionally, digital

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

promotional toolkits are provided to aid in increasing outreach and completion of well-care, immunizations, and lead screening. During the campaign, well-care is also a focus across UPHP's social media platforms, billboards, print and digital ads, while also running a two-month radio spot in the Region. New in 2024, UPHP initiated an incentive for members 5 - 21 years of age who complete a well-care visit at one of the four school-based clinics (SBC) connected to a local health department. The \$15 Subway gift card incentive is available to the first 20 UPHP Medicaid members who complete a well-care visit at each SBC during the year. UPHP utilizes a text/IVR campaign to outreach to members in the WCV measure. Separated into three age cohorts, 3-11 years of age, 12-17 years of age, and 18-21 years, a message campaign consisting of six unique messages is sent to members every few weeks educating them on the importance of WCV, encouraging completion, and providing links to schedule with their PCP, benefit information, transportation assistance, and more. A mailing was developed for children turning age 11 years of age that focuses on recommended immunizations, encouraging completion of these at their PCP office. This has the indirect effect of engaging these children in health care and completing a WCV. Seven community resource fairs have been cohosted and/or attended by UPHP Clinical Services staff so far in 2024, who have had booths sharing information and offering assistance for children and families' SDOH needs and overcoming barriers to obtaining preventive health care.

- *Kidney Health Evaluation for Patients with Diabetes—Ages 75 to 85 Years:* Measure is included in UPHP's Value-Based Payment Alternative Payment Model. UPHP conducts quarterly meetings with providers, care managers, and office staff. During the meetings, each clinic's Kidney Health Evaluation performance is reviewed, and barriers are identified. Analysis identified barriers including incorrect coding, providers not ordering all tests, and patient refusal of urine sample.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- *Chlamydia Screening in Women:* Rate has remained steady, 2022 rate was 45.755 and 2023 rate was 45.40%.
- *Child and Adolescent Well-Care Visits—Ages 12 to 17, Ages 18 to 21 Years and Child and Adolescent Well-Care Visits:* The HKHF campaign had a record 25 practice locations take part in the 7th annual campaign. This resulted in hundreds more patients across UPHP's coverage area having the opportunity for engagement and direct outreach from their PCP office. Preliminary data from the campaign show an overall average WCV improvement rate from July to August of 8.94%. Analysis of the WCV text/IVR outreach for MY2023 revealed a 37.75% improvement in WCV completion after the intervention.
 - WCV has seen rate improvements for all age cohorts year-over-year. Review of September 2023 versus September 2024 WCV rates show ages 3-11 increased 5.7% (37.13 to 42.83), ages 12-17 increased 5.72% (30.73 to 36.45), and ages 18-21 increased 4.51% (17.78 to 22.29). Overall, the year-over-year increase for WCV is 6.17% (31.78 to 37.95). Measurement year 2024 September rates for each age cohort and WCV overall are each the highest they have been in September of any year since the AWC measure was amended and WCV was created in MY 2021, with the exception of the 12-17 cohort. In September 2021 the 12-17 cohort was 36.99%, while the current rate is 36.45%, putting it 0.54% below the highest percentage achieved to date.
- *Kidney Health Evaluation for Patients with Diabetes—Ages 75 to 85 Years:* 2023 showed a rate increase of 13.44% points.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

c. Identify any barriers to implementing initiatives:

- *Chlamydia Screening in Women*: Declines noted due to use of birth control for reasons aside from preventing pregnancy.
- *Child and Adolescent Well-Care Visits—Ages 12 to 17, Ages 18 to 21 Years and Child and Adolescent Well-Care Visits*: Inaccurate contact information hinders reaching members with care gaps to ensure member facing initiatives are successful. This is especially prominent for members ages 18 – 21 who often have not had their information updated from when they were a minor and living with a guardian. UPHP clinical coordinators coordinate with a wide range of entities to improve successful contact with families, such as utilizing access to Upper Peninsula Health Information Exchange (UPHIE), Michigan Care Improvement Registry (MCIR), PCP electronic medical records (EMR), contacting PCP/OBGYN/Specialists shown on recent claims data, LHDs, homeless shelters UPHP CHWs serve, the Regional Health Liaison Officer for MDHHS Foster Care, etc. Initiatives that involve direct contact via telephone from a clinical coordinator at UPHP have been found to be inefficient and not as welcomed as when parents/members hear directly from their PCP office. Having the child's provider's office reach out to those with gaps has proven beneficial, as parents have built a positive, trusting relationship with not only the provider, but also the nursing and support staff. Communications coming from their office are more positively received than outreach coming from their Medicaid plan. Another barrier to initiative implementation is that health care providers are stretched and have significant competing priorities, often with limited resources. Combining limited staff with a significant number of daily health care tasks can mean that contacting patients who are not engaged or are behind is not always a priority. For this reason, UPHP attempts to make it as easy as possible by identifying the attributed members with care gaps and providing the listing to the clinic. UPHP provides gap lists to clinics for outreach and appointment scheduling on a routine basis and encourages the clinics to contact the children's health clinical coordinator directly for any assistance that will help ease their workload. UPHP also provides clinics with Cotiviti Provider Intelligence and Member Registry Tool so they can log in at any time to review their attributed members care gaps. On the patient side, clinics routinely report parents feel well-care visits are unnecessary. UPHP works to mitigate this belief by providing education to provider staff on the importance of utilizing every touchpoint to discuss the benefits of WCV and providing them with materials for members/patients and their families.
- *Kidney Health Evaluation for Patients with Diabetes—Ages 75 to 85 Years*: Denominator remains small, 71 members for 2022 and 86 members for 2023. Analysis identified barriers including incorrect coding, providers not ordering all tests, and patient refusal of urine sample.

HSAG Assessment: HSAG has determined that **UPP** has partially addressed the prior year's recommendations. **UPP** has put forth effort to address HSAG's prior year recommendation for the *Chlamydia Screening in Women (CHL)* measure indicators by implementing a text message campaign to all eligible members with education on the importance of screening, including a chlamydia article in its provider newsletter, and highlighting chlamydia screening in its annual collaborative HKHF campaign toolkit for providers and members. However, the rates for the *Chlamydia Screening in Women (CHL)—Ages 16 to 20 Years, Ages 21 to 24 Years, and Total* measure indicators ranked below the 25th percentile. Barriers noted by **UPP** include members declining screening due to use of birth control for reasons aside from preventing pregnancy. HSAG recommends that **UPP** continue its efforts to improve performance for the *Chlamydia Screening in Women (CHL)* measure, initiatives should be monitored and expanded upon as additional contributing factors are identified.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measure Validation

HSAG has determined that **UPP** addressed the prior year's recommendation for the *Child and Adolescent Well-Care Visits (WCV)—Ages 12 to 17, Ages 18 to 21 Years*, and *Total* measure indicators. **UPP** conducted an annual collaborative HKHF campaign aimed at increasing annual well-care visits, provided clinic specific care gap lists for targeted outreach during the campaign, provided digital promotional toolkits to members to promote complete well-care visits, and utilized various platform such as billboards, digital ads, and radio spots to promote completion of well-care visits. All measure indicator rates increased from the prior measurement year and ranked between the 50th and 74th percentiles for MY 2023, demonstrating improved performance for the *Child and Adolescent Well-Care Visits (WCV)—Ages 12 to 17, Ages 18 to 21 Years*, and *Total* measure indicators.

HSAG has determined that **UPP** addressed the prior year recommendation for the *Kidney Health Evaluation for Patients with Diabetes (KED)—Ages 75 to 85 Years* measure indicator. **UPP** conducted quarterly meetings with providers and reviewed each clinic's performance and identified any barriers. Additionally, the rate increased by over 13 percentage points from the prior measurement year and ranked between the 50th and 74th percentiles for MY 2023, demonstrating improved performance.

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

HSAG recommended the following:

- While **UPP** demonstrated moderate performance overall (i.e., 80 percent or higher but less than 90 percent) in the Providers standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for elements 2.17 – *Provider Site Performance Standards and Thresholds*, 2.21 – *Secret Shopper Calls – PCP Secret Shopper Calls*, and 2.22 *Non-Emergency Medical Transportation (NEMT)*. **UPP** was required to submit a CAP to address element 2.22, which was approved by MDHHS. However, for element 2.17, **UPP** entered a CAP with NCQA; therefore, MDHHS did not require any further action. Additionally, at the time MDHHS provided HSAG with the compliance review findings, MDHHS had not yet determined if a CAP will be required to address element 2.21. As such, HSAG recommends that **UPP** continue to implement action plans and monitoring processes to ensure that the MHP sets appropriate standards and thresholds for provider site reviews, ensures all contracted providers are aware of their contracts and notify the MHP when they are no longer accepting new patients, and checks all states' sex offender registries for NEMT driver qualifications.
- While **UPP** demonstrated high performance overall (i.e., 90 percent or higher but less than 100 percent) in the Members standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for element 3.20 – *Maintaining and Sharing Member Health Records*. **UPP** entered a CAP with NCQA; therefore, MDHHS did not require any further action. As such, HSAG recommends that **UPP** continue to implement action plans developed as part of the NCQA CAP process, review the results of the action plans regularly, and update its action plans as necessary.

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 element 2.17-*Provider Site Performance Standards and Thresholds*, UPP developed policy 104-048 Practitioner Office Site Quality effective 02/06/2023. This policy was reviewed by NCQA during UPP's 2023 Health Plan Accreditation survey and UPP achieved a MET score for standard MED 3.

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

- For element 3.20 – *Maintaining and Sharing Member Health Record*, UPHP updated policy 104-043 Medical Record Documentation and Maintenance standards on 03/13/2023 and 04/04/23. This policy was reviewed by NCQA during UPHP’s 2023 Health Plan Accreditation survey and UPHP achieved a MET score for standard MED 5B.
- For element 2.21 – *Secret Shopper Calls – PCP Secret Shopper Calls*, UPHP implemented SOP 510-1054 Secret Shopper Survey, to conduct annual review of provider network to verify accuracy of information provided from offices.
- For element 2.22 *Non-Emergency Medical Transportation (NEMT)*, UPHP updated UPHP Policy 401-031 NEMT Provider Attestation to include and implemented checking the Michigan State Policy Sex Offender Registry (MSPSOR) which also requires registration of all sex offenders including out of state offenses for those that come to MI from another state. This is done prior to onboarding and annually thereafter.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- For element 2.17- *Provider Site Performance Standards and Thresholds*, UPHP has an established process for site visits.
- For element 2.21, UPHP established 510-1054 Secret Shopper Survey, to conduct calls annually to verify provider office acceptance rate and provide education to providers who do not meet requirements.

c. Identify any barriers to implementing initiatives:

- For element 2.17 and 3.20 there were no barriers identified.
- For element 2.21, provider offices continue to experience staffing issues with providers.

HSAG Assessment: HSAG has determined that **UPP** partially addressed the prior year’s recommendation. The SFY 2024 compliance review activity demonstrated that **UPP** received a *Met* score for elements 2.17, 3.20, and 2.22, confirming the MHP’s action steps were successful in remediating the deficiencies. However, **UPP** received a *Not Met* score for element 2.21 as the MHP did not meet the 75 percent standard for the following items: *PCPs who are “accepting new patients” in submitted provider file and online directory and is confirmed during the call, PCPs who have the “acceptance of Medicaid MHP” on the submitted provider file that matches what shows in the online directory and is confirmed during the call, Pediatric PCPs who are “accepting new patients” in submitted provider file and online directory and is confirmed during the call, Pediatric PCPs who have location and contact data on the submitted provider file that matches what shows in the online directory and confirmed during the call, and Pediatric PCPs who have the “acceptance of Medicaid MHP” on the submitted provider file that matches what shows in the online directory and is confirmed during the call.* MDHHS did not require any action related to these deficiencies as it was analyzing findings for possible enforcement action. As such, HSAG recommends that **UPP** continue to implement action plans and monitoring processes to improve the accuracy of provider data and its provider directory.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

- Of the locations reached, only 77.5 percent confirmed the requested insurance was accepted. HSAG recommends that **UPP** use the case-level analytic data files containing provider deficiencies identified during the survey (i.e., records with incorrect insurance information) to address the provider data deficiencies.
- Of the cases responding to the survey and accepting the insurance and new patients, only 66.2 percent of locations offered an appointment date. However, pediatric providers had an appointment availability rate of

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

87.5 percent, PCPs had an appointment availability rate of 65.4 percent, while OB/GYN provider locations had an appointment availability rate of 50.0 percent. HSAG recommends that **UPP** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **UPP** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

MCE's Response: *(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:

- UPHP continues to conduct an annual secret shopper survey on the provider network to verify information is listed correctly and verify provider acceptance. UPHP also conducts phone outreach to provider offices based off the provider demographic information within the Provider Directory to verify accuracy. This is conducted quarterly. Any discrepancies are corrected within the provider database. UPHP continues to send Quarterly Provider Practice Verification forms to all contracted provider groups to verify and update provider demographic information. Continue to provide education to provider offices regarding UPHP acceptance of members and members wait times for available dates through Provider Newsletters, Provider InService, and New Provider Orientation Packets. UPHP updated policy 200-013 Timely Access to Care.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- The audits have corrected any discrepancies of provider demographic information that is listed within the provider database. Information is corrected immediately within the provider database.

c. Identify any barriers to implementing initiatives:

- Provider offices continue to have staffing issues between office staff and providers, which prevents these offices in accepting new patients.

HSAG Assessment: HSAG has determined that **UPP** has addressed the prior year's recommendations. **UPP** implemented initiatives to ensure provider data accuracy (e.g., annual secret shopper survey, scheduled provider outreach) and promoting appointment availability through provider education on appointment wait times.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

HSAG recommended the following:

- **UPP** did not indicate timeliness quality checks performed for claims/encounters stored in its data warehouses. **UPP** should build a comprehensive set of monitoring reports to evaluate encounter data accuracy, completeness, and timeliness for encounters collected by **UPP**.
- Although greater than 99.9 percent of provider NPIs identified in the medical/dental data were identified in the provider data, approximately 88 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data. **UPP** should work with MDHHS to ensure both entities have an accurate and complete database of contracted providers.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data 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)*:
 - UPHP implemented a monthly encounter monitoring activity on the auditing and monitoring workplan which reviews timeliness, acceptance rates and rejection outliers in April 2024.
 - UPHP currently reviews weekly encounter files and continues to work with our encounter vendor in monitoring file submissions and responses to ensure acceptance and timeliness.
 - UPHP and our pharmacy vendor meet monthly to review provider data to ensure it aligns with MDHHS provider data.
- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - No improvement to date but the Encounter trends are formally documented within the Encounter auditing & monitoring monthly workplan.
- c. Identify any barriers to implementing initiatives:
 - At this time, none are noted.

HSAG Assessment: HSAG has determined that **UPP** has not fully addressed the specific recommendations provided in the prior year report.

For the recommendation to build a comprehensive set of monitoring reports to evaluate encounter data accuracy, completeness, and timeliness, **UPP's** response focused on general provider engagement and service coordination rather than addressing the development of monitoring tools. There is no evidence of specific initiatives or tools designed to meet this requirement. This recommendation was not addressed. Developing and implementing robust monitoring systems is essential for ensuring high-quality encounter data.

Regarding the recommendation to work with MDHHS to maintain an accurate and complete database of contracted providers, **UPP's** response does not indicate any specific actions taken to address discrepancies in pharmacy provider NPIs. While **UPP** has improved provider collaboration through trainings and meetings, there is no evidence of direct collaboration with MDHHS to resolve NPI mismatches. This recommendation was not addressed. Active collaboration with MDHHS and implementing automated systems for database alignment are necessary steps to improve provider data accuracy.

In conclusion, while **UPP** has demonstrated efforts to improve provider relationships and member service outcomes, it has not taken direct action to address HSAG's recommendations for encounter data monitoring or provider database accuracy. To fully resolve these gaps, **UPP** should prioritize the development of monitoring tools that evaluate encounter data accuracy, completeness, and timeliness. Additionally, proactive collaboration with MDHHS to address provider NPI mismatches is critical. Although **UPP** faces challenges related to provider availability, these should not impede progress on critical compliance and data quality initiatives. Focused efforts and resource allocation can help **UPP** meet these expectations effectively.

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis—Adult and Child Medicaid

HSAG recommended the following:

- **UPP**'s 2023 top-box score was statistically significantly lower than the 2022 adult Medicaid top-box score for one measure, *Rating of Health Plan*. HSAG recommends that **UPP** continue to explore the drivers of this lower experience score and develop initiatives designed to improve quality of care.
- **UPP**'s 2023 top-box score was statistically significantly lower than the 2022 child Medicaid national average and 2022 child Medicaid top-box score for one measure, *Rating of All Health Care*. HSAG recommends that **UPP** continue to explore the drivers of this lower experience score and develop initiatives designed to improve quality of care.

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*):
 - The UPHP CAHPS Taskforce, a dedicated group within our Service Advisory Committee (SAC), meets regularly throughout the year to review CAHPS scores and identify actions to maintain or boost our performance. We've rolled out several initiatives to enhance services and coordination across the UPHP Adult and Child Medicaid/CSHCS and HMP provider network. We've focused on building stronger relationships with providers through in-service trainings and personalized one-on-one sessions. In these meetings, UPHP staff walks through available member services and support tools for providers, ensuring everyone has the resources they need for success.
- Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - Our one-on-one sessions with provider offices have received positive feedback, which has strengthened our collaboration with providers.
 - For 2024 Medicaid Adult CAHPS UPHP showed improvement in *Rating of All Health Plan* against 2022 and 2023 numbers.
- Identify any barriers to implementing initiatives:
 - We continue to explore provider education opportunities, though we face challenges due to the limited time availability of providers.

HSAG Assessment: HSAG has determined that **UPP** has partially addressed the prior year's recommendations. The SFY 2024 CAHPS activity confirmed that **UPP**'s 2024 score for *Rating of All Health Care* for the child Medicaid population was statistically significantly lower than the 2023 NCQA child Medicaid national average. However, the SFY 2024 CAHPS activity confirmed that **UPP**'s 2024 score for *Rating of Health Plan* for the adult Medicaid population was statistically significantly higher than the 2023 NCQA adult Medicaid national average. **UPP** has reported several performance improvement initiatives that continue to be in progress. HSAG recommends that **UPP** continue to implement performance improvement interventions and evaluate their effectiveness.

7. Prior Year Recommendation from the EQR Technical Report for Performance Results—CSHCS

HSAG recommended the following:

- **UPP**'s 2023 top-box scores were not statistically significantly lower than the 2022 NCQA child Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified. HSAG recommends that **UPP** monitor the measures to ensure significant decreases in scores over time do not occur.

7. Prior Year Recommendation from the EQR Technical Report for Performance Results—CSHCS

MCE's Response: *(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

- a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:
 - As mentioned earlier, the UPP CAHPS Taskforce, a dedicated group within our Service Advisory Committee (SAC), meets regularly throughout the year to review CAHPS scores and implement strategies to maintain or enhance our performance. Additionally, we distribute an annual CSHCS feedback survey to evaluate how well our team is managing all aspects of care coordination for these members.
- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - The CSHCS survey team is currently reviewing results and create action items based on any gaps found.
- c. Identify any barriers to implementing initiatives:
 - Communication of services for this population can be difficult. We are looking at finding more creative ways to engage with members.

HSAG Assessment: HSAG has determined that **UPP** has addressed the prior year's recommendations. The SFY 2023 CAHPS activity confirmed that **UPP's** score for *Rating of Health Plan* and *Customer Service* was statistically significantly higher than the 2023 NCQA child Medicaid national average. Furthermore, scores were comparable to the national average and the 2023 top-box scores for all measures for the CSHCS population.

8. Prior Year Recommendation from the EQR Technical Report for Performance Results—HMP

HSAG recommended the following:

- **UPP's** 2023 top-box scores were not statistically significantly lower than the 2022 NCQA adult Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified. HSAG recommends that **UPP** monitor the measures to ensure significant decreases in scores over time do not occur.

MCE's Response: *(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

- a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:
 - The UPHP CAHPS Taskforce, a dedicated group within our Service Advisory Committee (SAC), meets regularly throughout the year to review CAHPS scores and identify actions to maintain or boost our performance. We've rolled out several initiatives to enhance services and coordination across the UPHP Adult and Child Medicaid/CSHCS and HMP provider network. We've focused on building stronger relationships with providers through in-service trainings and personalized one-on-one sessions. In these meetings, UPHP staff walks through available member services and support tools for providers, ensuring everyone has the resources they need for success.
- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - Our one-on-one sessions with provider offices have received positive feedback, which has strengthened our collaboration with providers.

8. Prior Year Recommendation from the EQR Technical Report for Performance Results—HMP

c. Identify any barriers to implementing initiatives:

- Provider education remains a challenge due to the limited time providers have available for direct training.

HSAG Assessment: HSAG has determined that **UPP** has addressed the prior year's recommendations as no weaknesses were identified since all 2023 scores were comparable to national averages and the 2022 top-box scores for all measures. HSAG could not verify whether the MHP's initiatives were successful since HMP CAHPS was not conducted in 2024.

5. Medicaid Health Plan Comparative Information

In addition to performing a comprehensive assessment of each MHP's performance, HSAG uses a step-by-step process methodology to compare the findings and conclusions established for each MHP to assess the CHCP. Specifically, HSAG identifies any patterns and commonalities that exist across the nine MHPs and the CHCP, draws conclusions about the overall strengths and weaknesses of the program, and identifies areas in which MDHHS could leverage or modify Michigan's CQS to promote improvement.

Medicaid Health Plan External Quality Review Activity Results

This section provides the summarized results for the mandatory and optional EQR activities across the MHPs.

Validation of Performance Improvement Projects

For the SFY 2024 validation, the MHPs submitted Remeasurement 2 data for the state-mandated PIP topic addressing disparities in care. Table 5-1 displays each PIP and whether a disparity exists, and provides a comparison of the validation rating and outcome scores by MHP.

Table 5-1—Comparison of PIP Validation by MHP

MHP	PIP Topic	Validation Rating 1	Validation Rating 2	Design and Implementation Scores			Outcomes Scores			Disparity (Yes/No)
				Met	Partially Met	Not Met	Met	Partially Met	Not Met	
AET	<i>Addressing Disparities in Timeliness of Prenatal Care</i>	<i>High Confidence</i>	<i>Moderate Confidence</i>	100%	0%	0%	67%	0%	33%	No
BCC	<i>Reducing Racial Disparities Within Timeliness of Prenatal Care</i>	<i>High Confidence</i>	<i>No Confidence</i>	100%	0%	0%	33%	0%	67%	Yes
HCS	<i>Improving the Timeliness of Prenatal Care</i>	<i>High Confidence</i>	<i>No Confidence</i>	100%	0%	0%	33%	0%	67%	NA
MCL	<i>Addressing Disparities in Timeliness of Prenatal Care</i>	<i>High Confidence</i>	<i>No Confidence</i>	100%	0%	0%	33%	0%	67%	Yes
MER	<i>Addressing Disparities for Timeliness of Prenatal Care:</i>	<i>High Confidence</i>	<i>No Confidence</i>	100%	0%	0%	33%	0%	67%	No

MHP	PIP Topic	Validation Rating 1	Validation Rating 2	Design and Implementation Scores			Outcomes Scores			Disparity (Yes/No)
				Met	Partially Met	Not Met	Met	Partially Met	Not Met	
	<i>Addressing Racial Health Disparities</i>									
MOL	<i>Addressing Disparities for Timeliness of Prenatal Care</i>	<i>High Confidence</i>	<i>No Confidence</i>	94%	6%	0%	33%	0%	67%	Yes
PRI	<i>Improving Timeliness of Prenatal Care for African American Women</i>	<i>High Confidence</i>	<i>No Confidence</i>	100%	0%	0%	33%	0%	67%	Yes
UNI	<i>Addressing Disparities in Timeliness of Prenatal Care</i>	<i>High Confidence</i>	<i>No Confidence</i>	100%	0%	0%	33%	0%	67%	NA
UPP	<i>Reducing Racial Disparities in Adult Ambulatory and Preventive Access to Care in Members Ages 20–44</i>	<i>High Confidence</i>	<i>No Confidence</i>	100%	0%	0%	33%	0%	67%	Yes

NA = The MHP did not identify a disparity within its population; therefore, an assessment of an existing disparity during R2 is not applicable.

Performance Measure Validation

Table 5-2 displays the HEDIS MY 2023 performance levels. Table 5-3 displays the HEDIS MY 2022 and HEDIS MY 2023 Michigan Medicaid weighted averages, comparison of performance between 2022 and 2023, and the performance level for 2023. Statewide weighted averages were calculated and compared from HEDIS MY 2022 to HEDIS MY 2023, and comparisons were based on a Chi-square test of statistical significance with a p value of <0.01 considered statistically significant due to large denominators. Of note, 2022 to 2023 comparison values are based on comparisons of the exact HEDIS MY 2022 and HEDIS MY 2023 statewide weighted averages rather than on rounded values.

For most measures in Table 5-3, the performance levels compare the HEDIS MY 2023 statewide weighted average to the NCQA Quality Compass national Medicaid HMO percentiles for HEDIS MY 2022 (referred to as “percentiles”), as displayed in Table 5-2.¹¹³

Table 5-2—HEDIS MY 2023 Performance Levels

Performance Levels	Percentile
★★★★★	90th percentile and above
★★★★	75th to 89th percentile
★★★	50th to 74th percentile
★★	25th to 49th percentile
★	Below 25th percentile

Table 5-3—Overall Statewide Averages for HEDIS MY 2022 and HEDIS MY 2023 Performance Measures

Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–2023 Comparison ¹	MY 2023 Performance Level ²
Child & Adolescent Care				
<i>Childhood Immunization Status (CIS)</i>				
Combination 3	57.62%	58.72%	+1.10 ⁺	★★
Combination 7	49.59%	50.19%	+0.59	★
Combination 10	25.29%	23.67%	-1.62 ⁺⁺	★
<i>Well-Child Visits in the First 30 Months of Life (W30)</i>				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	60.06%	64.33%	+4.27 ⁺	★★★★★

¹¹³ MY 2023 performance levels were based on comparisons to national Medicaid HMO Quality Compass HEDIS MY 2022 benchmarks.

Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–2023 Comparison ¹	MY 2023 Performance Level ²
<i>Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i>	60.86%	66.19%	+5.34 ⁺	★★
Lead Screening in Children (LSC)				
<i>Lead Screening in Children</i>	54.78%	58.40%	+3.62 ⁺	★★
Child and Adolescent Well-Care Visits (WCV)				
<i>Ages 3 to 11 Years</i>	59.20%	61.33%	+2.13 ⁺	★★★★
<i>Ages 12 to 17 Years</i>	50.38%	52.14%	+1.76 ⁺	★★★★
<i>Ages 18 to 21 Years</i>	28.31%	30.51%	+2.20 ⁺	★★★★★
<i>Total</i>	50.89%	53.31%	+2.41 ⁺	★★★★
Immunizations for Adolescents (IMA)				
<i>Combination 1 (Meningococcal, Tdap)</i>	76.96%	79.43%	+2.47 ⁺	★★
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	29.35%	32.73%	+3.37 ⁺	★★
Women—Adult Care				
Chlamydia Screening in Women (CHL)⁴				
<i>Ages 16 to 20 Years</i>	59.35%	57.65%	-1.71 ⁺⁺	★★★★
<i>Ages 21 to 24 Years</i>	66.34%	64.80%	-1.54 ⁺⁺	★★★★
<i>Total</i>	62.76%	61.06%	-1.70 ⁺⁺	★★★★
Cervical Cancer Screening (CCS-E)				
<i>Cervical Cancer Screening</i>	59.16%	54.97%	-4.19 ⁺⁺	★★
Breast Cancer Screening (BCS-E)				
<i>Breast Cancer Screening</i>	53.61%	55.00%	+1.39 ⁺	★★★★
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
<i>Ages 20 to 44 Years</i>	72.86%	73.23%	+0.37 ⁺	★★★★
<i>Ages 45 to 64 Years</i>	82.59%	82.76%	+0.17	★★★★
<i>Ages 65 Years and Older</i>	89.52%	89.13%	-0.39	★★★★★
<i>Total</i>	76.43%	76.80%	+0.37 ⁺	★★★★
Pregnancy Care				
Prenatal and Postpartum Care (PPC)⁴				
<i>Timeliness of Prenatal Care</i>	78.45%	83.81%	+5.36 ⁺	★★
<i>Postpartum Care</i>	75.33%	76.15%	+0.82	★★

Measure	HEDIS MY 2022	HEDIS MY 2023	MY 2022–2023 Comparison ¹	MY 2023 Performance Level ²
Living With Illness				
Hemoglobin A1c Control for Patients With Diabetes (HBD)				
Poor HbA1c Control (>9.0%)*	39.01%	33.05%	-5.96 ⁺	★★★★★
HbA1c Control (<8.0%)	53.53%	59.05%	+5.52 ⁺	★★★★★
Eye Exam for Patients With Diabetes (EED)⁴				
Eye Exam for Patients With Diabetes	54.81%	57.29%	+2.48 ⁺	★★★★
Blood Pressure Control for Patients With Diabetes (BPD)				
Blood Pressure Control for Patients With Diabetes	66.93%	70.49%	+3.57 ⁺	★★★★★
Kidney Health Evaluation for Patients With Diabetes (KED)				
Ages 18 to 64 Years	35.09%	38.15%	+3.06 ⁺	★★★★
Ages 65 to 74 Years	36.52%	39.64%	+3.11 ⁺	★★★★
Ages 75 to 85 Years	34.44%	38.57%	+4.13	★★★★
Total	35.16%	38.24%	+3.08 ⁺	★★★★
Asthma Medication Ratio (AMR)				
Total	57.73%	57.78%	+0.05	★
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	62.07%	63.71%	+1.63 ⁺	★★★★
Diagnosed Mental Health Disorders (DMH)				
Ages 1 to 17 Years	21.17%	23.87%	+2.70 ⁺	★★★★
Ages 18 to 64 Years	32.84%	35.37%	+2.53 ⁺	★★★★
Ages 65 Years and older	37.34%	36.93%	-0.40	★★★★
Total	28.56%	30.95%	+2.39 ⁺	★★★★

¹ Weighted averages were calculated and compared from HEDIS MY 2022 to HEDIS MY 2023, and comparisons were based on a Chi-square test of statistical significance with a p value of <0.01 due to large denominators. Rates shaded green with one cross (+) indicate statistically significant improvement from the previous year. Rates shaded red with two crosses (++) indicate statistically significant decline in performance from the previous year. Of note, MY 2022–2023 Comparison values are based on comparisons of the exact HEDIS MY 2022 and HEDIS MY 2023 statewide weighted averages, not rounded values.

² Performance Levels for MY 2023 were based on comparisons of the HEDIS MY 2023 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks.

³Significance testing was not performed for Utilization-based measure indicator rates.

Green Shading⁺ Indicates that the HEDIS MY 2023 MWA demonstrated a significant improvement from the HEDIS MY 2022 MWA.

Red Shading⁺⁺ Indicates that the HEDIS MY 2023 MWA demonstrated a significant decline from the HEDIS MY 2022 MWA.

⁴ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

Please note that for the *Diagnosed Mental Health Disorders (DMH)* measure, a higher or lower rate does not indicate better performance, as the measure provides information on the diagnosed prevalence of mental health disorders.

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

HEDIS MY 2023 Performance Levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Table 5-4 presents, by measure, the number of MHPs that performed at each performance level. The counts include only measures with a valid, reportable rate that could be compared to percentiles. Therefore, not all row totals will equal nine MHPs.

Table 5-4—Count of MHPs by Performance Level

HEDIS Measure	MHPs' Performance Level – Star Count				
	★	★★	★★★	★★★★	★★★★★
Child & Adolescent Care					
<i>Childhood Immunization Status (CIS)</i>					
<i>Combination 3</i>	4	4	1	0	0
<i>Combination 7</i>	6	2	1	0	0
<i>Combination 10</i>	8	0	1	0	0
<i>Well-Child Visits in the First 30 Months of Life (W30)</i>					
<i>Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	1	1	1	5	1
<i>Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i>	2	4	2	1	0
<i>Lead Screening in Children (LSC)</i>					
<i>Lead Screening in Children</i>	0	8	1	0	0
<i>Child and Adolescent Well-Care Visits (WCV)</i>					
<i>Ages 3 to 11 Years</i>	0	2	7	0	0
<i>Ages 12 to 17 Years</i>	1	2	6	0	0
<i>Ages 18 to 21 Years</i>	0	1	3	5	0
<i>Total</i>	1	1	7	0	0
<i>Immunizations for Adolescents (IMA)</i>					
<i>Combination 1 (Meningococcal, Tdap)</i>	1	7	1	0	0
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	2	6	1	0	0

HEDIS Measure	MHPs' Performance Level – Star Count				
	★	★★	★★★	★★★★	★★★★★
Women—Adult Care					
<i>Chlamydia Screening in Women (CHL)</i>¹					
<i>Ages 16 to 20 Years</i>	1	0	4	3	1
<i>Ages 21 to 24 Years</i>	1	0	5	3	0
<i>Total</i>	1	0	4	3	1
<i>Cervical Cancer Screening (CCS-E)</i>					
<i>Cervical Cancer Screening</i>	2	7	0	0	0
<i>Breast Cancer Screening (BCS-E)</i>					
<i>Breast Cancer Screening</i>	0	1	7	1	0
Access to Care					
<i>Adults' Access to Preventive/Ambulatory Health Services (AAP)</i>					
<i>Ages 20 to 44 Years</i>	1	1	5	2	0
<i>Ages 45 to 64 Years</i>	0	2	5	2	0
<i>Ages 65 Years and Older</i>	2	0	1	5	1
<i>Total</i>	0	1	5	2	0
Pregnancy Care					
<i>Prenatal and Postpartum Care (PPC)</i>¹					
<i>Timeliness of Prenatal Care</i>	3	2	3	0	1
<i>Postpartum Care</i>	4	3	1	0	1
Living With Illness					
<i>Hemoglobin A1c Control for Patients With Diabetes (HBD)</i>					
<i>HbA1c Control (<8.0%)</i>	0	1	1	2	5
<i>Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*</i>	0	1	2	3	3
<i>Blood Pressure Control for Patients With Diabetes (BPD)</i>					
<i>Blood Pressure Control for Patients With Diabetes</i>	0	2	3	2	2
<i>Eye Exam for Patients With Diabetes (EED)</i>¹					
<i>Eye Exam for Patients With Diabetes</i>	0	0	6	3	0
<i>Kidney Health Evaluation for Patients With Diabetes (KED)</i>					
<i>Ages 18 to 64 Years</i>	0	1	7	1	0
<i>Ages 65 to 74 Years</i>	0	2	6	1	0
<i>Ages 75 to 85 Years</i>	0	4	3	1	0
<i>Total</i>	0	1	7	1	0

HEDIS Measure	MHPs' Performance Level – Star Count				
	★	★★	★★★	★★★★	★★★★★
Asthma Medication Ratio (AMR)					
Total	5	4	0	0	0
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure	1	1	4	2	1
Diagnosed Mental Health Disorders (DMH)					
Ages 1 to 17 Years	0	3	2	3	0
Ages 18 to 64 Years	0	2	3	2	1
Ages 65 Years and older	1	1	4	1	1
Total	0	2	3	2	1
Utilization					
Plan All-Cause Readmissions (PCR)					
Observed Readmissions—Total	NC	NC	NC	NC	NC
Expected Readmissions—Total	NC	NC	NC	NC	NC
O/E Ratio—Total	3	0	3	1	2
Total	51	80	126	57	22

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

1 Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

Performance Levels for MY 2023 represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Table 5-5 provides an MHP-to-MHP comparison with the statewide average in the four selected HEDIS measure domains. **Green** shading represents best MHP performance in comparison to the statewide average. **Red** shading represents worst MHP performance in comparison to the statewide average.

Table 5-5—MHP-to-MHP Comparison and Statewide Average

HEDIS Measure	MY 2023 Statewide Average	AET	BCC	HCS	MCL	MER	MOL	PRI	UNI	UPP
Child & Adolescent Care										
Childhood Immunization Status (CIS)										
Combination 3	58.72%	48.91%	60.34%	50.46%	58.88%	55.47%	56.93%	68.13%	59.37%	61.74%
Combination 7	50.19%	36.98%	51.09%	41.31%	49.79%	49.39%	48.18%	59.61%	48.66%	50.92%
Combination 10	23.67%	13.87%	23.60%	17.39%	21.87%	23.60%	22.63%	34.06%	19.71%	24.03%
Well-Child Visits in the First 30 Months of Life (W30)										
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	64.33%	49.72%	67.71%	54.92%	65.75%	63.67%	61.48%	66.39%	64.92%	72.82%
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	66.19%	50.85%	67.86%	59.13%	66.45%	66.37%	65.58%	69.86%	63.62%	72.18%
Lead Screening in Children (LSC)										
Lead Screening in Children	58.40%	50.70%	57.22%	55.97%	51.89%	58.30%	59.85%	65.94%	58.39%	59.12%
Child and Adolescent Well-Care Visits (WCV)										
Ages 3 to 11 Years	61.33%	54.61%	62.53%	51.14%	59.38%	62.34%	62.17%	62.07%	60.23%	58.81%
Ages 12 to 17 Years	52.14%	44.81%	51.35%	37.01%	47.44%	53.53%	54.18%	51.91%	53.14%	50.57%
Ages 18 to 21 Years	30.51%	26.37%	31.88%	20.81%	24.42%	30.08%	33.12%	30.69%	32.82%	27.97%
Total	53.31%	46.57%	54.19%	41.56%	49.89%	54.49%	54.51%	53.82%	53.09%	51.22%
Immunizations for Adolescents (IMA)										
Combination 1 (Meningococcal, Tdap)	79.43%	77.86%	78.59%	69.28%	79.32%	80.05%	82.00%	76.64%	79.08%	75.40%
Combination 2 (Meningococcal, Tdap, HPV)	32.73%	28.71%	33.82%	22.87%	29.68%	32.12%	36.25%	34.06%	31.14%	29.74%

HEDIS Measure	MY 2023 Statewide Average	AET	BCC	HCS	MCL	MER	MOL	PRI	UNI	UPP
Women—Adult Care										
<i>Chlamydia Screening in Women (CHL)</i>¹										
<i>Ages 16 to 20 Years</i>	57.65%	68.53%	61.32%	62.96%	52.75%	55.38%	62.80%	53.89%	59.17%	40.28%
<i>Ages 21 to 24 Years</i>	64.80%	70.10%	66.55%	65.08%	62.65%	64.49%	68.74%	63.33%	62.51%	51.24%
<i>Total</i>	61.06%	69.35%	64.05%	64.29%	57.67%	59.62%	65.51%	58.35%	60.67%	45.40%
<i>Cervical Cancer Screening (CCS-E)</i>										
<i>Cervical Cancer Screening</i>	54.97%	44.16%	55.35%	45.23%	53.26%	57.00%	55.92%	55.04%	54.41%	54.25%
<i>Breast Cancer Screening (BCS-E)</i>										
<i>Breast Cancer Screening</i>	55.00%	49.59%	54.29%	55.11%	54.76%	55.06%	55.49%	54.52%	55.49%	60.10%
Access to Care										
<i>Adults' Access to Preventive/Ambulatory Health Services (AAP)</i>										
<i>Ages 20 to 44 Years</i>	73.23%	66.87%	74.46%	62.38%	70.70%	74.64%	75.08%	71.97%	73.02%	75.30%
<i>Ages 45 to 64 Years</i>	82.76%	79.82%	82.04%	75.57%	80.87%	83.55%	84.44%	81.65%	84.27%	83.79%
<i>Ages 65 Years and Older</i>	89.13%	89.72%	72.29%	90.08%	67.30%	87.59%	91.83%	88.46%	91.05%	95.16%
<i>Total</i>	76.80%	73.56%	77.02%	69.16%	74.00%	77.86%	78.76%	75.46%	77.29%	79.60%
Pregnancy Care										
<i>Prenatal and Postpartum Care (PPC)</i>¹										
<i>Timeliness of Prenatal Care</i>	83.81%	72.75%	88.16%	76.11%	78.36%	83.21%	84.50%	85.40%	83.45%	94.16%
<i>Postpartum Care</i>	76.15%	65.21%	81.62%	65.00%	77.78%	76.16%	73.39%	77.86%	71.78%	87.35%
Living With Illness										
<i>Hemoglobin A1c Control for Patients With Diabetes (HBD)</i>										
<i>HbA1c Control (<8.0%)</i>	59.05%	61.80%	58.92%	60.25%	49.39%	60.34%	56.93%	63.26%	62.29%	66.18%

HEDIS Measure	MY 2023 Statewide Average	AET	BCC	HCS	MCL	MER	MOL	PRI	UNI	UPP
<i>Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*</i>	33.05%	29.93%	35.21%	32.35%	42.58%	30.17%	37.47%	28.22%	27.98%	25.06%
Blood Pressure Control for Patients With Diabetes (BPD)										
<i>Blood Pressure Control for Patients With Diabetes</i>	70.49%	62.77%	65.77%	66.17%	62.53%	73.24%	69.59%	77.37%	73.48%	84.67%
Eye Exam for Patients With Diabetes (EED)¹										
<i>Eye Exam for Patients With Diabetes</i>	57.29%	60.83%	56.97%	53.33%	56.93%	61.31%	53.53%	62.04%	52.55%	57.18%
Kidney Health Evaluation for Patients With Diabetes (KED)										
<i>Ages 18 to 64 Years</i>	38.15%	29.35%	36.39%	38.72%	35.76%	40.25%	36.57%	39.33%	41.46%	37.83%
<i>Ages 65 to 74 Years</i>	39.64%	34.97%	41.71%	42.58%	43.55%	37.58%	35.76%	41.12%	50.25%	39.93%
<i>Ages 75 to 85 Years</i>	38.57%	33.03%	35.62%	38.50%	NA	34.79%	34.21%	46.41%	51.85%	43.02%
<i>Total</i>	38.24%	30.55%	36.45%	39.37%	35.81%	39.99%	36.46%	39.55%	42.10%	38.22%
Asthma Medication Ratio (AMR)										
<i>Total</i>	57.78%	51.26%	50.42%	55.56%	49.55%	61.18%	57.57%	64.64%	63.47%	62.28%
Controlling High Blood Pressure (CBP)										
<i>Controlling High Blood Pressure</i>	63.71%	59.12%	64.34%	65.72%	52.80%	62.04%	61.72%	69.10%	71.78%	78.10%
Diagnosed Mental Health Disorders (DMH)										
<i>Ages 1 to 17 Years</i>	23.87%	19.01%	23.14%	16.99%	28.43%	27.02%	18.19%	22.85%	NR	27.90%
<i>Ages 18 to 64 Years</i>	35.37%	30.07%	32.90%	26.61%	38.45%	37.98%	30.92%	36.87%	NR	45.12%
<i>Ages 65 Years and older</i>	36.93%	38.23%	18.17%	36.20%	26.17%	35.91%	37.71%	36.07%	NR	53.20%
<i>Total</i>	30.95%	27.31%	29.39%	25.18%	34.68%	33.47%	25.77%	31.20%	NR	39.37%

HEDIS Measure	MY 2023 Statewide Average	AET	BCC	HCS	MCL	MER	MOL	PRI	UNI	UPP
Utilization										
Plan All-Cause Readmissions (PCR)										
<i>Observed Readmissions— Total</i>	9.57%	13.39%	11.55%	9.60%	8.52%	11.29%	8.38%	7.59%	10.24%	7.12%
<i>Expected Readmissions— Total</i>	9.97%	10.73%	10.31%	10.19%	9.38%	10.40%	9.67%	9.69%	10.65%	9.70%
<i>O/E Ratio— Total</i>	0.9600	1.2484	1.1200	0.9415	0.9089	1.0855	0.8666	0.7829	0.9619	0.7340

¹ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

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

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.


NR indicates one of the following designations: The MHP chose not to report the required measure indicator rate.


Compliance Review

MDHHS calculated the CHCP overall performance in each of the six performance areas. Table 5-6 compares the CHCP average compliance score in each of the six performance areas (i.e., standards) with the compliance score achieved by each MHP. The percentages of requirements met for each of the six standards reviewed during the SFY 2024 compliance review are provided.

Table 5-6—Compliance Monitoring Comparative Results

Standard		AET	BCC	HAP	MCL	MER	MOL	PRI	UNI	UPP	CHCP ¹
1	Administrative	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2	Providers	96%	96%	92%	96%	96%	96%	96%	96%	96%	95.4%
3	Members	100%	100%	100%	100%	100%	97%	93%	100%	100%	98.9%
4	Quality	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
5	MIS/Financial	100%	96%	90%	96%	88%	100%	92%	98%	90%	94.6%
6	OIG/Program Integrity	90%	90%	80%	90%	70%	90%	90%	80%	90%	85.6%
Overall Score		99%	97%	94%	97%	93%	98%	94%	97%	95%	96.0%

 Indicates the highest-performing MHP(s) in the standard.

 Indicates the lowest-performing MHP(s) in the standard.

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

Network Adequacy Validation

Network Adequacy Analysis

Each MHP was assessed based on its adherence to MDHHS methodologies and interpretations of expectations. However, there are opportunities for closer collaboration with MDHHS to standardize provider network reporting across all MHPs. HSAG found that the MHPs used differing time frames for enrollment and provider data in their network adequacy calculations and employed varying methodologies to calculate ratios. Additionally, while the MHPs submitted similar network adequacy summary results—containing the required MDHHS information—these were provided in different formats, such as standalone files with Quest screenshots, embedded screenshots in the Network Access Plan (section 2.7-6a), at the end of documents, and in Microsoft Excel files. Due to the inconsistent methodologies applied to network adequacy indicator reporting, programwide and comparative results are not available, as the data cannot be aggregated or compared across MHPs.

Network Validation Survey

HSAG conducted provider directory reviews on 3,368 providers across all MHPs. HSAG was able to locate 89.8 percent of PCPs, 88.8 percent of pediatric providers, and 88.2 percent of OB/GYN providers in the MHPs' online directories.¹¹⁴ Notably, **MER** had the lowest rate of providers found in the online directory for PCP (47.5 percent), pediatric providers (52.5 percent), and OB/GYN providers (48.7 percent). Among the located providers, all overall PDV study indicator match rates scored over 90.0 percent, indicating a relatively high level of agreement between the MHPs' provider data files and the online directories.

Table 5-7 and Table 5-8 display the percentage of providers found in the directory and the percentage of indicators with matches between the MHPs' provider data files and the online directories, respectively.

Table 5-7—Providers Found in the Directory

MHP	Number of Sampled Providers	PCPs		Pediatric Providers		OB/GYN Providers	
		Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
AET	360	135	83.9%	127	78.9%	30	78.9%
BCC	388	185	96.4%	187	97.4%	2	50.0%
HCS	404	201	99.5%	200	99.0%	NA	NA
MCL	437	202	93.5%	195	90.3%	3	60.0%

¹¹⁴ No OB/GYN providers were sampled for **HCS**, and low numbers of OB/GYN providers were sampled for **BCC** (four providers), **MCL** (five providers), **PRI** (eight providers), **UPP** (17 providers), **AET** (38 providers), and **MER** (39 providers) due to the eligible population criteria (i.e., providers with the PCP indicator), which reduced the number of eligible OB/GYN providers.

MHP	Number of Sampled Providers	PCPs		Pediatric Providers		OB/GYN Providers	
		Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
MER	393	84	47.5%	93	52.5%	19	48.7%
MOL	423	140	99.3%	137	97.2%	137	97.2%
PRI	428	203	96.7%	204	97.1%	8	100%
UNI	411	135	98.5%	132	96.4%	129	94.2%
UPP	124	85	95.5%	16	88.9%	15	88.2%
MHP Total	3,368	1,370	89.8%	1,291	88.8%	343	88.2%

¹ The denominator includes the number of sampled providers.

NA means “Not Applicable” and indicates that no OB/GYN providers were sampled.

Table 5-8—PDV Study Indicator Aggregate Match Rates

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		Overall	
	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
Provider Name	1,370	100%	1,291	100%	343	100%	3,004	100%
Provider Street Address	1,268	92.6%	1,174	90.9%	298	86.9%	2,740	91.2%
Provider Suite Number	1,341	97.9%	1,258	97.4%	316	92.1%	2,915	97.0%
Provider City	1,304	95.2%	1,207	93.5%	318	92.7%	2,829	94.2%
Provider State	1,363	99.5%	1,287	99.7%	342	99.7%	2,992	99.6%
Provider ZIP Code	1,299	94.8%	1,197	92.7%	309	90.1%	2,805	93.4%
Provider Telephone Number	1,287	93.9%	1,180	91.4%	296	86.3%	2,763	92.0%
Provider Type/Specialty	1,361	99.3%	1,270	98.4%	342	99.7%	2,973	99.0%
Provider Accepting New Patients	1,357	99.1%	1,274	98.7%	313	91.3%	2,944	98.0%
Provider Gender	1,365	99.6%	1,291	100%	343	100%	2,999	99.8%
Provider Primary Language ²	1,353	98.8%	1,270	98.4%	335	97.7%	2,958	98.5%
Non-English Language Speaking Provider (including American Sign Language) ²	1,369	99.9%	1,288	99.8%	342	99.7%	2,999	99.8%

¹ The denominator for each study indicator includes the number of cases in which the provider was found in the directory.

² The PDV review evaluated whether the indicator was present in the directory, but specific values were not validated.

HSAG included cases in the telephone survey only if those cases matched on eight key provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, provider type/specialty,

and new patient acceptance. PDV cases that did not match on these indicators were not included in the secret shopper survey. HSAG attempted to contact 2,633 sampled provider locations (i.e., “cases”), with an overall response rate of 67.4 percent among the MHPs. Among the cases reached, 72.1 percent confirmed affiliation with the sampled provider, 68.5 percent confirmed the location, 61.0 percent offered the requested services, and 46.3 percent accepted the requested MHP and MI Medicaid. Moreover, only 41.2 percent accepted new patients, with 23.9 percent offering an appointment to the caller. Overall, 80.9 percent of offered appointments that were compliant with the 30-business-day standard for routine care appointments and seven-business-day standard for prenatal care appointments. The overall average wait time for routine care and prenatal care visits was 18 business days.

Table 5-9 and Table 5-10 display the results of the telephone survey and appointment availability and wait time results, respectively.

Table 5-9—Telephone Survey Results

MHP	Rate of Cases Reached ¹	Rate of Cases Confirming Provider ²	Rate of Cases Confirming Location ²	Rate of Cases Offering Requested Services ²	Rate of Cases Accepting Insurance ²	Rate of Cases Accepting New Patients ²
AET	51.3%	57.4%	53.0%	51.3%	42.6%	42.6%
BCC	84.6%	87.6%	83.2%	78.0%	63.2%	58.1%
HCS	65.7%	76.9%	72.9%	62.4%	41.2%	37.3%
MCL	68.9%	60.7%	56.4%	46.3%	33.1%	24.5%
MER	90.0%	80.0%	80.0%	77.8%	66.7%	64.4%
MOL	71.8%	66.3%	62.6%	54.4%	43.3%	37.8%
PRI	60.9%	68.7%	65.8%	59.7%	39.9%	33.3%
UNI	54.6%	74.1%	70.6%	60.2%	47.3%	42.8%
UPP	88.3%	77.6%	75.5%	71.4%	61.2%	58.2%
MHP Total	67.4%	72.1%	68.5%	61.0%	46.3%	41.2%

¹ The denominator includes the total number of survey cases (i.e., cases that were found in the online directory and matched on eight key provider indicators: name, address, city, state, ZIP Code, telephone number, provider type/specialty, and new patient acceptance).

² The denominator includes cases reached.

Table 5-10—Appointment Availability and Wait Time Results

MHP	Rate of Cases Offered Appointment ^{1,2}	Rate of Cases Within Standard ³	Average Appointment Wait Time (Business Days)
AET	24.3%	85.7%	16
BCC	38.5%	92.0%	12
HCS	22.4%	93.0%	11

MHP	Rate of Cases Offered Appointment ^{1,2}	Rate of Cases Within Standard ³	Average Appointment Wait Time (Business Days)
MCL	16.7%	69.8%	27
MER	33.3%	93.3%	11
MOL	18.9%	74.5%	25
PRI	14.0%	79.4%	18
UNI	22.4%	57.8%	22
UPP	39.8%	71.8%	19
MHP Total	23.9%	80.9%	18

¹ The denominator includes cases reached.

² Cases offered appointment rates were calculated using cases accepting new patients as the denominator in the 2022 and 2023 reports. However, the denominator used in the 2024 report was cases reached. Caution should be exercised when comparing 2024 cases offered appointment rates with the rates in the 2022 and 2023 reports.

³ The denominator includes cases that offered an appointment.

Encounter Data Validation

Representatives from each MHP procured medical records for sampled members from their contracted providers based on the final sample list provided by HSAG. These records included documentation of services rendered during the review period and served as the primary source for validating the completeness and accuracy of encounter data. The evaluation focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*, to identify discrepancies and ensure alignment between the medical records and the encounter data submitted to MDHHS.

Table 5-11 presents the EDV MRR results for all MHPs stratified by key data elements. The analysis categorized findings using three levels of concern: “✓” indicated no or minor concerns noted, “–” indicated moderate concerns noted, and “✗” indicated major concerns noted. For MHP-specific results, refer to Section 3.

Medical Record Procurement Status

The *Medical Record Procurement Status Rate* was assessed based on the following criteria: rates of 95 percent and above were assigned a “✓,” rates 90 percent to less than 95 percent were assigned a “–,” and rates below 90 percent were assigned an “✗.”

Encounter Data Completeness

The completeness of encounter data was assessed based on the four key data elements (i.e., *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*). A “✓” was assigned if all data elements had an omission rate of 10 percent or less. A “–” was assigned if any single data element had an omission rate exceeding 10 percent. An “✗” was applied under any of the following conditions: if one data element had an omission rate exceeding 25 percent, if two data elements had omission rates exceeding 20 percent, or if three data elements had omission rates above 15 percent. These thresholds help identify potential gaps in data submission and provide a consistent standard for completeness evaluation.

Encounter Data Accuracy

For the accuracy rate assessment, the *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *All-Element Accuracy Rates* were used as primary metrics. At the individual level, if all data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) had accuracy rates of at least 95 percent, a “✓” was assigned. If at least one individual element rate was from 90 percent to less than 95 percent, a “–” was assigned, and if at least one individual element rate was below 90 percent an “✗” was assigned. For the *All-Element Accuracy Rate*, the following classifications were applied: rates of 80 percent or above were assigned a “✓,” rates from 60 percent to below 80 percent were assigned a “–,” and rates below 60 percent were assigned an “✗.”

This classification helps assess the reliability of encounter data across MHPs and highlights areas where accuracy improvements may be necessary. It is important to note that the denominator for the element accuracy rate for each individual data element was defined differently than the denominator for the all-element accuracy rate. Therefore, the all-element accuracy rate could not be derived from the individual data element accuracy rates. Using the *Diagnosis Code* data element as an example, each diagnosis code was assigned to one of the four mutually exclusive categories: medical record omission, encounter data omission, accurate, or inaccurate. When evaluating the element accuracy for each key data element, the denominator is the number of values in the categories of accurate and inaccurate. However, for the all-element accuracy rate, the denominator is the total number of dates of service that matched between the medical records and encounter data, with the numerator representing the total number of dates of service where all key data elements had the same values. Therefore, for each date of service, if any of the data elements were classified under the medical record omission, encounter data omission, or inaccurate categories, the date of service was not counted in the numerator for the all-element accuracy rate.

By applying these evaluation criteria, the MRR provides a comprehensive assessment of data integrity, allowing for targeted improvements in MHP data submission practices.

Table 5-11—EDV MHP Comparison

Analysis	AET	BCC	HCS	MCL	MER	MOL	PRI	UNI	UPP
Medical Record Procurement Status									
Medical Record Procurement Rate	✓	✓	✗	—	—	✗	✓	✓	✓
Second Date of Service Submission Rate	✓	✓	✓	✓	✓	✓	✓	✓	✓
Encounter Data Completeness									
Medical Record Omission Rate	—	—	✗	—	—	✗	—	—	—
Encounter Data Omission Rate	✓	✓	✓	✓	✓	✓	✓	✓	✓
Encounter Data Accuracy									
Diagnosis Code Accuracy Rate	✓	✓	✓	✓	✓	✓	✓	✓	✓
Procedure Code Accuracy Rate	✓	✓	✓	✓	✓	✓	✓	✓	✓
Procedure Code Modifier Accuracy Rate	✓	✓	✓	✓	✓	✓	✓	✓	✓
All-Element Accuracy Rate	—	—	—	—	—	—	—	—	✓

✓	No or minor concerns noted.
—	Moderate concerns noted.
✗	Major concerns noted.

Consumer Assessment of Healthcare Providers and Systems Analysis

Comparative analyses identified whether one MHP performed statistically significantly higher or lower on each measure compared to the program average for a specific population, as well as the overall member experience ratings when 2024 scores were compared to NCQA's 2023 Quality Compass Benchmark and Compare Quality Data and 2023 scores were compared to NCQA's 2022 Quality Compass Benchmark and Compare Data.^{115,116,117,118,119} Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each measure, where one is the lowest possible rating (i.e., Poor) and five is the highest possible rating (i.e., Excellent), as shown in Table 5-12.

Table 5-12—Star Ratings

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

¹¹⁵ National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023*. Washington, DC: NCQA, September 2023.

¹¹⁶ National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2022*. Washington, DC: NCQA, September 2022.

¹¹⁷ The source for the national data contained in this publication is Quality Compass® 2023 and is used with the permission of NCQA. Quality Compass 2023 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS® is a registered trademark of AHRQ.

¹¹⁸ Since certain survey questions in the CAHPS 5.1 Child Medicaid Health Plan Survey were modified for inclusion in the CSHCS Survey, the results are not comparable to the NCQA benchmark data; therefore, NCQA comparison results were not presented in the 2022 and 2023 Michigan CSHCS CAHPS Reports. Only the scores and statistically significant results are presented in the Michigan CSHCS comparison tables.

¹¹⁹ Since scores were updated to two decimal places in the 2023 Michigan Adult and Child Medicaid CAHPS Reports and 2023 Michigan HMP CAHPS Report, the star ratings for the 2022 scores could be different than what was presented in the 2022 Michigan Adult and Child Medicaid CAHPS Reports and 2022 Michigan HMP CAHPS Report.

Table 5-13 through Table 5-18 provide a summary of the statistically significant findings (noted with arrows) from the MHP comparisons, as well as the overall member experience ratings (noted with stars) from the NCQA comparisons of the adult and child Medicaid populations. Arrows (↑ or ↓) indicate 2024 scores were statistically significantly higher or lower than the 2024 Medicaid Managed Care Program average.

Table 5-13—Statewide Comparisons: Adult Medicaid Global Ratings

Program/ Plan Name ¹²⁰	Rating of Health Plan		Rating of All Health Care		Rating of Personal Doctor		Rating of Specialist Seen Most Often	
	2023	2024	2023	2024	2023	2024	2023	2024
Medicaid Managed Care Program	★★★★ 63.43%	★★★★ 62.72%	★★★★ 58.01%	★★ 55.46%	★★ 64.71%	★★ 67.52%	★ 64.05%	★★★★★ 68.93%
AET	★ 57.89%	★★★★ 62.12%	★★ 54.19%	★★ 55.97%	★★ 68.00%	★★★★ 68.34%	★ 64.66%	★★ 65.63%
BCC	★★★★ 63.23%	★★★★ 63.67%	★★★★ 58.74%	★★★★ 57.84%	★ 62.14%	★★ 65.78%	★ 63.36%	★★★★ 68.75%
HAP	★★★★ 63.89%	★★ 59.84%	★★★★ 57.14%	★★★★★ 64.60%	★★★★ 71.03%	★★★★★ 72.14%	★+ 63.10%	★★★★★ 70.00%
MCL	★★★★ 63.35%	★★ 61.45%	★★★★ 57.14%	★★ 54.78%	★★ 65.41%	★ 60.87%	★+ 56.04%	★★★★★+ 74.70%
MER	★★★★ 63.76%	★★ 60.10%	★★ 56.58%	★ 49.62%	★★ 65.22%	★★★★ 70.22%	★+ 64.65%	★★+ 63.44%
MOL	★★★★ 65.67%	★★★★ 64.29%	★★★★★ 62.50%	★★★★★ 59.70%	★★ 65.67%	★★ 68.05%	★★★★ 68.00%	★★★★★+ 77.91%
PRI	★★ 61.72%	★★★★★ 66.94%	★ 52.00%	★★ 55.28%	★★ 64.80%	★★ 66.36%	★+ 60.20%	★★ 66.04%
UNI	★★★★ 62.64%	★★ 61.50%	★★★★★ 62.18%	★★★★ 56.35%	★ 62.33%	★★★★ 68.99%	★★★★+ 69.41%	★★+ 66.27%
UPP	★★★★ 64.44%	★★★★★ 69.05%	★ 52.81%	★★★★★ 61.13%	★★ 67.48%	★★★★★ 72.75%	★ 64.61%	★★★★ 66.67%

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

↑ Indicates the 2024 score is statistically significantly higher than the 2024 Medicaid Managed Care Program average.

↓ Indicates the 2024 score is statistically significantly lower than the 2024 Medicaid Managed Care Program average.

No arrows (↑ or ↓) indicate the 2024 score was not statistically significantly higher or lower than the 2024 Medicaid Managed Care Program average.

Table 5-14—Statewide Comparisons: Adult Medicaid Composite Measures

Program/ Plan Name	Getting Needed Care		Getting Care Quickly		How Well Doctors Communicate		Customer Service	
	2023	2024	2023	2024	2023	2024	2023	2024
Medicaid Managed Care Program	★★★★ 83.46%	★★ 81.27%	★★★★ 83.21%	★★★★ 82.92%	★★ 91.85%	★★★★ 93.11%	★★ 88.56%	★★ 88.68%
AET	★★★★ 83.11%	★★★★ 83.26%	★★ 77.26%	★★ 80.76%	★★ 91.04%	★ 91.01%	★★★★ 89.65%	★★★★ 89.99%
BCC	★★★★ 84.50%	★★★★ 83.36%	★★★★ 82.90%	★★★★ 83.76%	★★ 92.10%	★★★★ 93.83%	★★★★★ 91.65%	★★ 89.10%
HAP	★★ 80.54%	★★★★ 83.64%	★★+ 78.70%	★★★★ 82.98%	★★★★ 93.32%	★★ 92.05%	★★★★+ 90.26%	★★★★★ 92.07%
MCL	★★★★★ 87.78%	★★ 81.04%	★★★★★ 87.87%	★★★★+ 81.87%	★★ 92.11%	★★ 92.22%	★★+ 88.34%	★★+ 88.87%
MER	★★ 81.81%	★★ 77.97%	★★★★ 82.68%	★★★★ 81.67%	★★ 91.44%	★★★★★ 95.35%	★★★★+ 90.55%	★+ 85.22%
MOL	★★ 82.10%	★★ 80.48%	★★ 79.94%	★★★★+ 82.85%	★ 90.47%	★★ 92.02%	★ 83.68%	★★★★+ 89.96%
PRI	★★★★ 83.70%	★★★★★ 84.74%	★★★★★+ 90.11%	★★★★ 84.49%	★★★★ 93.49%	★★ 91.82%	★★★★★+ 92.35%	★★+ 88.85%
UNI	★★★★ 83.65%	★★ 81.43%	★★+ 80.29%	★★★★+ 83.70%	★★ 91.76%	★★ 91.61%	★+ 82.84%	★★★★+ 90.76%
UPP	★★★★ 83.19%	★★★★★ 86.48%	★★★★★ 85.88%	★★★★★ 86.94%	★★★★★ 95.44%	★★★★★ 95.03%	★★★★★ 92.77%	★★★★★ 94.15%

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

↑ Indicates the 2024 score is statistically significantly higher than the 2024 Medicaid Managed Care Program average.

↓ Indicates the 2024 score is statistically significantly lower than the 2024 Medicaid Managed Care Program average.

No arrows (↑ or ↓) indicate the 2024 score was not statistically significantly higher or lower than the 2024 Medicaid Managed Care Program average.

Table 5-15—Statewide Comparisons: Adult Medicaid Individual Item and Medical Assistance With Smoking and Tobacco Use Cessation Items

Program/ Plan Name	Coordination of Care		Advising Smokers and Tobacco Users to Quit*		Discussing Cessation Medications*		Discussing Cessation Strategies*	
	2023	2024	2023	2024	2023	2024	2023	2024
Medicaid Managed Care Program	★★★★ 85.97%	★★ 83.78%	★★★★★ 76.80%	★★★★ 76.11%	★★★★★ 55.74%	★★★★★ 55.61%	★★★★ 49.16%	★★★★ 48.02%
AET	★★ 84.43%	★ 76.87%	★★ 70.86%	★★★★ 73.28%	★★★★ 54.34%	★★★★★ 55.46%	★★★★★ 51.20%	★★ 46.19%
BCC	★★★★ 85.22%	★★★★★ ⁺ 87.37%	★★★★ 75.48%	★★★★ 76.65%	★★★★ 54.49%	★★★★ 52.98%	★★★★ 47.40%	★★ 45.83%
HAP	★★★★ ⁺ 86.67%	★ ⁺ 79.17%	★ 65.69%	★ 63.81%	★★ 46.08%	★★ 47.52%	★ 38.83%	★★ 45.10%
MCL	★★ ⁺ 83.95%	★★ ⁺ 84.48%	★★ 72.05%	★★ 71.43%	★★ 50.31%	★★ 48.65%	★★★★ 46.54%	★★ 43.12%
MER	★★★★★ ⁺ 87.37%	★ ⁺ 80.00%	★★★★★ 78.13%	★★★★★ 80.45%	★★★★★ 55.20%	★★★★★ 60.77%	★★★★★ 50.39%	★★★★★ 54.96%
MOL	★★★★★ 87.18%	★★★★ ⁺ 86.49%	★★★★★ 82.45%	★★★★ 74.82%	★★★★★ 62.11%	★★★★ 53.15%	★★★★★ 55.38%	★★★★ 48.20%
PRI	★★★★★ ⁺ 91.78%	★★ 84.55%	★★★★ 74.80%	★★★★ 75.83%	★★★★ 51.56%	★★★★ 54.62%	★★ 40.77%	★★ 41.67%
UNI	★ ⁺ 79.31%	★★ ⁺ 83.33%	★★★★★ 78.57%	★★★★★ 77.14%	★★★★★ 61.26%	★★★★★ 61.32%	★★★★★ 51.85%	★★★★ 49.04%
UPP	★★★★★ 87.65%	★★★★★ 89.25%	★★★★ 73.44%	★★ 72.34%	★★★★ 53.18%	★★★★ 53.79%	★★★★ 48.10%	★★ 43.93%

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

* These rates follow NCQA's methodology of calculating a rolling two-year average.

↑ Indicates the 2024 score is statistically significantly higher than the 2024 Medicaid Managed Care Program average.

↓ Indicates the 2024 score is statistically significantly lower than the 2024 Medicaid Managed Care Program average.

No arrows (↑ or ↓) indicate the 2024 score was not statistically significantly higher or lower than the 2024 Medicaid Managed Care Program average.

Table 5-16—Statewide Comparisons: Child Medicaid Global Ratings

Program/ Plan Name	Rating of Health Plan		Rating of All Health Care		Rating of Personal Doctor		Rating of Specialist Seen Most Often	
	2023	2024	2023	2024	2023	2024	2023	2024
Medicaid Managed Care Program	★★ 70.50%	★ 68.30%	★★ 66.74%	★ 64.51%	★★ 74.00%	★★ 73.92%	★★★★ 72.25%	★★★★ 72.25%
AET	★ 66.67%	★ 66.05%	★ 67.54%	★★ 67.44% ⁺	★★ 74.72%	★ 72.86%	★ 65.96% ⁺	★★★★ 75.00% ⁺
BCC	★★★★ 72.76%	★★ 69.68%	★★ 68.79%	★★ 66.67%	★ 72.97%	★★★★★ 80.73%	★★ 71.67% ⁺	★★★★ 76.79% ⁺
HAP	★★ 69.14%	★ 64.38%	★★ 69.70% ⁺	★ 61.76%	★ 72.46%	★★ 75.71%	★★★★★ 84.85% ⁺	★ 65.79% ⁺
MCL	★★ 71.43%	★★★★ 72.36%	★ 59.44%	★★★★ 70.77%	★★ 74.78%	★★ 75.14%	★★★★ 74.70% ⁺	★★★★ 73.33% ⁺
MER	★★ 70.29%	★★ 69.01%	★★ 68.64%	★ 59.87% [↓]	★ 73.58%	★ 72.34%	★★★★ 75.76% ⁺	★★★★★ 80.00% ⁺
MOL	★★ 71.05%	★★ 69.23%	★ 65.07%	★★ 66.41%	★★ 74.65%	★ 72.04%	★★ 70.91% ⁺	★ 63.83% ⁺
PRI	★★ 69.83%	★ 67.00%	★ 67.07%	★ 62.04%	★★ 75.85%	★★ 75.00%	★★★★ 72.22% ⁺	★ 65.45% ⁺
UNI	★★ 68.65%	★ 63.13% [↓]	★★ 69.57%	★★ 66.67%	★ 72.90%	★ 71.12%	★ 67.31% ⁺	★★★★ 70.91% ⁺
UPP	★★ 70.43%	★ 66.67%	★ 60.93%	★ 56.90% [↓]	★ 73.09%	★★ 73.73%	★ 63.77% ⁺	★ 64.15% ⁺

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

↑ Indicates the 2024 score is statistically significantly higher than the 2024 Medicaid Managed Care Program average.

↓ Indicates the 2024 score is statistically significantly lower than the 2024 Medicaid Managed Care Program average.

No arrows (↑ or ↓) indicate the 2024 score was not statistically significantly higher or lower than the 2024 Medicaid Managed Care Program average.

Table 5-17—Statewide Comparisons: Child Medicaid Composite and Individual Item Measures¹²¹

Program/ Plan Name	Getting Needed Care		Getting Care Quickly		How Well Doctors Communicate	
	2023	2024	2023	2024	2023	2024
Medicaid Managed Care Program	★★★★ 86.13%	★★★★ 83.64%	★★★★ 89.01%	★★★★ 87.60%	★★★★ 94.92%	★★★★ 94.25%
AET	★★ 82.12% ⁺	★★★★ 86.10% ⁺	★★ 85.03% ⁺	★★★★★ 90.23% ⁺	★ 92.23%	★ 89.78% ⁺
BCC	★★ 83.22%	★★★★ 83.48%	★★★★ 89.54%	★★★★ 88.34% ⁺	★★★★★ 96.83%	★★★★★ 96.33%↑
HAP	★ 79.24% ⁺	★ 79.18% ⁺	★★★★ 87.50% ⁺	★ 81.80% ⁺	★★ 93.96%	★★★★★ 95.60%
MCL	★★★★★ 88.13%	★★★★★ 87.14% ⁺	★★★★ 89.75%	★★★★ 87.42% ⁺	★★ 94.20%	★★★★ 94.90%
MER	★★★★ 87.24%	★★ 82.50%	★★★★ 89.03%	★★★★★ 89.74% ⁺	★★★★ 95.61%	★★★★ 93.98%
MOL	★★★★ 85.43%	★★ 81.86% ⁺	★★★★ 89.65%	★★ 83.91% ⁺	★★★★ 95.04%	★★ 92.53%
PRI	★★★★★ 93.49%	★★ 80.78% ⁺	★★★★★ 90.60%	★★★★ 87.43% ⁺	★★★★★ 96.36%	★★★★ 94.11%
UNI	★ 80.31%	★★★★★ 87.26% ⁺	★★ 85.81%	★★★★ 87.58% ⁺	★ 90.94%	★★★★ 94.71%
UPP	★★★★★ 89.89%	★★★★★ 87.36%	★★★★★ 92.67%	★★★★★ 90.97%↑	★★★★★ 98.48%	★★★★★ 97.08%↑

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

↑ Indicates the 2024 score is statistically significantly higher than the 2024 Medicaid Managed Care Program average.

↓ Indicates the 2024 score is statistically significantly lower than the 2024 Medicaid Managed Care Program average.

No arrows (↑ or ↓) indicate the 2024 score was not statistically significantly higher or lower than the 2024 Medicaid Managed Care Program average.

¹²¹ The *Transportation* composite measure survey questions are not included in the standard CAHPS 5.1H Child Medicaid Health Plan Survey. These questions are NCQA-approved supplemental items that were added to the survey. A 2023 and 2024 NCQA benchmark is not available for this measure.

Table 5-18—Statewide Comparisons: Child Medicaid Composite and Individual Item Measures (Continued)

Program/ Plan Name	Customer Service		Coordination of Care		Transportation	
	2023	2024	2023	2024	2023	2024
Medicaid Managed Care Program	★★★★★ 92.12%	★★ 86.04%	★★★★ 86.33%	★★★★ 86.70%	65.96% ⁺	67.57% ⁺
AET	★★★★ 90.04% ⁺	★★ 87.50% ⁺	★★ 83.02% ⁺	★ 75.61% ⁺	55.56% ⁺	57.91% ⁺
BCC	★★★★ 88.04% ⁺	★★★★★ 90.50% ⁺	★★ 82.76% ⁺	★★★★★ 90.77% ⁺	NA	NA
HAP	★★ 86.79% ⁺	★★ 87.00% ⁺	★★ 82.35% ⁺	★ 79.17% ⁺	NA	NA
MCL	★★★★★ 90.38% ⁺	★★★★★ 91.00% ⁺	★★ 83.72% ⁺	★ 77.61% ⁺	NA	NA
MER	★★★★★ 96.14% ⁺	★ 79.92% ⁺	★★★★★ 94.19% ⁺	★★★★★ 87.32% ⁺	NA	NA
MOL	★★★★★ 91.67% ⁺	★★ 86.35% ⁺	★ 80.60% ⁺	★★★★★ 87.69% ⁺	56.67% ⁺	65.00% ⁺
PRI	★★★★★ 94.10% ⁺	★★★★★ 92.65% ⁺	★★★★★ 91.43% ⁺	★★★★ 86.44% ⁺	NA	NA
UNI	★★★★ 88.10% ⁺	★ 82.46% ⁺	★ 79.69% ⁺	★★★★★ 89.55% ⁺	NA	NA
UPP	★★★★★ 97.30% ⁺	★★★★ 89.47% ⁺	★★★★★ 91.00%	★★★★★ 90.67% ⁺ ↑	79.41% ⁺	NA

⁺ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

NA Indicates that results for this measure are not displayed because too few members responded to the questions.

↑ Indicates the 2024 score is statistically significantly higher than the 2024 Medicaid Managed Care Program average.

↓ Indicates the 2024 score is statistically significantly lower than the 2024 Medicaid Managed Care Program average.

No arrows (↑ or ↓) indicate the 2024 score was not statistically significantly higher or lower than the 2024 Medicaid Managed Care Program average.

Table 5-19 through Table 5-21 provide a summary of the statistically significant findings of the CSHCS population analysis. Upward green or downward red arrows (↑ or ↓) indicate 2024 scores were statistically significantly higher or lower than the 2023 CSHCS Managed Care Program average. Upward green or downward red triangles (▲ or ▼) indicate 2024 CSHCS Managed Care Program average scores were statistically significantly higher or lower than the 2023 CSHCS Managed Care Program average scores.

Table 5-19—Statewide Comparisons: CSHCS Global Ratings

Program/ Plan Name	Rating of Health Plan		Rating of Health Care		Rating of Specialist Seen Most Often	
	2023	2024	2023	2024	2023	2024
CSHCS Managed Care Program	67.37%	68.83%	67.94%	69.57%	73.95%	71.50%
AET	81.25% ⁺	58.33% ⁺	88.89% ⁺	83.33% ⁺	85.71% ⁺	81.82% ⁺
BCC	65.49%	66.79%	68.30%	64.79%	70.48%	67.88%
HCS	76.92% ⁺	60.00% ⁺	76.92% ⁺	73.33% ⁺	NA	NA
MCL	68.64%	73.63%	72.02%	73.72%	78.65%	74.89%
MER	63.98%	65.69%	68.69%	68.06%	75.54%	66.96%
MOL	66.67%	67.45%	66.43%	73.04%	75.13%	76.41%
PRI	67.62%	72.43%	65.87%	69.20%	70.06%	70.20%
UNI	71.07%	69.03%	66.67%	68.08%	73.85%	72.99%
UPP	73.33%	75.82% ⁺	69.16%	73.12% ⁺	77.42% ⁺	70.49% ⁺

⁺ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

↑ Indicates the 2024 score is statistically significantly higher than the 2024 CSHCS Managed Care Program average.

↓ Indicates the 2024 score is statistically significantly lower than the 2024 CSHCS Managed Care Program average.

No arrow (↑ or ↓) indicates the 2024 score was not statistically significantly higher or lower than the 2024 CSHCS Managed Care Program average.

▲ Indicates the 2024 CSHCS Managed Care Program average is statistically significantly higher than the 2023 CSHCS Managed Care Program average.

▼ Indicates the 2024 CSHCS Managed Care Program average is statistically significantly lower than the 2023 CSHCS Managed Care Program average.

No triangle (▲ or ▼) indicates the 2024 CSHCS Managed Care Program average was not statistically significantly higher or lower than the 2023 CSHCS Managed Care Program average.

NA Indicates that results for this measure are not displayed because fewer than 11 respondents responded to the questions.

Table 5-20—Statewide Comparisons: CSHCS Composite Measures

Program/ Plan Name	Customer Service		How Well Doctors Communicate		Access to Specialized Services		Transportation	
	2023	2024	2023	2024	2023	2024	2023	2024
CSHCS Managed Care Program	85.84%	87.53%	93.64%	94.42%	69.98%	71.22%	64.05%	71.49%
AET	NA	NA	96.15% ⁺	NA	NA	NA	NA	NA
BCC	82.35% ⁺	87.12% ⁺	92.52%	93.72%	67.06% ⁺	78.90% ⁺	NA	90.00% ⁺ ▲
HCS	NA	NA	100.00% ⁺	89.58% ⁺	NA	NA	NA	NA
MCL	95.95% ⁺	88.33% ⁺	95.44%	95.16%	72.03% ⁺	73.17% ⁺	82.05% ⁺	71.19% ⁺
MER	83.12% ⁺	87.01% ⁺	93.08%	93.18%	64.39% ⁺	61.98% ⁺	54.66% ⁺	60.54% ⁺
MOL	86.68% ⁺	89.13% ⁺	94.99%	95.12%	67.36% ⁺	70.57% ⁺	64.84% ⁺	69.91% ⁺
PRI	85.96% ⁺	88.09% ⁺	93.89%	95.01%	72.60% ⁺	73.11% ⁺	70.54% ⁺	70.18% ⁺
UNI	83.90% ⁺	82.49% ⁺	90.92%	93.71%	76.47% ⁺	67.29% ⁺	79.29% ⁺	62.28% ⁺
UPP	92.50% ⁺	98.15% ⁺ ▲	98.77% ⁺	97.56% ⁺	75.47% ⁺	82.44% ⁺	92.37% ⁺	87.35% ⁺ ▲

⁺ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

▲ Indicates the 2024 score is statistically significantly higher than the 2024 CSHCS Managed Care Program average.

▼ Indicates the 2024 score is statistically significantly lower than the 2024 CSHCS Managed Care Program average.

No arrow (▲ or ▼) indicates the 2024 score was not statistically significantly higher or lower than the 2024 CSHCS Managed Care Program average.

▲ Indicates the 2024 CSHCS Managed Care Program average is statistically significantly higher than the 2023 CSHCS Managed Care Program average.

▼ Indicates the 2024 CSHCS Managed Care Program average is statistically significantly lower than the 2023 CSHCS Managed Care Program average.

No triangle (▲ or ▼) indicates the 2024 CSHCS Managed Care Program average was not statistically significantly higher or lower than the 2023 CSHCS Managed Care Program average.

NA Indicates that results for this measure are not displayed because too few members responded to the questions.

Table 5-21—Statewide Comparisons: CSHCS Individual Item Measures

Program/ Plan Name	Access to Prescription Medicines		Not Felt Treated Unfairly: Race and Ethnicity		Not Felt Treated Unfairly: Health Insurance Type	
	2023	2024	2023	2024	2023	2024
CSHCS Managed Care Program	88.95%	89.40%	96.93%	96.60%	93.42%	94.12%
AET	100.00% ⁺	NA	92.31% ⁺	NA	100.00% ⁺	NA
BCC	85.80%	88.38%	97.55%	95.50%	95.73%	93.53%
HCS	NA	91.67% ⁺	100.00% ⁺	91.67% ⁺	100.00% ⁺	91.67% ⁺
MCL	89.39%	89.52%	99.49%	97.36%	95.41%	94.71%

Program/ Plan Name	Access to Prescription Medicines		Not Felt Treated Unfairly: Race and Ethnicity		Not Felt Treated Unfairly: Health Insurance Type	
	2023	2024	2023	2024	2023	2024
MER	86.92%	87.76%	96.98%	96.02%	92.78%	93.25%
MOL	89.62%	92.58%	96.65%	97.16%	90.87%	93.81%
PRI	91.71%	87.05%	97.47%	97.38%	94.44%	94.30%
UNI	88.26%	88.89%	93.81%	95.93%	91.75%	94.57%
UPP	96.10% ⁺	93.75% ⁺	100.00% ⁺	98.78% ⁺	95.06% ⁺	98.78% ⁺

⁺ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

↑ Indicates the 2024 score is statistically significantly higher than the 2024 CSHCS Managed Care Program average.

↓ Indicates the 2024 score is statistically significantly lower than the 2024 CSHCS Managed Care Program average.

No arrow (↑ or ↓) indicates the 2024 score was not statistically significantly higher or lower than the 2024 CSHCS Managed Care Program average.

▲ Indicates the 2024 CSHCS Managed Care Program average is statistically significantly higher than the 2023 CSHCS Managed Care Program average.

▼ Indicates the 2024 CSHCS Managed Care Program average is statistically significantly lower than the 2023 CSHCS Managed Care Program average.

No triangle (▲ or ▼) indicates the 2024 CSHCS Managed Care Program average was not statistically significantly higher or lower than the 2023 CSHCS Managed Care Program average.

NA Indicates that results for this measure are not displayed because fewer than 11 respondents responded to the questions.

Quality Rating

HSAG analyzed MY 2023 HEDIS results, including MY 2023 CAHPS data from the nine MHPs, for presentation in the 2024 Michigan Consumer Guide. The 2024 Michigan Consumer Guide analysis helps to support MDHHS’ public reporting of health plan performance information. The 2024 Michigan Consumer Guide used a five-level rating scale to provide potential and enrolled Medicaid members with an easy-to-read “picture” of quality performance across MHPs and presented data in a manner that emphasizes meaningful differences between MHPs. The 2024 Michigan Consumer Guide used apples to display results for each MHP, which correlated to the performance ratings defined in Table 5-22. Table 5-23 shows the 2024 Michigan Consumer Guide, which demonstrates MHP comparative performance in MDHHS-established categories.

Table 5-22—Apple Ratings for the 2024 Michigan Consumer Guide






















































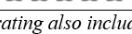
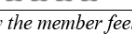
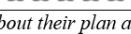
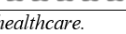
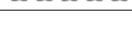
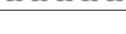
Rating	MHP Performance Compared to Statewide Average	
	Highest Performance	The MHP's performance was 1.96 standard deviations or more above the Michigan Medicaid average
	High Performance	The MHP's performance was 1 standard deviation or more above the Michigan Medicaid average
	Average Performance	The MHP's performance was within 1 standard deviation of the Michigan Medicaid average
	Low Performance	The MHP's performance was 1 standard deviation or more below the Michigan Medicaid average
	Lowest Performance	The MHP's performance was 1.96 standard deviations or more below the Michigan Medicaid average

Table 5-23—2024 Michigan Consumer Guide

Plan	Overall Rating*	Doctors' Communication and Service	Getting Care	Keeping Kids Healthy	Living With Illness	Taking Care of Women
Aetna Better Health of Michigan ^{^^}						
Blue Cross Complete of Michigan [^]						
HAP CareSource						
McLaren Health Plan [^]						
Meridian Health Plan of Michigan [^]						
Molina Healthcare of Michigan [^]						
Priority Health Choice, Inc. [^]						
UnitedHealthcare Community Plan ^{^^}						
Upper Peninsula Health Plan						

*This rating includes all categories. This rating also includes how the member feels about their plan and healthcare.

[^]indicates the plan received Health Equity Accreditation from the National Committee for Quality Assurance (NCQA) as of October 2024.

^{^^}indicates the plan received Health Equity Accreditation Plus from NCQA as of September 2024. Further details may be found on the NCQA website located here: <https://reportcards.ncqa.org/methodology>.

6. Programwide Conclusions and Recommendations

HSAG performed a comprehensive assessment of the performance of the MHPs and identified their strengths and weaknesses related to the provision of healthcare services. The aggregated findings from all EQR activities were thoroughly analyzed and reviewed across the continuum of program areas and the activities that comprise the CHCP to identify programwide conclusions. HSAG presents these programwide conclusions and corresponding recommendations to MDHHS to drive progress toward achieving the goals of the MDHHS CQS and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid members. Table 6-1 displays each CQS goal and indicates whether the EQR activity results positively (✓), negatively (✗), or minimally (m) impacted the CHCP'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 Medicaid members. A dash (–) is noted in Table 6-1 if no trends were identified through an EQR activity that substantially impacted a goal or the EQR activity results could not be used to evaluate a goal.

Table 6-1—Programwide Conclusions and Recommendations

Performance Impact on Goals and Objectives ¹²²		Performance Domain
Goal #1—Ensure high quality and high levels of access to care		
✓	CQS Objective 1.1: The CHCP reached the statewide 2026 performance target to achieve the national 75th percentile for the <i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i> quality measure. The CHCP ranked between the 75th and 89th percentiles and its rate demonstrated a statistically significant increase from the prior year.	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
✓	CQS Objective 1.1: The CHCP made progress toward reaching the statewide 2026 performance target to achieve the national 50th percentile for the <i>Childhood Immunization Status—Combination 3</i> quality measure. While the CHCP ranked between the 25th and 49th percentiles, its rate demonstrated a statistically significant increase from the prior year.	
✓	CQS Objective 1.1: The CHCP reached the statewide 2026 performance target to achieve 67.98 percent for the <i>Global Rating of Health Plan</i> quality measure for CSHCS. The CHCP's rate was 68.83 percent and while not statistically significant, increased in performance from the prior year.	
✓	CQS Objectives 1.1 and 1.3: The CHCP reached the statewide 2026 performance target to achieve greater than or equal to 68.22 percent for the <i>Global Rating of Health Care</i> quality measure for CSHCS. The CHCP's rate was 69.57 percent and while not statistically significant, increased in performance from the prior year.	

¹²² All EQR activities were considered in HSAG's analysis, as applicable. However, HSAG's analysis did not include all CAHPS measures or performance measures and instead focused on the measures with a corresponding quality measure with the CQS.

Performance Impact on Goals and Objectives ¹²²		Performance Domain
✓	CQS Objective 1.1 and 1.2: The CHCP reached the statewide 2026 performance target to achieve greater than or equal to 70.6 percent for the <i>Composite Measure for Access to Specialized Services</i> quality measure for CSHCS. The CHCP's rate was 71.22 percent and while not statistically significant, increased in performance from the prior year.	
✓	CQS Objective 1.2: The CHCP made progress toward reaching the statewide 2026 performance target to achieve the national 75th percentile for the <i>Comprehensive Diabetes Care (CDC)—Eye Exams</i> quality measure. While the CHCP ranked between the 50th and 74th percentiles, its rate demonstrated a statistically significant increase from the prior year. ¹²³	
✓	CQS Objective 1.2: The CHCP made progress toward reaching the statewide 2026 performance target to achieve the national 75th percentile for the <i>Controlling High Blood Pressure</i> quality measure. While the CHCP ranked between the 50th and 74th percentiles, its rate demonstrated a statistically significant increase from the prior year.	
m	CQS Objective 1.1: The CHCP made minimal progress toward reaching the statewide 2026 performance target to achieve the national 50th percentile for the <i>Prenatal and Postpartum Care—Postpartum Care</i> quality measure. The CHCP ranked between the 25th and 49th percentiles and while not statistically significant, the rate increased in performance from the prior year.	
m	CQS Objective 1.1: The CHCP made minimal progress toward reaching the statewide 2026 performance target to achieve 83.3 percent for the <i>Composite Measure for Transportation</i> quality measure for CSHCS. The CHCP's rate was 71.49 percent and while not statistically significant, increased in performance from the prior year.	
m	CQS Objective 1.2: The CHCP made minimal progress toward reaching the statewide 2026 performance target to achieve the national 50th percentile for the <i>Asthma Medication Ratio—Total</i> quality measure. While the CHCP's rate increased from the prior year, the increase was not statistically significant and the CHCP ranked below the 25th percentile.	
m	CQS Objective 1.2: The CHCP made minimal progress toward reaching the statewide 2026 performance target to achieve greater than or equal to 94.79 percent for the <i>Composite Measure for How Well Doctors Communicate</i> quality measure for CSHCS. The CHCP's rate was 94.42 percent and while not statistically significant, increased in performance from the prior year.	
m	CQS Objective 1.2: The CHCP made minimal progress toward reaching the statewide 2026 performance target to achieve 91.21 percent for the <i>Composite Measure for Customer Service</i> quality measure for CSHCS. The CHCP's rate was 87.53 percent and while not statistically significant, increased in performance from the prior year.	

¹²³ NCQA replaced the *Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed* performance measure with the *Eye Exam for Patients With Diabetes (EED)* performance measure, the performance impact was based on the MHP's reported rate for *Eye Exam for Patients With Diabetes (EED)*.

Performance Impact on Goals and Objectives ¹²²		Performance Domain
m	CQS Objective 1.3: The CHCP made minimal progress toward reaching the statewide 2026 performance target to achieve 90.55 percent for the <i>Access to Prescription Medicines</i> quality measure for CSHCS. The CHCP’s rate was 89.40 percent and while not statistically significant, increased in performance from the prior year.	
✗	CQS Objective 1.1: The CHCP did not make progress toward reaching the statewide 2026 performance target to achieve greater than or equal to 73.83 percent for the <i>Global Rating of Specialist Seen Most Often</i> quality measure for CSHCS. The CHCP’s rate was 71.50 percent and while not statistically significant, decreased in performance from the prior year.	
✗	CQS Objective 1.3: The CHCP did not make progress toward reaching the statewide 2026 performance target to achieve the national 75th percentile for the <i>Getting Care Quickly Composite (Adult CAHPS)</i> quality measure. The CHCP ranked between the 50th and 74th percentiles and its rate was not statistically significantly different than the prior year.	
–	CQS Objective 1.3: The EQR activities do not produce data to assess the impact of the <i>Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies</i> quality measure under this objective.	
–	While the MHPs reported according to their methodologies and interpretations of MDHHS’ expectations for calculating network adequacy standards, the MHPs used differing time frames for enrollment and provider data in their network adequacy calculations and employed varying methodologies to calculate ratios. The MHPs also submitted similar network adequacy summary results in different formats. Due to the inconsistent methodologies applied to network adequacy indicator reporting, network adequacy results could not be compared across MHPs or aggregated to provide programwide results. ¹²⁴	
Goal #2—Strengthen person and family-centered approaches		
✓	CQS Objective 2.1: The CHCP made progress toward reaching the statewide 2026 performance target to achieve the national 75th percentile for the <i>Adults' Access to Preventive/Ambulatory Health Services—20–44 Years Old</i> quality measure. While the CHCP ranked between the 50th and 74th percentiles, its rate demonstrated a statistically significant increase from the prior year.	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
✓	CQS Objective 2.1: The CHCP reached the statewide 2026 performance target to achieve 67.98 percent for the <i>Global Rating of Health Plan</i> quality measure for CSHCS. The CHCP’s rate was 68.83 percent and while not statistically significant, increased in performance from the prior year.	
✓	CQS Objectives 2.1: The CHCP reached the statewide 2026 performance target to achieve greater than or equal to 68.22 percent for the <i>Global Rating of Health Care</i> quality measure	

¹²⁴ While the CQS did not include a specific quality measure associated with the findings and results of the EQR activity, HSAG used the EQR activity results in its programwide assessment when it aligned with a goal and/or objective(s) within the CQS.

Performance Impact on Goals and Objectives ¹²²		Performance Domain
	for CSHCS. The CHCP's rate was 69.57 percent and while not statistically significant, increased in performance from the prior year.	
✓	CQS Objective 2.2: The CHCP reached the statewide 2026 performance target to achieve greater than or equal to 70.6 percent for the <i>Composite Measure for Access to Specialized Services</i> quality measure for CSHCS. The CHCP's rate was 71.22 percent and while not statistically significant, increased in performance from the prior year.	
m	CQS Objective 2.1: The CHCP made minimal progress toward reaching the statewide 2026 performance target to achieve greater than or equal to 94.79 percent for the <i>Composite Measure for How Well Doctors Communicate</i> quality measure for CSHCS. The CHCP's rate was 94.42 percent and while not statistically significant, increased in performance from the prior year.	
✗	CQS Objective 2.1: The CHCP did not make progress toward reaching the statewide 2026 performance target to achieve the national 90th percentile for the <i>Rating of Health Plan</i> quality measure. The CHCP ranked between the 50th and 74th percentiles and its rate was not statistically significantly different than the prior year.	
✗	CQS Objective 2.1: The CHCP did not make progress toward reaching the statewide 2026 performance target to achieve greater than or equal to 73.83 percent for the <i>Global Rating of Specialist Seen Most Often</i> quality measure for CSHCS. The CHCP's rate was 71.50 percent and while not statistically significant, decreased in performance from the prior year.	
—	CQS Objective 2.1: The EQR activities do not produce data to assess the impact of the <i>Completion of Annual Health Risk Assessment</i> quality measure under this objective.	
—	CQS Objective 2.2: The EQR activities do not produce data to assess the impact of the <i>SDOH: Total Member Screening Rate, SDOH: Total Member Referral Rate, and Social Need Screening and Intervention</i> quality measures under this objective.	
Goal #3—Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)		
✓	CQS Objective 3.2: The CHCP reached the statewide 2026 performance target to achieve 67.98 percent for the <i>Global Rating of Health Plan</i> quality measure for CSHCS. The CHCP's rate was 68.83 percent and while not statistically significant, increased in performance from the prior year.	
✓	CQS Objectives 3.2: The CHCP reached the statewide 2026 performance target to achieve greater than or equal to 68.22 percent for the <i>Global Rating of Health Care</i> quality measure for CSHCS. The CHCP's rate was 69.57 percent and while not statistically significant, increased in performance from the prior year.	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
—	CQS Objective 3.1: The EQR activities do not produce data to assess the impact of the <i>Follow-Up After Hospitalization for Mental Illness Within 30 Days (FUH) (Adults)</i> quality measure under this objective.	

Performance Impact on Goals and Objectives ¹²²		Performance Domain
–	CQS Objective 3.1: The EQR activities do not produce data to assess the impact of the <i>Coordination of Care</i> quality measure for CSHCS under this objective. ¹²⁵	
–	CQS Objective 3.2: The EQR activities do not produce data to assess the impact of the <i>Implementation of Joint Care Management Processes</i> quality measure under this objective.	
Goal #4—Reduce racial and ethnic disparities in healthcare and health outcomes		
m	While MDHHS required the MHPs to continue with PIP topics focused on addressing disparities within their populations (i.e., prenatal care for eight MHPs and adult preventive care for one MHP), only one MHP was successful in eliminating the disparity without a decline in performance for the comparison group. ¹²⁶ Further, for the remaining eight MHPs, while no rates were statistically significantly different than the prior remeasurement period, five MHP rates declined and three MHP rates improved. ¹¹⁷	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
✗	CQS Objective 4.1: The CHCP made minimal progress toward reaching the statewide 2026 performance target to achieve 98 percent for the <i>Not Felt Treated Unfairly: Race and Ethnicity</i> quality measure for CSHCS. The CHCP’s rate was 96.60 percent and while not statistically significant, decreased in performance from the prior year.	
–	CQS Objective 4.1: The EQR activities do not produce data to assess the impact of the <i>Chlamydia Screening in Women—Total, Prenatal and Postpartum Care—Postpartum Care, Children Immunization Combo 3, Lead Screening in Children, Comprehensive Diabetes Care—Eye Exam, Adults' Access to Preventive/Ambulatory Health Services—20–44 Years Old</i> quality measures under this objective. While there are reported HEDIS rates that are stratified by race/ethnicity, the EQR deliverables did not include an analysis of this data.	
Goal #5—Improve quality outcomes through value-based initiatives and payment reform		
–	CQS Objective 5.1: The EQR activities do not produce data to assess the impact of the <i>Average Percentage of Plan Payments to Providers Who Are in APM Arrangements ("Big Numerator")</i> and <i>Average Percentage of Plan Payments to Providers That Are Tied to Quality ("Small Numerator")</i> quality measures under this objective.	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access
Recommendations		
<p>Based on findings identified through the EQR activities that impacted the goals and objectives in MDHHS’ CQS, HSAG has identified the following recommendations to support improvement in the quality, timeliness, and accessibility of healthcare services furnished to CHCP members:</p> <ul style="list-style-type: none">While the MHPs reported according to their methodologies and interpretations of MDHHS’ expectations for calculating network adequacy standards, there are opportunities for closer collaboration with MDHHS to ensure provider network reporting follows a standardized methodology across all MHPs. HSAG recommends that		

¹²⁵ The *Coordination of Care* quality measure listed in the CQS did not align with HSAG's *Coordination of Care* CAHPS measure and was not included in the SFY 2024 CSHCS CAHPS activity. MDHHS has elected to include the *Coordination of Care* CAHPS measure in the SFY 2025 activity, and the results from this measure will be included in future technical reports.

¹²⁶ Two MHPs (**HCS** and **UNI**) identified no disparities within their populations.

Performance Impact on Goals and Objectives ¹²⁷	Performance Domain
<p>MDHHS issue formal guidance specifying the time frame the MHPs should apply to the enrollment and provider data used in network adequacy calculations, and the methodology the MHPs should use to calculate ratios. Additionally, HSAG recommends that all MHPs update their reporting in accordance with any future MDHHS-issued guidance.</p> <ul style="list-style-type: none"> While the MHPs submitted similar network adequacy summary results (i.e., similar MDHHS-required information was present), it was provided in different formats, including standalone files with screenshots from Quest, embedded Quest screenshots within the NAP under section 2.7-6a or at the end of the document, and in Microsoft Excel files. HSAG recommends standardizing the submission process to ensure consistency across all MHPs. A standardized format would improve clarity, streamline analyses, and facilitate the identification of any flaws or discrepancies. To comply with the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), MDHHS should update the contracts with its MHPs as follows within the required effective dates for each specific requirement: <ul style="list-style-type: none"> Require the MHPs to respond to prior authorization requests for covered items and services within seven calendar days for standard requests to improve patient care outcomes and ensure members have more timely access to services. Require the MHPs to publicly report prior authorization data for members and providers to better understand the types of items and services which require prior authorization and how each MHP performed over time for approvals and denials. This requirement is to assure transparency and accountability in the healthcare system and allow for the efficiency of prior authorization practices of each MHP, and it enables the MHPs to assess trends, identify areas for improvement, and work toward continuous process improvement while maintaining the necessary quality checks for quality and appropriateness of care. To comply with the Medicaid and Children’s Health Insurance Program Managed Care Access, Finance, and Quality Final Rule (CMS-2439-F), MDHHS should implement the following within the required effective dates for each specific requirement: <ul style="list-style-type: none"> Review the maximum appointment wait time standards (e.g., 15 business days for primary care and OB/GYN) and update its contracts with its MHPs, as applicable. As NCQA replaced the <i>Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed</i> performance measure with the <i>Eye Exam for Patients With Diabetes (EED)</i> performance measure, MDHHS should consider updating the <i>Comprehensive Diabetes Care (CDC)—Eye Exams</i> quality measure under CQS Objective 1.2 to <i>Exam for Patients With Diabetes (EED)</i>. NCQA’s <i>Medical Assistance With Smoking and Tobacco Use Cessation (MSC)</i> performance measure assesses whether current smokers were advised to quit and discussed cessation medication and strategies with their clinician. A new measure will expand to adolescents and will leverage electronic clinical data to incorporate prevention, screening, and receipt of evidence-based cessation interventions. As NCQA intends to retire the survey measure when the replacement measure is ready (planned for HEDIS Measurement Year 2026), MDHHS should consider updating the <i>Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies</i> quality measure under CQS Objective 1.3 when the new measure is released.¹²⁷ 	

¹²⁷ National Committee on Quality Assurance. *Retiring and Replacing HEDIS Measures, 2024-2026*. July 17, 2023. Available at: <https://www.ncqa.org/blog/retiring-and-replacing-hedis-measures-2024-2026/>. Accessed on: Feb 18, 2025.

Appendix A. External Quality Review Activity Methodologies

Methods for Conducting External Quality Review Activities

Validation of Performance Improvement Projects

Activity Objectives

Validating PIPs is one of the mandatory activities described at 42 CFR §438.330(b)(1). In accordance with §438.330(d), MCOs, PIHPs, PAHPs, and primary care case management (PCCM) entities are required to have a QAPI program, which includes PIPs that focus on both clinical and nonclinical areas. Each PIP must involve:

- Measuring performance using objective quality indicators.
- Implementing system interventions to achieve 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 PIPs required by the State and underway during the preceding 12 months.

The primary objective of PIP validation is to determine the MHP's compliance with the requirements of 42 CFR §438.330(d). HSAG's evaluation of the PIP includes two key components of the quality improvement process:

1. HSAG evaluates the technical structure of the PIP to ensure that the MHP designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., study question, population, indicator[s], sampling techniques, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once designed, a MHP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, identification of causes and barriers, and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the MHP improves its rates through implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results).

The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that the MHP executed a methodologically sound improvement project, and any reported improvement is related to and can be reasonably linked to the quality improvement strategies and activities conducted by the MHP during the PIP.

MDHHS requires that each MHP conduct one PIP subject to validation by HSAG. For this year's SFY 2024 validation, eight of the 9 MHPs submitted Remeasurement 2 data for the state-mandated PIP topic, *Addressing Disparities in Timeliness of Prenatal Care*. The selected PIP topic is based on the HEDIS *Prenatal and Postpartum Care* measure; however, each MHP was required to use historical data to identify racial/ethnic disparities within its population related to timeliness of prenatal care.

This topic has the potential to improve the health of pregnant members through increasing early initiation of prenatal care. Women who do not receive adequate or timely prenatal care are at an increased risk of complications and poor birth outcomes. The selected study topic addressed CMS' requirements related to quality outcomes—specifically, the quality, timeliness, and accessibility of care and services.

Of note, one MHP (i.e., **UPP**) did not have a disparity related to timeliness of prenatal care. Therefore, MDHHS permitted this MHP to focus on reducing racial disparities in adult ambulatory and preventive access to care in members between the ages of 20 and 44 years.

Technical Methods of Data Collection and Analysis

In its PIP evaluation and validation, HSAG used the CMS EQR Protocol 1. Using this protocol, HSAG, in collaboration with MDHHS, developed the PIP Submission Form. Each MHP completed this form and submitted it to HSAG for review. The PIP Submission Form standardized the process for submitting information regarding the PIPs and ensured all CMS EQR Protocol 1 requirements were addressed.

HSAG, with MDHHS' input and approval, developed a PIP Validation Tool to ensure uniform validation of the PIPs. Using this tool, HSAG evaluated each of the PIPs according to the CMS EQR Protocols. The HSAG PIP Team consisted of, at a minimum, an analyst with expertise in statistics and PIP design and a clinician with expertise in performance improvement processes. The CMS EQR Protocols identify nine steps that should be validated for each PIP. For the SFY 2024 submissions, the MHPs reported Remeasurement 2 data and were validated for Steps 1 through 9 in the PIP Validation Tool.

The nine steps included in the PIP Validation Tool are listed below:

1. Review the Selected PIP Topic
2. Review the PIP Aim Statement
3. Review the Identified PIP Population
4. Review the Sampling Method
5. Review the Selected Performance Indicator(s)
6. Review the Data Collection Procedures
7. Review the Data Analysis and Interpretation of PIP Results
8. Assess the Improvement Strategies
9. Assess the Likelihood that Significant and Sustained Improvement Occurred

HSAG used the following methodology to evaluate PIPs conducted by the MHPs to determine PIP validity and to rate the percentage of compliance with CMS' protocol for conducting PIPs.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP 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 PIP process as “critical elements.” For a PIP to produce valid and reliable results, all critical elements must be *Met*.

In alignment with CMS Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. One validation rating reflects HSAG’s confidence that the MHP adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. This validation rating is based on the scores for applicable evaluation elements in Steps 1 through 8 of the PIP Validation Tool. The second validation rating is only assigned for PIPs that have progressed to the Outcomes stage (Step 9) and reflects HSAG’s confidence that the PIP’s performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP Validation Tool. For each applicable validation rating, HSAG reports the percentage of applicable evaluation elements that received a *Met* validation score and the corresponding confidence level: *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. The confidence level definitions for each validation rating are as follows for **HCS** and **UNI**’s PIPs:

1. Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)

- **High Confidence:** High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
- **Moderate Confidence:** Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
- **Low Confidence:** Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
- **No Confidence:** No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.

2. Overall Confidence That the PIP Achieved Significant Improvement (Step 9)

- **High Confidence:** All performance indicators demonstrated *statistically significant* improvement over the baseline.
- **Moderate Confidence:** One of the three scenarios below occurred:
 - All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
 - All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
 - Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
- **Low Confidence:** The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators

demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.

- **No Confidence:** The remeasurement methodology was not the same as the baseline methodology for all performance indicators **or** none of the performance indicators demonstrated improvement over the baseline.

The confidence level definitions for each validation rating are as follows for the remaining MHPs:

1. Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)

- **High Confidence:** High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
- **Moderate Confidence:** Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
- **Low Confidence:** Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
- **No Confidence:** No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.

2. Overall Confidence That the PIP Achieved Significant Improvement (Step 9)

- **High Confidence:** The remeasurement methodology was the same as the baseline methodology for all performance indicators. The disparate performance indicator demonstrated statistically significant improvement over the baseline performance **and** there was no statistically significant difference between the disparate group and comparison group **and** without a decline in performance for the comparison group.
- **Moderate Confidence:** The remeasurement methodology was the same as the baseline methodology for all performance indicators. The disparate performance indicator demonstrated statistically significant improvement over the baseline performance and there was no statistically significant difference between the disparate group and comparison group; however, there was a non-significant decline in performance for the comparison group.

Or the remeasurement methodology was the same as the baseline methodology for all performance indicators. The disparate group demonstrated statistically significant improvement over the baseline performance; however, there remains a statistically significant difference between the disparate group and the comparison group.

Or the remeasurement methodology was the same as the baseline methodology for all performance indicators. The disparate performance indicator did not demonstrate statistically significant improvement over the baseline; however, there was no statistically significant difference between the disparate group and comparison group and the comparison group did not have a decline in performance.

- **Low Confidence:** The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator. The disparate performance indicator demonstrated statistically significant improvement over the baseline performance and there was with no statistically significant difference between the disparate group and comparison group and without a decline in performance for the comparison group.

Or the remeasurement methodology was the same as the baseline methodology for all performance indicators. The disparate performance indicator did not demonstrate a statistically significant improvement over the baseline performance and there was no statistically significant difference between the disparate group and comparison group; however, the comparison group demonstrated a nonsignificant decline in performance.

Or the remeasurement methodology was not the same as the baseline methodology for at least one performance indicator. The disparate performance indicator did not demonstrate statistically significant improvement over the baseline performance and there was no statistically significant difference between the disparate group and comparison group, and without a decline in performance for the comparison group.

Or the remeasurement methodology was not the same as the baseline methodology for at least one performance indicator. The disparate performance indicator demonstrated statistically significant improvement over the baseline performance and there was no statistically significant difference between the disparate group and comparison group and there was a nonsignificant decline for the comparison group.

- **No Confidence:** The remeasurement methodology was not the same as the baseline methodology for all performance indicators.

Or the remeasurement methodology was not the same as the baseline methodology for at least one performance indicator and the disparate performance indicator did not demonstrate statistically significant improvement over the baseline and there was no statistically significant difference between the disparate group and comparison group; however, the comparison group demonstrated a significant decline in performance over the baseline.

Or the remeasurement methodology was not the same as the baseline methodology for at least one performance indicator and there was a statistically significant difference between the disparate group and comparison group.

Or the remeasurement methodology was the same as the baseline methodology for all performance indicators. The disparate performance indicator did not demonstrate statistically significant improvement over the baseline performance and there was a statistically significant difference between the disparate group and comparison group.

The MHPs had an opportunity to resubmit a revised PIP Submission Form and provide additional information or documentation in response to HSAG's initial validation scores of *Partially Met* or *Not Met*, regardless of whether the evaluation element was critical or noncritical. HSAG offered technical assistance to any MHP that requested an opportunity to review the initial validation scoring prior to resubmitting the PIP.

HSAG conducted a final validation for any resubmitted PIPs and documented the findings and recommendations for each PIP. Upon completion of the final validation, HSAG prepared a report of its findings and recommendations for each MHP. These reports, which complied with 42 CFR §438.364, were provided to MDHHS which distributed them to the MHPs.

Description of Data Obtained and Related Time Period

For SFY 2024, the MHPs submitted Remeasurement 2 data. The type of data obtained from each MHP and the performance indicator measurement period dates are listed below.

Table A-1—Description of Data Obtained and Measurement Periods

MHP	Data Obtained	Measurement Period	Period to Which the Data Applied
AET	Administrative	Remeasurement 2	October 8, 2022–October 7, 2023
BCC	Administrative		
HCS	Hybrid		
MCL	Hybrid		
MER	Hybrid		
MOL	Administrative		
PRI	Hybrid		
UNI	Hybrid		
UPP	Administrative		

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MHP provided to members, HSAG validated the PIPs to ensure it used a sound methodology in its design, implementation, analysis, and reporting of the project’s findings and outcomes. The process assesses the validation findings on the likely validity and reliability of the results by assigning a validation score of *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. HSAG further analyzed the quantitative results (e.g., performance indicator results compared to baseline, prior remeasurement period results, and project goal) and qualitative results (e.g., technical design of the PIP, data analysis, and implementation of improvement strategies) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and access to care and services furnished to the MHP’s Medicaid members.

Performance Measure Validation

Activity Objectives

In accordance with 42 CFR §438.330(c), states must require that MCOs, PIHPs, PAHPs, and PCCM entities submit performance measurement data as part of their QAPI programs. Validating performance measures is one of the mandatory EQR activities described in §438.358(b)(2). For the MCO, PIHP, PAHP, and PCCM entity, the EQR technical report must include information regarding the validation of performance measures (as required by the State) and/or performance measures calculated by the State during the preceding 12 months.

The primary objectives of the PMV process are to:

- Evaluate the accuracy of the performance measure data collected by the MHP.
- Determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure.

To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough IS evaluation, to assess each MHP's support system available to report accurate HEDIS measures. Results for a selected list of HEDIS measures, provided by MDHHS, are included in the annual assessment. However, additional performance measures and performance measure results can be referenced in Appendix B.

Technical Methods of Data Collection and Analysis

MDHHS required each MHP to collect and report a set of Medicaid HEDIS measures. Developed and maintained by NCQA, HEDIS is a set of performance measures broadly accepted in the managed care environment as an industry standard.

Each MHP underwent an NCQA HEDIS Compliance Audit conducted by an NCQA licensed organization. The NCQA HEDIS Compliance Audit followed NCQA audit methodology as set out in NCQA's MY 2023 Volume 5, *HEDIS Compliance Audit: Standards, Policies and Procedures*. The NCQA HEDIS Compliance Audit encompasses an in-depth examination of the MHPs' processes consistent with the CMS EQR Protocols. To complete the validation of the performance measure process according to the CMS EQR Protocol 2, HSAG performed an independent evaluation of the audit results and findings to determine the validity of each performance measure.

Each NCQA HEDIS Compliance Audit was conducted by a certified HEDIS compliance auditor and included the following activities:

Pre-Site Review Activities: Each MHP was required to complete the NCQA Record of Administration, Data Management, and Processes (Roadmap), which is comparable to the Information Systems Capabilities Assessment Tool, Appendix V of the CMS EQR Protocols. Pre-on-site conference calls were held to follow up on any outstanding questions. HSAG conducted a thorough review of the

Roadmap and supporting documentation, including an evaluation of processes used for collecting, storing, validating, and reporting the performance measure data.

Site Review Activities: The on-site reviews, which typically lasted one to two days, included:

- An evaluation of system compliance, focusing on the processing of claims and encounters.
- An overview of data integration and control procedures, including discussion and observation.
- A review of how all data sources were combined and the method used to produce the performance measures.
- Interviews with MHP staff members involved with any aspect of performance measure reporting.
- A closing conference at which the auditor summarized preliminary findings and recommendations.

Post-Site Review Activities: For each performance measure calculated and reported by the MHPs, the auditor aggregated the findings from the pre-site review and site review activities to determine whether the reported measures were valid, based on an allowable bias. The auditor assigned each measure one of seven audit findings: (1) *Reportable* (a reportable rate was submitted for the measure), (2) *Small Denominator* (the MHP followed the specifications, but the denominator was too small [e.g., <30] to report a valid rate), (3) *No Benefit* (the MHP did not offer the health benefits required by the measure), (4) *Not Reportable* (the MHP chose not to report the measure), (5) *Not Required* (the MHP was not required to report the measure), (6) *Biased Rate* (the calculated rate was materially biased), or (7) *Un-Audited* (the MHP chose to report a measure that is not required to be audited).

HSAG performed a comprehensive review and analysis of the MHPs' Interactive Data Submission System (IDSS) results, data submission tools, and MHP-specific NCQA HEDIS Compliance Audit Reports and performance measure reports.

HSAG ensured that the following criteria were met prior to accepting any validation results:

- An NCQA-licensed organization completed the audit.
- An NCQA-certified HEDIS compliance auditor led the audit.
- The audit scope included all MDHHS-selected HEDIS measures.
- The audit scope focused on the Medicaid product line.
- Data were submitted via an auditor-locked NCQA IDSS.
- A final audit opinion, signed by the lead auditor and responsible officer within the licensed organization, was produced.

Description of Data Obtained and Related Time Period

As identified in the CMS EQR Protocol 2, the following key types of data were obtained and reviewed as part of the validation of performance measures. Table A-2 shows the data sources used in the validation of performance measures and the time period to which the data applied.

Table A-2—Description of Data Sources

Data Obtained	Measurement Period
NCQA HEDIS Compliance Audit Reports were obtained for each MHP, which included a description of the audit process, the results of the IS findings, and the final audit designations for each performance measure.	Calendar Year (CY) 2023 (HEDIS MY 2023)
Performance measure reports, submitted by the MHPs using NCQA’s IDSS, were analyzed and subsequently validated by HSAG.	CY 2023 (HEDIS MY 2023)
Previous performance measure reports were reviewed to assess trending patterns and the reasonability of rates.	CY 2022 (HEDIS MY 2022)

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MHP provided to members, HSAG evaluated the results for each performance measure assigned an audit finding of *Reportable*, *Small Denominator*, *No Benefit*, *Not Reportable*, *Not Required*, *Biased Rate*, or *Un-Audited*. HSAG further analyzed the results of the MHP’s HEDIS MY 2023 performance measure rates and 2023 performance levels based on comparisons to national percentiles to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MHP’s Medicaid members.

Compliance Review

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the MHPs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the member rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the QAPI requirements described in 42 CFR §438.330. To meet this requirement, MDHHS performed annual compliance reviews of its contracted MHPs.

The objectives of conducting compliance reviews are to ensure performance and adherence to contractual provisions as well as compliance with federal Medicaid managed care regulations. The reviews also aid in identifying areas of noncompliance and assist MHPs in developing corrective actions to achieve compliance with State and federal requirements.

Technical Methods of Data Collection and Analysis

MDHHS is responsible for conducting compliance activities that assess the MHPs' conformity with State requirements and federal Medicaid managed care regulations. To meet this requirement, MDHHS identifies the requirements necessary for review during the state fiscal year and divides the requirements into a 12-month compliance monitoring schedule. The MHPs were provided with a *FY2024 MHP Contract Compliance Review Timeline* that outlined the areas of focus for each month's review and the documents required to be submitted to MDHHS to demonstrate compliance.

This technical report presents the results of the compliance reviews performed during the SFY 2024 contract year. MDHHS conducted a compliance review of six standards listed in Table A-3. Table A-3 also crosswalks MDHHS' compliance review standards to the associated federal standards and citations.

Table A-3—Compliance Review Standards Crosswalk¹

MDHHS Compliance Review Standard		Federal Standard and Citation	
		Medicaid	CHIP
1	Administrative	§438.224	§457.1233(e)
2	Providers	§438.10 §438.206 §438.207 §438.210 §438.214 §438.230	§457.1207 §457.1230(a) §457.1230(b) §457.1230(d) §457.1233(a) §457.1233(b)

MDHHS Compliance Review Standard		Federal Standard and Citation	
		Medicaid	CHIP
3	Members	§438.10 §438.100 §438.114 §438.206 §438.208 §438.210 §438.228 §438.230 Part 438, Subpart F	§457.1207 §457.1220 §457.1228 §457.1230(a) §457.1230(c) §457.1230(d) §457.1260 §457.1233(b)
4	Quality	§438.208 §438.210 §438.236 §438.330	§457.1230(c) §457.1230(d) §457.1233(c) §457.1240(b)
5	MIS/Financial	§438.56 §438.242	§457.1212 §457.1233(d)
6	OIG/Program Integrity	§438.230 Part 438, Subpart H	§457.1233(b) §457.1285

¹ HSAG and MDHHS created a crosswalk to compare MDHHS compliance review standards to federal standards, but this crosswalk should not be interpreted to mean the State's standards include all specific federal requirements under 42 CFR §438.358(b)(1)(iii).

MDHHS reviewers used a compliance review tool for each MHP to document its findings and to identify, when applicable, specific action(s) required of the MHP to address any areas of noncompliance with contractual requirements.

Attestation—For certain elements, if an MHP met requirements in the last compliance review, the MHP was allowed to attest that the previously submitted documentation was still applicable and had not changed. These attestations are allowed every other year (e.g., if an MHP attested to an item in SFY 2023, it may not attest to the item again in SFY 2024). If the MHP attests two years in a row, it will be considered non-compliant, and the required submission will be considered overdue. No partial attestations were allowable and the MHP must have attested to all portions of the item. Partial attestations were to be scored as *Not Met* and considered overdue.

Deeming—As all MHPs are NCQA-accredited, MDHHS considered certain elements deemable. In order for these elements to be deemable, the MHP must have had the NCQA Medicaid module completed. If the module was completed, the MHP was only required to share the results of that survey. If the MHP did not have the NCQA Medicaid module completed, the MHP would have been required to submit documentation for MDHHS' review. The elements that MDHHS considers NCQA deemable are outlined in the MDHHS CQS. If the MHP received a *Met* score for an item within the NCQA deemable

portion of the compliance review during the SFY 2023 compliance review, and the documentation had not changed, an attestation that the documentation continues to include the required content was acceptable. If any item received a *Not Met* score in the SFY 2023 compliance review, documentation for that item must be submitted.

For each element reviewed, MDHHS assigned one of the following scores:

- *Met*—The MHP’s submission met contract and compliance review requirements.
- *Not Met*—The MHP’s submission did not meet contract or compliance review requirements.
- *Satisfied*—A compliance item was unable to be scored as *Met* for all portions of an item, but a narrative explanation satisfactorily justified the reason for not meeting the standard (only allowable for elements for items 5.13, 5.14, 5.15 or 5.16 within the MIS/Financial standard).
- *NA*—MDHHS determined the review element was not applicable during the compliance review.

For each MHP, MDHHS calculated a total percentage-of-compliance score for each of the standards and an overall percentage-of-compliance score across the standards. MDHHS calculated the total score for each standard by totaling the number of *Met* (i.e., 1 point) elements and the number of *Not Met* and *Satisfied*¹²⁸ (i.e., 0 points) elements, then dividing the summed score by the total number of elements for that standard. MDHHS determined the overall percentage-of-compliance score across the areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements). A summary of MHP-specific and program-wide results were provided to HSAG via the *All Plans MHP FY2024 CR Results* report.

Upon receiving a *Not Met* finding, the MHPs were required to submit a CAP,¹²⁹ which was reviewed by MDHHS to determine acceptability. If an acceptable CAP was received by the due date, MDHHS provided documentation in the compliance review tools and the *Not Met* score remained. If a CAP was not received by the due date or if the CAP received by MDHHS did not meet requirements, the MHP was subject to financial penalties or paying liquidation damages outlined in the contract. MDHHS’ CAP review process included the eight steps (with Step 2 having two separate components) identified in Table A-4.

¹²⁸ A *Satisfied* score was considered “neutral” by MDHHS (i.e., was not counted as being a *Met* score, but does not have the same penalty as a *Not Met* score in relation to the auto-assignment algorithm).

¹²⁹ Under limited circumstances, MDHHS did not require a CAP for a *Not Met* element. Reasons for not requiring a CAP included but were not limited to: when there is an existing or previous CAP related to the findings; an MDHHS reviewer determined the findings were not egregious due to a lack of clarity of the state-specific requirement; submission was compliant but was not submitted timely.

Table A-4—MDHHS CAP Review Process

Step	Entity Responsible for Completing Step	
	MDHHS	MHP
Step 1: Identify the Issue	✓	
Step 2: MHP Dispute of the CAP (optional)		✓
Step 2a: Response to Dispute	✓	
Step 3: MHP Corrective Action		✓
Step 4: Acceptance of Corrective Action	✓	
Step 5: MHP Revised Corrective Action (if needed)		✓
Step 6: Acceptance of Revised Corrective Action (if needed)	✓	
Step 7: Effectiveness of Corrective Action Plan		✓
Step 8: Closure	✓	

Focus Studies—MDHHS also conducts annual focus studies with each MHP that consists of staff interviews and select system demonstrations, when applicable. Each year MDHHS determines the scope of the study based on current initiatives and improvement opportunities in three areas: CSHCS, Operations, and Quality. Table A-5 displays the topics included in each of the three areas.

Table A-5—Focus Study Areas and Topics

Area	Topics
CSHCS	<ul style="list-style-type: none"> • Family Engagement • Care Coordination Agreement • Health Equity Project • Meetings with Office of Medical Affairs (OMA) • Transition • Adult Providers
Operations	<ul style="list-style-type: none"> • Network Adequacy • CAP Review • Plan-Specific Items • Automated Contact Tracking System • Live System Review • New Adult Dental Coverage • Public Health Emergency (PHE) Unwind • Pharmacy <ul style="list-style-type: none"> – Processes for the Michigan Pharmaceutical Product List (MPPL) – Drug Formulary for Medical Benefits – Internal Medication Therapy Management (MTM)

Area	Topics
Quality	<ul style="list-style-type: none"> Maternal Infant Health Program (MIHP) Immunizations (IMMS) Doula Policy

The MHPs had pre-submission requirements for portions of the focused study in addition to the case review. MDHHS also requested that each MHP submit copies of slide decks, as applicable, and all presentation materials used during the study. Specific MDHHS staff members were responsible for taking notes during each component of the review (i.e., CSHCS, Operations, and Quality) to document the findings of the focus studies. The elements of the focus studies are not scored, but the findings were used to supplement the compliance review activity.

Description of Data Obtained and Related Time Period

To assess the MHPs' compliance with federal and State requirements, MDHHS obtained information from a wide range of materials produced by the MHPs throughout SFY 2024, including, but not limited to, the following:

- Policies and procedures
- Accreditation certificates or letters, organizational charts, governing board member appointment documentation, and board meeting minutes
- Operational plans, health plan profiles, administrative position descriptions, and management and financial reports
- Consolidated Annual Report, including financial information and member and provider incentives
- Provider contracts, network access plan, network access and provider availability documentation, and provider appeal logs
- Subcontract/delegation agreements and monitoring documentation
- CPGs and supporting documentation
- Member material timeliness documentation, including ID card mailings and new member packets
- Copies of member materials, including new member packets, member handbooks, member newsletters, member websites, and provider directories
- Maximum allowable cost (MAC) pricing reconsiderations process
- Grievance, appeal, and prior-authorization reports and notice templates
- QIPs and UM programs, quality improvement workplans and worksheets, utilization reports, quality improvement effectiveness reports, and committee meeting minutes
- Enrollment and disenrollment procedures
- PIPs
- Compliance plan and employee training documentation
- Program integrity forms and reports

Process for Drawing Conclusions

To draw conclusions and provide an understanding of the strengths and weaknesses of each MHP individually, HSAG used the quantitative results and percentage-of-compliance score calculated by MDHHS for each standard. HSAG determined each MHP's substantial strengths and weaknesses as follows:

- Strength—Any standard that achieved a 100 percent compliance score.
- Weakness—Any standard that scored below the statewide compliance score.

HSAG further analyzed the qualitative results of each strength and weakness (i.e., findings that resulted in the strength or weakness) to draw conclusions about the quality, timeliness, and accessibility of care and services that each MHP provided to members by determining whether each strength and weakness impacted one or more of the domains of quality, timeliness, and access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to each MHP's Medicaid members.

Network Adequacy Validation

In accordance with 42 CFR §438.350(a), states that contract with MCOs, PIHPs, or PAHPs are required to have a qualified EQRO perform an annual EQR that includes validation of network adequacy to ensure provider networks are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across the continuum of services.

The objectives of the validation of network adequacy are to:

- Assess the accuracy of the MDHHS-defined network adequacy indicators reported by the MHPs.
- Evaluate the collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, and systems and processes used.
- Determine an indicator-level validation rating, which refers to the overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators, as set forth by MDHHS.

Technical Methods of Data Collection and Analysis

HSAG collected network adequacy data from the MHPs via a secure file transfer protocol (SFTP) site and via virtual NAV audits. HSAG used the collected data to conduct the validation of network adequacy in accordance with the CMS EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 4).¹³⁰

¹³⁰ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Oct 8, 2024.

HSAG conducted a virtual review with the MHPs. HSAG collected information using several methods, including interviews, system demonstrations, review of source data output files, primary source verification (PSV), observation of data processing, and review of final network adequacy indicator-level reports. The virtual review activities performed for each MHP included the following:

- Opening meeting
- Review of the Information Systems Capabilities Assessment Tool (ISCAT) and supporting documentation
- Evaluation of underlying systems and processes
- Overview of data collection, integration, methods, and control procedures
- Network adequacy source data PSV and results
- Closing conference
- HSAG conducted interviews with key MHP staff members who were involved with the calculation and reporting of network adequacy indicators.

Description of Data Obtained and Related Time Period

HSAG prepared a document request packet that was submitted to each MHP outlining the activities conducted during the validation process. The document request packet included a request for documentation to support HSAG's ability to assess each MHP information systems and processes, network adequacy indicator methodology, and accuracy of network adequacy reporting at the indicator level. Documents requested included an ISCAT, a timetable for completion, and instructions for submission. HSAG worked with the MHP to identify all data sources informing calculation and reporting at the network adequacy indicator level. HSAG obtained the following data and documentation from the MHP to conduct the NAV audits:

- Information systems data from the ISCAT
- Network adequacy logic for calculation of network adequacy indicators
- Network adequacy data files
- Network adequacy monitoring data
- Supporting documentation, including policies and procedures, data dictionaries, system flow diagrams, system log files, and data collection process descriptions
- Network Adequacy Reporting Template submission to MDHHS using the November 2023 member enrollment and provider network table, along with the most recent GeoAccess data available.

Process for Drawing Conclusions

HSAG calculated each network adequacy indicator’s validation score by identifying the number of *Met* and *Not Met* elements recorded in the HSAG CMS EQR Protocol 4 Worksheet 4.6, noted in Table A-6.

Table A-6—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of <i>Met</i> elements
B. Total number of <i>Not Met</i> elements
Score = $A / (A + B) \times 100\%$
Number of <i>Not Met</i> elements determined to have significant bias on the results

The overall validation rating refers to HSAG’s overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. The CMS EQR Protocol 4 defines validation rating designations at the indicator level, which are defined in Table A-7 and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table A-7—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	<i>High Confidence</i>
50.0% to 89.9%	<i>Moderate Confidence</i>
10.0% to 49.9%	<i>Low Confidence</i>
Less than 10% and/or any <i>Not Met</i> element has significant bias on the results	<i>No Confidence</i>

By assessing each MHP’s performance and NAV reporting process, HSAG identified areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the MHPs, HSAG assigned each of the standards reviewed for NAV activities to one or more of three domains of care. This assignment to domains of care is depicted in Table A-8.

Table A-8—Assignment of NAV Audit Activities to the Quality, Timeliness, and Access Domains

NAV Standard	Quality	Timeliness	Access
Time and Distance		✓	✓

Network Provider Survey

Activity Objectives

The primary purpose of this survey was to assess the accuracy of the managed care network information supplied to Comprehensive Health Care Program (CHCP)¹³¹ members by comparing data obtained from three sources: the MHPs' provider data files, the MHPs' online provider directories, and telephone survey calls to sampled provider locations. As a secondary survey objective, HSAG collected appointment availability information for routine PCP, pediatric, and OB/GYN provider visits among new patients enrolled with an MHP under the MI Medicaid program. Specific survey objectives included the following:

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

Technical Methods of Data Collection and Analysis

Each MHP submitted provider data to HSAG, reflecting PCPs actively contracted with the MHP at the time the data file was created to serve individuals enrolled in the CHCP. Service locations with addresses outside of Michigan, Indiana, Ohio, or Wisconsin were excluded from the sample frame. Out-of-state service locations were included if the provider is located within a reasonable distance (i.e., 30 minutes or 30 miles) of each MHP's applicable region. HSAG used these data to conduct the NVS.

The NVS included a provider directory validation (PDV) in which HSAG compared key indicators published in each online directory with the data in the MHP's provider file to confirm whether each MHP's website met the federal requirements in Title 42 Code of Federal Regulations (42 CFR) Section (§) 438.10(h) and the state-specific requirements outlined in the CHCP for the MDHHS contract. HSAG then validated the accuracy of the online directories by completing a secret shopper telephone survey to evaluate the accuracy of the provider information located in the directories. The secret shopper survey also collected information on appointment availability and wait times with the sampled providers for routine PCP and prenatal care visits. The secret shopper approach allows for objective data collection from healthcare providers without the potential bias introduced by knowing the identity of the caller. Using the provider data supplied to HSAG by each MHP, secret shopper callers contacted sampled provider locations between April and June 2024.

¹³¹ CCHP is also known as MI Medicaid.

Several limitations and analytic considerations must be noted when reviewing NVS results:

- The provider data submitted by the MHPs in March 2024 may have changed and subsequently been updated in the MHPs' data systems and/or online directories prior to HSAG's PDV reviews and secret shopper survey calls between April and June 2024.
- Reviewers conducted the directory reviews using desktop computers with high-speed Internet connections. Reviewers did not attempt to access or navigate the MHPs' online directories from mobile devices or using accessibility tools (e.g., software that reads the website content for users with limited eyesight). The current study cannot speak to whether the results are maintained across the different types of devices that members may use to access provider directories.
- HSAG included cases in the telephone survey only if those cases matched on eight key provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, provider type/specialty, and new patient acceptance. PDV cases that did not match on these indicators were not included in the secret shopper survey. It is unknown whether the telephone survey results would have been better, similar, or worse among the PDV cases that did not match on the eight key provider indicators described.
- To maintain the secret nature of the survey and to ensure consistent data collection across cases, callers used a standardized survey script and posed as members or parents/caretakers of child 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 or who may accept scenarios outside of the survey script (e.g., leaving voicemails for an office, supplying personally identifying information, or obtaining an appointment through an Internet-based scheduling portal).
- HSAG based wait time survey results on the time to the first available appointment at the sampled location. As such, survey results may underrepresent timely appointments for situations when members are willing to travel to an alternate location.
- Survey findings were compiled from self-reported responses supplied to callers by providers' office personnel. As such, survey responses may vary from information obtained at other times or by using other methods of communication (e.g., online portals, speaking to a different representative at the provider's office).
- The survey script did not address specific clinical conditions that may have resulted in more timely appointments or greater availability of services (e.g., a patient with a time-sensitive health condition or a referral from another provider).
- Appointment availability rates were calculated using cases accepting new patients as the denominator in the 2022 and 2023 reports. However, the denominator used in the 2024 report was cases reached. Caution should be exercised when comparing 2024 appointment availability rates with the rates in the 2022 and 2023 reports.
- No OB/GYN providers were sampled for **HCS**, and low numbers of OB/GYN providers were sampled for **BCC** (four providers), **MCL** (five providers), **PRI** (eight providers), **UPP** (17 providers), **AET** (38 providers), and **MER** (39 providers) due to the eligible population criteria (i.e., providers with the PCP indicator), which reduced the number of eligible OB/GYN providers.

Caution should be exercised when interpreting OB/GYN results for **AET**, **BCC**, **HCS**, **MCL**, **MER**, **PRI**, and **UPP**.

- As a result of **MER**'s low rate of providers found in the online directory and cases that matched on all eight key provider indicators in the PDV, there were a limited number of cases included for the secret shopper survey. Caution should be exercised when interpreting **MER**'s secret shopper survey results.
- MHPs are responsible for ensuring that MI Medicaid members have access to a provider location within MDHHS' contract standards, rather than requiring that each individual provider or location offer appointments within specified time frames. As such, extended appointment wait times from individual provider locations should be considered in the context of the MHP's processes for assisting MI Medicaid members who require timely appointments.

Description of Data Obtained and Related Time Period

HSAG completed PDV reviews and secret shopper calls during April and June 2024. Prior to analyzing the results, HSAG reviewed the responses to ensure complete and accurate data entry.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MHP provided to members, HSAG analyzed the results of the activity to determine each MHP's substantial strengths and weaknesses by assessing (1) the degree to which the MHPs' online provider directory information is accurate, up-to-date, and easy to locate and navigate; (2) which service locations accepted patients enrolled with the requested MHP for the MI Medicaid program and the degree to which MHP and MI Medicaid acceptance aligned with the MHPs' provider data; (3) whether service locations accepting MI Medicaid for the requested MHP accepted new patients and the degree to which new patient acceptance aligned with the MHPs' provider data; and (4) appointment availability with the sampled service locations for routine PCP, pediatric, and OB/GYN visits.

Encounter Data Validation

Activity Objectives

Accurate and complete encounter data are critical to the success of a managed care program. State Medicaid agencies rely on the quality of encounter data submissions from contracted MCEs to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During SFY 2024, MDHHS contracted with HSAG to conduct an EDV activity. HSAG conducted the following core evaluation activity for all nine MHPs:

- MRR— analysis of MDHHS' electronic encounter data completeness and accuracy by comparing the MDHHS' electronic encounter data to the information documented in the corresponding

members' medical records for services rendered from October 1, 2022, through September 30, 2023. This activity aligns with *Activity 4: Review Medical Records* in the CMS EQR Protocol 5.

The review aimed to verify whether key data elements in the encounter data (i.e., *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*), were supported by the information found in the medical records. The goal was to answer the following question:

- Are the data elements in the professional encounters complete and accurate when compared to information in the medical records?

Technical Methods of Data Collection and Analysis

The technical methodology for data collection and analysis for the EDV activity involved several key components:

- **Eligible Population Identification and Sampling:** HSAG identified eligible members continuously enrolled in the MHP during the review period and generated a sample of members based on this eligibility. Random sampling was used to select 411 members from the eligible population for each MHP. The SURVEYSELECT procedure in SAS[®],¹³² was used to randomly select one professional visit for each sampled member.
- **Medical Record Procurement:** Each MHP procured medical records from its contracted providers and submitted to HSAG through a secure data exchange platform. To improve procurement rates, HSAG conducted a technical assistance session to guide MHPs in the procurement process.
- **Review Process:** HSAG's trained reviewers verified whether the selected service date from MDHHS' encounter data could be matched with the medical record. For any discrepancies, reviewers documented omissions or inaccuracies. Reviewers also checked for documentation for a second service date within the study period and validated associated key data elements if available.
- **Data Collection and Tool:** An HSAG-designed electronic data collection tool was used to ensure consistency in documenting findings. This tool included built-in checks to ensure data accuracy.
- **Data Validation and Quality Control:** HSAG reviewers underwent thorough training and interrater reliability testing, and the collected data were cross-checked to ensure consistency and accuracy throughout the review process.
- **Review Indicators and Analysis:** After the data collection, HSAG analysts conducted data analysis using specific review indicators. Table A-9 displays the review indicators that were used to report the MRR results.

¹³² SAS and all other SAS Institute Inc. product or service names are registered trademarks or trademarks of SAS Institute Inc. in the USA and other countries. ® indicates USA registration.

Table A-9—MRR Indicators

Review Indicator	Denominator	Numerator
Medical Record Procurement Rate: Percentage of medical records submitted. Additionally, the reasons for missing medical records were presented.	Total number of requested sample cases.	Number of requested sample cases with medical records submitted for either the sampled date of service or the second date of service.
Second Date of Service Submission Rate: Percentage of sample cases with a second date of service submitted in the medical records.	Number of sample cases with medical records submitted.	Number of sample cases with a second date of service submitted in the medical records.
Medical Record Omission Rate: Percentage of data elements (e.g., <i>Date of Service</i>) identified in MDHHS' data warehouse that are not found in the members' medical records. HSAG calculated this review indicator for each data element.	Total number of data elements (e.g., <i>Date of Service</i>) identified in MDHHS' data warehouse (i.e., based on the sample dates of service and the second dates of service that are found in MDHHS' data warehouse).	Number of data elements (e.g., <i>Date of Service</i>) in the denominator but not found in the medical records.
Encounter Data Omission Rate: Percentage of data elements (e.g., <i>Date of Service</i>) identified in members' medical records, but not found in MDHHS' data warehouse. HSAG calculated this review indicator for each data element.	Total number of data elements (e.g., <i>Date of Service</i>) identified in members' medical records (i.e., based on the medical records procured for the sample dates of service and second dates of service).	Number of data elements (e.g., <i>Date of Service</i>) in the denominator but not found in MDHHS' data warehouse.
Diagnosis Code Accuracy: Percentage of diagnosis codes supported by the medical records. Additionally, the frequency count of associated reasons for inaccuracy were presented.	Total number of diagnosis codes that met the following two criteria: <ul style="list-style-type: none"> For dates of service (i.e., including both the sample dates of service and the second dates of service) that exist in both MDHHS' encounter data and the medical records. Diagnosis codes present for both MDHHS' encounter data and the medical records. 	Number of diagnosis codes supported by the medical records.

Review Indicator	Denominator	Numerator
Procedure Code Accuracy: Percentage of procedure codes supported by the medical records. Additionally, the frequency count of associated reasons for inaccuracy were presented.	Total number of procedure codes that met the following two criteria: <ul style="list-style-type: none"> For dates of service (i.e., including both the sample dates of service and the second dates of service) that exist in both MDHHS' encounter data and the medical records. Procedure codes present for both MDHHS' encounter data and the medical records. 	Number of procedure codes supported by the medical records.
Procedure Code Modifier Accuracy: Percentage of procedure code modifiers supported by the medical records.	Total number of procedure code modifiers that met the following two criteria: <ul style="list-style-type: none"> For dates of service (i.e., including both the sample dates of service and the second dates of service) that exist in both MDHHS' encounter data and the medical records. Procedure code modifiers present for both MDHHS' encounter data and the medical records. 	Number of procedure code modifiers supported by the medical records.
All-Element Accuracy Rate: Percentage of dates of service present in both MDHHS' encounter data and the medical records, with the same values for all data elements.	Total number of dates of service (i.e., including both the sample dates of service and second dates of service) that are in both MDHHS' encounter data and the medical records.	The number of dates of service in the denominator with the same diagnosis codes, procedure codes, and procedure code modifiers for a given date of service.

Description of Data Obtained and Related Time Period

Data obtained from MDHHS included:

- Claims and encounter data with dates of service from October 1, 2022, through September 30, 2023.
- Member demographic and enrollment data.
- Provider data.

Data obtained from the MHPs included:

- Medical records for services rendered from October 1, 2022, through September 30, 2023.

Process for Drawing Conclusions

To draw conclusions about the encounter data completeness and accuracy between each MHP's medical records and key data elements from MDHHS' encounter data, HSAG analyzed the results using key metrics previously described. To identify areas of strengths and weaknesses, HSAG leveraged its extensive experience working with other states in assessing the completeness and accuracy of encounter data, and medical records. This approach provided a comparative framework that enabled a thorough assessment of each MHP's performance. HSAG determined each MHP's substantial strengths and weaknesses as follows:

- Strength—Identified areas where data completeness and accuracy were consistently high, highlighting best practices and successful methodologies implemented by the MHPs.
- Weakness—Highlighted areas with recurring data errors or omissions, assessing the impact on overall data reliability and compliance with MDHHS' requirements.

Additionally, for each identified weakness, HSAG provided recommendations to support improvements in the quality of encounter data submissions to MDHHS, aiming to enhance data integrity and ensure alignment with state requirements.

Consumer Assessment of Healthcare Providers and Systems Analysis

Activity Objectives

The CAHPS surveys ask adult members and parents/caretaker of child members to report on and evaluate their experiences with healthcare. The surveys cover topics that are important to members, such as the communication skills of providers and the accessibility of services. The CAHPS surveys are recognized nationally as an industry standard for both commercial and public payers. The sampling and data collection procedures promote both the standardized administration of survey instruments and the comparability of the resulting data.

Technical Methods of Data Collection and Analysis

The technical method of data collection was through administration of the CAHPS 5.1H Adult Medicaid Health Plan Survey to the adult Medicaid population, and the CAHPS 5.1H Child Medicaid Health Plan Survey (without the CCC measurement set) to the child Medicaid population for the adult and child Medicaid CAHPS surveys. Various methods of data collection were used for the CAHPS surveys, such as mixed-mode (i.e., mailed surveys followed by telephone interviews of non-respondents) or mixed-mode and Internet protocol methodology (i.e., mailed surveys with an Internet link included on the cover letter followed by telephone interviews of non-respondents). For the adult and child Medicaid CAHPS

surveys, based on NCQA protocol, adult members included as eligible for the survey were 18 years of age or older as of December 31, 2023; and child members included as eligible for the survey were 17 years of age or younger as of December 31, 2023.

The survey questions were categorized into various measures of member experience. For the adult and child Medicaid surveys, these measures included four global ratings, four composite measures, and three medical assistance with smoking and tobacco use cessation items.¹³³ The global ratings reflected respondents' overall experience with their/their child's personal doctor, specialist, health plan, and all healthcare. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*). The medical assistance with smoking and tobacco use cessation items assessed the various aspects of providing assistance with smoking and tobacco use cessation in the adult population.

For the CSHCS CAHPS survey, a modified version of the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and CCC measurement set was used for data collection for the child Medicaid populations. Data were collected using mail-only methodology. All sampled members received an English version of the survey via mail. A toll-free number was provided for a member to call to complete a survey via Computer Assisted Telephone Interviewing (CATI). For the CSHCS CAHPS survey, child members included as eligible for the survey were 17 years of age or younger as of February 29, 2024.

For the CSHCS CAHPS survey, these measures included three global rating questions, four composite measures, and three individual item measures. The global ratings reflected respondents' overall experience with the health plan, healthcare, and specialists. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Customer Service* and *How Well Doctors Communicate*). The individual item measures were individual questions that looked at specific areas of care (e.g., *Access to Prescription Medicines*).

NCQA requires a minimum of 100 respondents on each item to report the measure as a valid CAHPS survey result; however, for this report, if available, the MHPs' results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Measure results that did not meet the minimum number of 100 respondents are denoted in the tables with a cross (+). Caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

For each of the global ratings, the percentage of respondents who chose the top experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. For each of the composite measures, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices were "Never," "Sometimes," "Usually," or "Always." A positive or top-box response for the composites was defined as a response of "Always" or "Usually." The percentage of top-box responses is referred to as a top-box score for the composite measures. For the medical assistance with smoking and tobacco use cessation measure items, responses of "Always/Usually/Sometimes" were

¹³³ The medical assistance with smoking and tobacco use cessation measure items related to smoking cessation were only included for the adult surveys.

used to determine if the respondent qualified for inclusion in the numerator. The rates presented follow NCQA's methodology of calculating a rolling average using the current and prior year's results. Individual item measure question response choices were "Never," "Sometimes," "Usually," or "Always," and "Extremely Dissatisfied," "Somewhat Dissatisfied," "Neither Satisfied Nor Dissatisfied," "Somewhat Satisfied," or "Extremely Satisfied." A positive or top-box response for the individual items was defined as a response of "Always" or "Usually," "Somewhat Satisfied" or "Extremely Satisfied," and "Never" (i.e., *Not Felt Treated Unfairly* individual item measures).

NCQA National Average Comparisons

As applicable, each MHP's 2024 adult and child CAHPS scores were compared to the 2023 NCQA adult and child Medicaid national averages, respectively.¹³⁴ A *t* test was performed to determine whether 2024 top-box scores were statistically significantly different from the 2023 NCQA national averages. A difference was considered statistically significant if the two-sided *p* value of the *t* test was less than 0.05.

Colored arrows are used to note statistically significant differences. An upward green arrow (↑) indicates a 2024 top-box score that was statistically significantly higher than the 2023 NCQA national average. A downward red arrow (↓) indicates a 2024 top-box score that was statistically significantly lower than the 2023 NCQA national average. The 2024 scores that were not statistically significantly higher or lower than the 2023 NCQA national averages are not denoted with arrows.

Plan Comparisons

The results of the MHPs were compared to the applicable program (i.e., Medicaid managed care program and CSHCS managed care program). Two types of hypothesis tests were applied to these results. First, a global *F* test was calculated, which determined whether the difference between the MHPs' scores was significant. If the *F* test demonstrated plan-level differences (i.e., *p* value < 0.05), then a *t* test was performed for each MHP. The *t* test determined whether each MHP's score was statistically significantly different from the applicable program.

Colored arrows are used to note statistically significant differences. An upward green arrow (↑) indicates a 2024 top-box score that was statistically significantly higher than the applicable program's 2024 top-box score. A downward red arrow (↓) indicates a 2024 top-box score that was statistically significantly lower than the applicable program's 2024 top-box score. The 2024 top-box scores that were not statistically significantly higher or lower than the applicable program are not denoted with arrows.

Trend Analysis

HSAG performed a *t* test to determine whether results in 2024 were statistically significantly different from results in 2023. A difference was considered statistically significant if the two-sided *p* value of the

¹³⁴ National Committee for Quality Assurance. *Quality Compass: Benchmark and Compare Quality Data 2023*. Washington, DC: NCQA, September 2023.

t test was less than 0.05. The two-sided p value of the t test is the probability of observing a test statistic as extreme as or more extreme than the one actually observed under the assumption of no difference between years.

An upward green triangle (▲) indicates a 2024 top-box score was statistically significantly higher than the 2023 top-box score. A downward red triangle (▼) indicates a 2024 top-box score was statistically significantly lower than the 2023 top-box score. The 2024 top-box scores that were not statistically significantly higher or lower than the 2023 top-box scores are not denoted with triangles. For CSHCS, an upward green triangle (▲) also indicates the 2024 CSHCS Managed Care Program average was statistically significantly higher than the 2023 CSHCS Managed Care Program average and a downward red triangle (▼) indicates the 2024 CSHCS Managed Care Program average was statistically significantly lower than the 2023 CSHCS Managed Care Program average.

Description of Data Obtained and Related Time Period

HSAG administered the CAHPS surveys to the child Medicaid population for the MHPs. The MHPs provided HSAG with the adult Medicaid CAHPS survey data presented in this report. The MHPs reported that NCQA protocols were followed for administering the CAHPS surveys. The CAHPS 5.1H Child Medicaid Health Plan Survey was administered to parents/caretakers of child members enrolled in the MHPs from February to May 2024.

HSAG administered the CSHCS CAHPS survey to child members enrolled in CSHCS. The CSHCS CAHPS survey was administered to parents/caretakers of child members enrolled in the CSHCS Program from July to October 2024.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of services provided by the MHPs, HSAG assigned each of the measures to one or more of these three domains. This assignment to domains is depicted in Table A-10.

Table A-10—Assignment of Measures to the Quality, Timeliness, and Access Domains

Measure	Quality	Timeliness	Access
Adult and Child Medicaid/HMP			
Global Ratings			
<i>Rating of Health Plan</i>	✓		
<i>Rating of All Health Care</i>	✓		
<i>Rating of Personal Doctor</i>	✓		
<i>Rating of Specialist Seen Most Often</i>	✓		
Composite Measures			
<i>Getting Needed Care</i>	✓		✓
<i>Getting Care Quickly</i>	✓	✓	

Measure	Quality	Timeliness	Access
<i>How Well Doctors Communicate</i>	✓		
<i>Customer Service</i>	✓		
<i>Transportation*</i>	✓		✓
Individual Item Measure			
<i>Coordination of Care</i>	✓		
Medical Assistance With Smoking and Tobacco Use Cessation			
<i>Advising Smokers and Tobacco Users to Quit</i>	✓		
<i>Discussing Cessation Medications</i>	✓		
<i>Discussing Cessation Strategies</i>	✓		
CSHCS			
Global Ratings			
<i>Rating of Health Plan</i>	✓		
<i>Rating of All Health Care</i>	✓		
<i>Rating of Specialist Seen Most Often</i>	✓		
Composite Measures			
<i>Customer Service</i>	✓		
<i>How Well Doctors Communicate</i>	✓		
<i>Access to Specialized Services</i>	✓		✓
<i>Transportation</i>	✓		✓
Individual Item Measures			
<i>Access to Prescription Medicines</i>	✓		✓
<i>Not Felt Treated Unfairly: Race and Ethnicity</i>	✓		
<i>Not Felt Treated Unfairly: Health Insurance Type</i>	✓		

Quality Rating

Activity Objectives

MDHHS contracted with HSAG to analyze MY 2023 HEDIS results, including MY 2023 CAHPS data from the nine MHPs for presentation in the 2024 Michigan Consumer Guide. The 2024 Michigan Consumer Guide analysis helps to support MDHHS' public reporting of health plan performance information.

Technical Methods of Data Collection and Analysis

MDHHS, in collaboration with HSAG, chose measures for the 2024 Michigan Consumer Guide based on a number of factors that were consistent with previous years. Per NCQA specifications, the CAHPS 5.1H Adult Medicaid Health Plan Survey instrument was used for the adult population and the CAHPS 5.1H Child Medicaid Health Plan Survey instrument was used for the child population.

Table A-11 lists the 39 measures, 14 CAHPS and 25 HEDIS, and their associated weights.¹³⁵ The measures are organized by reporting category and subcategory.

Table A-11—MDHHS MHP Consumer Guide Reporting Categories, Subcategories, Measures, and Weights

Measures	Measure Weight
Overall Rating¹³⁶	
Adult Medicaid— <i>Rating of Health Plan</i> (CAHPS Global Rating)	1
Child Medicaid— <i>Rating of Health Plan</i> (CAHPS Global Rating)	1
Adult Medicaid— <i>Rating of All Health Care</i> (CAHPS Global Rating)	1
Child Medicaid— <i>Rating of All Health Care</i> (CAHPS Global Rating)	1
Doctors' Communication and Service	
Satisfaction With Providers	
Adult Medicaid— <i>How Well Doctors Communicate</i> (CAHPS Composite)	1
Child Medicaid— <i>How Well Doctors Communicate</i> (CAHPS Composite)	1
Adult Medicaid— <i>Rating of Personal Doctor</i> (CAHPS Global Rating)	1
Child Medicaid— <i>Rating of Personal Doctor</i> (CAHPS Global Rating)	1
Adult Medicaid— <i>Rating of Specialist Seen Most Often</i> (CAHPS Global Rating)	1

¹³⁵ Five measures, *Adult Medicaid—Customer Service* (CAHPS Composite), *Child Medicaid—Customer Service* (CAHPS Composite), *Child Medicaid—Rating of Specialist Seen Most Often* (CAHPS Global Rating), *Child Medicaid—Getting Needed Care* (CAHPS Composite), and *Child Medicaid—Getting Care Quickly* (CAHPS Composite) were excluded from the 2024 Consumer Guide based on insufficient data reported by more than half of the MHPs.

¹³⁶ To calculate the Overall Rating category, all 39 CAHPS and HEDIS measures were included in the analysis. Please note that the CAHPS measures listed in the Overall Rating reporting category were exclusive to the reporting category.

Measures	Measure Weight
Patient Engagement	
<i>Medical Assistance With Smoking and Tobacco Use Cessation</i>	
<i>Advising Smokers and Tobacco Users to Quit</i>	1/3
<i>Discussing Cessation Medications</i>	1/3
<i>Discussing Cessation Strategies</i>	1/3
Getting Care	
Access	
<i>Adult Medicaid—Getting Needed Care (CAHPS Composite)</i>	1
<i>Adult Medicaid—Getting Care Quickly (CAHPS Composite)</i>	1
<i>Adults' Access to Preventive/Ambulatory Health Services</i>	
<i>Ages 20–44 Years</i>	1/3
<i>Ages 45–64 Years</i>	1/3
<i>Ages 65+ Years</i>	1/3
Keeping Kids Healthy	
Immunizations and Screenings for Young Children	
<i>Childhood Immunization Status</i>	
<i>Combination 3</i>	1
<i>Lead Screening in Children</i>	1
Immunizations for Adolescents	
<i>Immunizations for Adolescents</i>	
<i>Combination 2</i>	1
Preventive Care	
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i>	
<i>Body Mass Index (BMI) Percentile Documentation—Total</i>	1/3
<i>Counseling for Nutrition—Total</i>	1/3
<i>Counseling for Physical Activity—Total</i>	1/3
<i>Well-Child Visits in the First 30 Months of Life</i>	
<i>Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	1
<i>Well-Child Visits for Ages 15 Months–30 Months—Two or More Well-Child Visits</i>	1
<i>Child and Adolescent Well-Care Visits</i>	
<i>Ages 3–11 Years</i>	1
<i>Ages 12–17 Years</i>	1
<i>Ages 18–21 Years</i>	1

Measures	Measure Weight
Living With Illness	
Diabetes	
<i>Blood Pressure Control for Patients With Diabetes</i>	1/4
<i>Eye Exam for Patients with Diabetes</i>	1/4
<i>Hemoglobin A1c (HbA1c) Control for Patients With Diabetes</i>	
<i>HbA1c Control (<8.0%)</i>	1/4
<i>HbA1c Poor Control (>9.0%)</i>	1/4
Cardiovascular	
<i>Controlling High Blood Pressure</i>	1
Respiratory	
<i>Asthma Medication Ratio—Total</i>	1
Taking Care of Women	
Screenings for Women	
<i>Breast Cancer Screening</i>	1
<i>Cervical Cancer Screening</i>	1
<i>Chlamydia Screening in Women—Total</i>	1
Maternal Health	
<i>Prenatal and Postpartum Care</i>	
<i>Timeliness of Prenatal Care</i>	1
<i>Postpartum Care</i>	1

HSAG computed six reporting category and 11 subcategory summary scores for each MHP, as well as the summary mean values for the MHPs as a group. Each score is a standardized score where higher values represent more favorable performance. Summary scores for the six reporting categories (Overall Rating, Doctors’ Communication and Service, Getting Care, Keeping Kids Healthy, Living With Illness, and Taking Care of Women) and 11 subcategories (Satisfaction With Providers, Patient Engagement, Access, Immunizations and Screenings for Young Children, Immunizations for Adolescents, Preventive Care, Diabetes, Cardiovascular, Respiratory, Screenings for Women, and Maternal Health) were calculated from MHP scores on select HEDIS measures and CAHPS questions and composites.

1. HEDIS rates were extracted from the auditor-locked IDSS data sets and HSAG calculated the CAHPS rates using the NCQA CAHPS member-level data files. To calculate a rate for a CAHPS measure, HSAG converted each individual question by assigning the top-box responses (i.e., “Usually/Always” and “9/10,” where applicable) to a 1 for each individual question, as described in *HEDIS Volume 3: Specifications for Survey Measures*. All other non-missing responses were assigned a value of 0. HSAG then calculated the percentage of respondents with a top-box response (i.e., a 1). For composite measures, HSAG calculated the composite rate by taking the average percentage for each question within the composite.

2. For each HEDIS and CAHPS measure, HSAG calculated the measure variance. The measure variance for HEDIS measures was calculated as follows:

$$\frac{p_k(1-p_k)}{n_k-1}$$

where: p_k = MHP k score
 n_k = number of members in the measure sample for MHP k

For CAHPS global rating measures, the variance was calculated as follows:

$$\frac{1}{n} \frac{\sum_{i=1}^n (x_i - \bar{x})^2}{n-1}$$

where: x_i = response of member i
 \bar{x} = the mean score for MHP k
 n = number of responses in MHP k

For CAHPS composite measures, the variance was calculated as follows:

$$\frac{N}{N-1} \sum_{i=1}^N \left(\sum_{j=1}^m \frac{1}{m} \frac{(x_{ij} - \bar{x}_j)}{n_j} \right)^2$$

where: $j = 1, \dots, m$ questions in the composite measure
 $i = 1, \dots, n_j$ members responding to question j
 x_{ij} = response of member i to question j
 \bar{x}_j = MHP mean for question j
 N = members responding to at least one question in the composite

3. For MHPs with an *NA* status, or *NR* or *BR* audit results, HSAG used the average variance of the non-missing rates across all MHPs. This ensured that all rates reflected some level of variability, rather than simply omitting the missing variances in subsequent calculations.
4. HSAG computed the MHP mean for each CAHPS and HEDIS measure.
5. Each MHP mean (CAHPS or HEDIS) was standardized by subtracting the mean of the MHP means and dividing by the standard deviation of the MHP means to give each measure equal weight toward the category rating. If the measures were not standardized, a measure with higher variability would contribute disproportionately toward the category rating.
6. HSAG summed the standardized MHP means, weighted by the individual measure weights to derive the MHP category summary measure score.

7. For each MHP k , HSAG calculated the category variance, CV_k , as: $CV_k = \sum_{j=1}^m \frac{w_j}{c_j^2} V_j$

where: $j = 1, \dots, m$ HEDIS or CAHPS measures in the summary
 V_j = variance for measure j
 c_j = group standard deviation for measure j
 w_j = measure weight for measure j

8. The summary scores were used to compute the group mean and the difference scores. The group mean was the average of the MHP summary measure scores. The difference score, d_k , was calculated as $d_k = \text{MHP } k \text{ score} - \text{group mean}$.

9. For each MHP k , HSAG calculated the variance of the difference scores, $Var(d_k)$, as:

$$Var(d_k) = \frac{P(P-2)}{P^2} CV_k + \frac{1}{P^2} \sum_{k=1}^P CV_k$$

where: P = total number of MHPs
 CV_k = category variance for MHP k

10. The statistical significance of each difference was determined by computing a confidence interval (CI). A 95 percent CI and 68 percent CI was calculated around each difference score to identify MHPs that were significantly higher than or significantly lower than the mean. MHPs with differences significantly above or below zero at the 95 percent confidence level (i.e., 1.96 standard deviations above or below zero) received the top (Highest Performance) and bottom (Lowest Performance) designations, respectively. MHPs with differences significantly above or below zero at the 68 percent confidence level, but not at the 95 percent confidence level (i.e., between 1 and 1.96 standard deviations above or below zero), received High Performance and Low Performance designations, respectively. An MHP was significantly above zero if the lower limit of the CI was greater than zero; and was significantly below zero if the upper limit of the CI was below zero. MHPs that did not fall either above or below zero at the 95 percent or 68 percent confidence level received the middle designation (Average Performance). For a given measure, the formula for calculating the CIs were:

$$95\% \text{ CI} = d_k \pm 1.96 \sqrt{Var(d_k)}$$

$$68\% \text{ CI} = d_k \pm \sqrt{Var(d_k)}$$

A five-level rating scale provides consumers with an easy-to-read “picture” of quality performance across MHPs and presents data in a manner that emphasizes meaningful differences between MHPs. The 2024 Michigan Consumer Guide used apples to display results for each MHP.

Description of Data Obtained and Related Time Period

HEDIS MY 2023 rates were extracted from the auditor-locked IDSS data sets, and HSAG calculated the CAHPS rates using the NCQA CAHPS member-level data files.

Appendix B. 2024 HEDIS Aggregate Report for Michigan Medicaid

Appendix B presents the final *2024 HEDIS Aggregate Report for Michigan Medicaid*.



2024 HEDIS Aggregate Report for Michigan Medicaid

October 2024



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1. Executive Summary

Introduction

During 2023, the Michigan Department of Health and Human Services (MDHHS) contracted with nine health plans to provide managed care services to Michigan Medicaid members. MDHHS expects its contracted Medicaid health plans (MHPs) to support claims systems, membership and provider files, as well as hardware/software management tools that facilitate valid reporting of the Healthcare Effectiveness Data and Information Set (HEDIS®)¹ measures. MDHHS contracted with Health Services Advisory Group, Inc. (HSAG), to calculate statewide average rates based on the MHPs' rates and evaluate each MHP's current performance level, as well as the statewide performance, relative to national Medicaid percentiles.

MDHHS selected HEDIS measures to evaluate Michigan MHPs within the following eight measure domains:

- Child & Adolescent Care
- Women—Adult Care
- Access to Care
- Obesity
- Pregnancy Care
- Living With Illness
- Health Plan Diversity
- Utilization

Of note, all measures in the Health Plan Diversity domain and some measures in the Utilization domain are provided within this report for information only as they assess the health plans' use of services and/or describe health plan characteristics and are not related to performance. Therefore, most of these rates were not evaluated in comparison to national percentiles, and changes in these rates across years were not analyzed by HSAG for statistical significance.

The performance levels are based on national percentiles and were set at specific, attainable rates. MHPs that met the high performance level (HPL) exhibited rates that were among the 90th percentile in comparison to the national average. The low performance level (LPL) was set to identify MHPs that were among the 25th percentile in comparison to the national average and have the greatest need for improvement. Details describing these performance levels are presented in Section 2, "How to Get the Most From This Report."

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

In addition, Section 11 (“HEDIS Reporting Capabilities—Information Systems Findings”) provides a summary of the HEDIS data collection processes used by the Michigan MHPs and the audit findings in relation to the National Committee for Quality Assurance’s (NCQA’s) information system (IS) standards.²

Michigan Medicaid Health Plan Names

Table 1-1 presents a list of the Michigan MHPs discussed within this report and their corresponding abbreviations.

Table 1-1—2024 Michigan MHP Names and Abbreviations

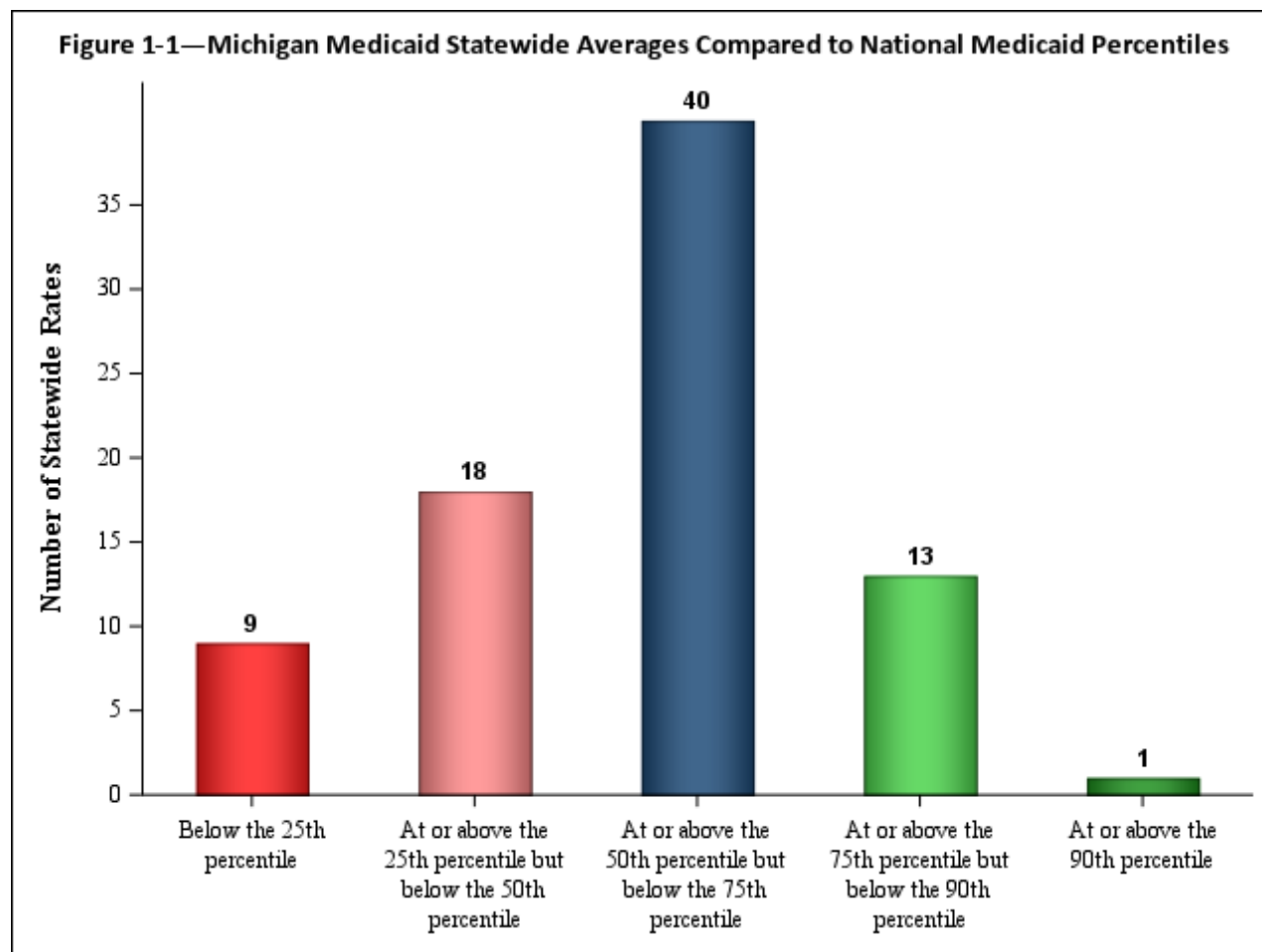
MHP Name	Abbreviation
Aetna Better Health of Michigan	AET
Blue Cross Complete of Michigan	BCC
HAP CareSource	HCS
McLaren Health Plan	MCL
Meridian Health Plan of Michigan	MER
Molina Healthcare of Michigan	MOL
Priority Health Choice	PRI
UnitedHealthcare Community Plan	UNI
Upper Peninsula Health Plan	UPP

Summary of Performance

Figure 1-1 compares the Michigan Medicaid program’s overall rates with NCQA’s Quality Compass[®] national Medicaid health maintenance organization (HMO) percentiles for HEDIS MY 2023, which are referred to as “percentiles” throughout this report.³ For measures that were comparable to percentiles, the bars represent the number of Michigan Medicaid Weighted Average (MWA) measure indicator rates that fell into each percentile range.

² National Committee for Quality Assurance. *HEDIS[®] MY 2023, Volume 5: HEDIS Compliance AuditTM: Standards, Policies and Procedures*. Washington D.C.

³ Quality Compass[®] is a registered trademark for the NCQA.



Of the 81 reported rates that were comparable to national Medicaid percentiles, nine of the MWA rates fell below the 25th percentile, and 27 rates (about 33 percent) were below the 50th percentile. These results demonstrate a general statewide increase in performance in comparison to the MY 2022 rates, which showed approximately 51 percent of the rates falling below the 50th percentile. A summary of MWA performance for each measure domain is presented on the following pages.

Child & Adolescent Care

For the Child & Adolescent Care domain, the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*; *Child and Adolescent Well-Care Visits—Ages 3 to 11 Years, Ages 12 to 17 Years, Ages 18 to 21 Years, and Total*; and *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure indicators were an area of strength. All measure indicators ranked at or above the 50th percentile and demonstrated significant improvement from the HEDIS MY 2022 MWA. **BCC**, **MOL**, **PRI**, and **UPP** ranked above the 50th percentile for the most measure indicators within the Child & Adolescent Care domain. **UPP** ranked

above the HPL for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator.

The MWA demonstrated a significant decline for the *Childhood Immunization Status—Combination 10* indicator, had an MWA decrease of over 1 percentage point from HEDIS MY 2022, and ranked below the 25th percentile. The *Childhood Immunization Status—Combination 7* and *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* indicators also ranked below the 25th percentile.

MDHHS should continue to monitor the MHPs' performance on the *Childhood Immunization Status—Combination 7* and *Combination 10*, and *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure indicators to ensure that the MHPs' performance does not continue to decline, while working with the MHPs and providers to target improving child vaccination rates and monitoring of ADHD medication. Immunizations are essential for disease prevention and are a critical aspect of preventable care for children. Vaccination coverage must be maintained in order to prevent a resurgence of vaccine-preventable diseases.⁴ When managed appropriately, ADHD medication can control symptoms of hyperactivity, impulsiveness, and the inability to sustain concentration. To ensure that medication is prescribed and managed correctly, it is important that children be monitored by a pediatrician with prescribing authority.⁵

Additionally, MDHHS should work with the MHPs and providers to identify potential root causes for the significant rate decline for the *Childhood Immunization Status—Combination 10* measure indicator.

Women—Adult Care

For the Women—Adult Care domain, the *Breast Cancer Screening* measure indicator was an area of strength, as the measure indicator ranked at or above the 50th percentile. Additionally, the *Breast Cancer Screening* measure indicator demonstrated significant improvement from the HEDIS MY 2022 MWA. **BCC**, **MCL**, **MER**, **MOL**, **PRI**, and **UNI** ranked above the 50th percentile for the most measure indicators within the Women—Adult Care domain. In addition, **AET** ranked above the HPL for the *Chlamydia Screening in Women—16 to 20 Years* and *Total* measure indicators.

The MWA demonstrated a significant decline for the *Chlamydia Screening in Women—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total* indicators, with the MWA for each declining more than 1 percentage point from HEDIS MY 2022; similarly, the MWA for the *Cervical Cancer Screening* indicator also demonstrated a significant decline, with the MWA declining more than 4 percentage points. The *Cervical Cancer Screening* indicator also ranked below the 50th percentile.

⁴ National Committee for Quality Assurance. Childhood Immunization Status. Available at: <https://www.ncqa.org/hedis/measures/childhood-immunization-status/>. Accessed on: Sept 17, 2024.

⁵ National Committee for Quality Assurance. Follow-Up Care for Children Prescribed ADHD Medication. Available at: <https://www.ncqa.org/hedis/measures/follow-up-care-for-children-prescribed-adhd-medication/>. Accessed on: Sept 17, 2024.

MDHHS should continue to monitor the MHPs' performance related to the *Chlamydia Screening in Women—Ages 16 to 20 Years, Ages 21 to 24 Years, and Total*; and *Cervical Cancer Screening* measure indicators within the Women—Adult Care domain to further improve performance. Untreated chlamydia infections can lead to serious and irreversible complications. Screening is important, as infections can be asymptomatic. This results in delayed medical care and treatment.⁶ Each year in the United States, about 11,500 new cases of cervical cancer are diagnosed and about 4,000 women die of this cancer.⁷ Effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate.⁸ MDHHS should consider promoting the integration of targeted outreach interventions that MHPs could employ to increase adherence to *Chlamydia Screening in Women* and *Cervical Cancer Screening* such as sending automated text messages, distributing pamphlets or brochures further educating members on the importance of timely screenings, and imbedding health screening reminders into routine case management touch points with members.

Access to Care

For the Access to Care domain, the *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years and Total*; *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years and Total*; and *Appropriate Testing for Pharyngitis—Ages 3 to 17 Years, Ages 18 to 64 Years, and Total* measure indicators demonstrated significant improvement from the HEDIS MY 2022 MWA. **MER**, **PRI**, and **UPP** ranked above the 50th percentile for the most measure indicators within the Access to Care domain. In addition, **UPP** ranked above the HPL for *Adults' Access to Preventive/Ambulatory Health Services—Ages 65 Years and Older*; and *Appropriate Testing for Pharyngitis—Ages 3–17 Years, Ages 18–64 Years, and Total* measure indicators. **PRI** ranked above the HPL for *Appropriate Testing for Pharyngitis—Ages 18–64 Years and Total* measure indicators.

The MWA demonstrated a significant decline for the *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years, Ages 18 to 64 Years, and Total* measure indicators, each with an MWA decrease of over 1 percentage point from HEDIS MY 2022. Additionally, the MWA ranked below the 25th percentile for the *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years and Total* measure indicators.

MDHHS should conduct ongoing monitoring of the MHPs' performance and declining rates for the *Appropriate Treatment for Upper Respiratory Infection* measure indicators in the Access to Care domain. MDHHS could consider conducting a causal factor analysis to identify potential reasons that contribute to declining rates and assist MHPs in developing targeted interventions. Underperforming MHPs should be given suggested interventions, based on MHP-specific capabilities, to improve rates. Too often, antibiotics are prescribed inappropriately. Efforts to use antibiotics judiciously can result in

⁶ National Committee for Quality Assurance. Chlamydia Screening in Women. Available at: <https://www.ncqa.org/hedis/measures/chlamydia-screening-in-women/>. Accessed on: Sept 17, 2024.

⁷ Centers for Disease Control and Prevention. Cervical Cancer Statistics. Available at: <https://www.cdc.gov/cervical-cancer/statistics/index.html>. Accessed on: Sept 17, 2024.

⁸ National Committee for Quality Assurance. Cervical Cancer Screening. Available at: <https://www.ncqa.org/hedis/measures/cervical-cancer-screening/>. Accessed on: Sept 17, 2024.

fewer inappropriate antibiotics prescribed. Additionally, increased education and awareness of appropriate treatment for upper respiratory infections can reduce the danger of antibiotic-resistant bacteria.⁹

Obesity

For the Obesity domain, all *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators were an area of strength. All measure indicators ranked at or above the 50th percentile and demonstrated significant improvement from the HEDIS MY 2022 MWA. **PRI**, **UNI**, and **UPP** ranked above the HPL for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* measure indicator. **HCS** ranked above the HPL for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* measure indicator.

While none of the measure indicators in the Obesity domain demonstrated a significant decline in the MWA from HEDIS MY 2022 or ranked below the 50th percentile, MDHHS should continue to monitor the MHPs' performance for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators to ensure continued improvement. MHPs and providers should continue to strategize the best way to utilize every office visit or virtual visit to encourage a healthy lifestyle and provide education on healthy habits for children and adolescents. Additionally, MDHHS should continue to monitor **MCL**'s performance for this measure to ensure the MHP's performance does not continue to decline and encourage higher-performing MHPs to share and discuss best practices. Healthy lifestyle habits, including healthy eating and physical activity, can lower the risk of becoming obese and developing related diseases. Obesity can become a lifelong health issue; therefore, it is important to monitor weight problems in children and adolescents and provide guidance for maintaining a healthy weight and lifestyle.¹⁰

Pregnancy Care

For the Pregnancy Care domain, *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* were an area of strength, as the measure indicators demonstrated significant improvement from the HEDIS MY 2022 MWA. Additionally, **BCC** and **UPP** ranked above the 50th percentile for both of the measure indicators within the Pregnancy Care domain, with **UPP** ranking above the HPL for both *Timeliness of Prenatal Care* and *Postpartum Care* measure indicators.

⁹ National Committee for Quality Assurance. Appropriate Treatment for Upper Respiratory Infection. Available at: <https://www.ncqa.org/hedis/measures/appropriate-treatment-for-upper-respiratory-infection/>. Accessed on: Sept 17, 2024.

¹⁰ National Committee for Quality Assurance. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents. Available at: <https://www.ncqa.org/hedis/measures/weight-assessment-and-counseling-for-nutrition-and-physical-activity-for-children-adolescents/>. Accessed on: Sept 17, 2024.

AET, **HCS**, and **MCL** all fell below the LPL for *Prenatal and Postpartum Care—Timeliness of Prenatal Care*; **AET**, **HCS**, **MOL**, and **UNI** all fell below the LPL for *Prenatal and Postpartum Care—Postpartum Care*.

Timely and adequate prenatal and postpartum care can set the stage for long-term health and well-being of new mothers and their infants.¹¹ MDHHS should continue monitoring the MHPs' performance in the Pregnancy Care domain and assess the need for or evaluation of current prenatal and postpartum care coordination programs for lower-performing MHPs. Effective care coordination efforts or programs could potentially assist with scheduling prenatal and postpartum appointments, arranging transportation, and educating members on the importance of keeping appointments. MDHHS is also encouraged to work with the higher-performing MHPs to identify best practices for ensuring women's access to prenatal and postpartum care which can then be shared with the lower-performing MHPs to improve overall access.

Living With Illness

For the Living With Illness domain, the following measure indicators were areas of significant strength:

- *Hemoglobin A1c Control for Patients With Diabetes—Poor Hemoglobin A1c (HbA1c) Control (>9.0%) and HbA1c Control (<8.0%)*
- *Blood Pressure Control for Patients With Diabetes*
- *Eye Exam for Patients With Diabetes*
- *Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years, Ages 65 to 74 Years, Ages 75 to 85 Years, and Total*
- *Controlling High Blood Pressure*
- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Diabetes Monitoring for People With Diabetes and Schizophrenia*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
- *Diagnosed Mental Health Disorders—Ages 1 to 17 Years, Ages 18 to 64 Years, Ages 65 Years and Older, and Total*

All of these measure indicators ranked at or above the 50th percentile, with both of the *Hemoglobin A1c Control for Patients With Diabetes* measure indicators; *Blood Pressure Control for Patients With Diabetes*, *Antidepressant Medication Management—Effective Acute Phase Treatment*; and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* ranking at or above the 75th percentile. All of these measure indicators also demonstrated

¹¹ National Committee for Quality Assurance. Prenatal and Postpartum Care. Available at: <https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/>. Accessed on: Sept 17, 2024.

significant improvement from the HEDIS MY 2022 MWA. **BCC, MER, PRI, UNI,** and **UPP** ranked above the 50th percentile for the most measure indicators within the Living With Illness domain. **UPP** ranked above the HPL for the most measure indicators within the Living With Illness domain.

While the HEDIS MY 2023 MWA demonstrated considerable improvement from HEDIS MY 2022 across the Living With Illness domain, the *Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator rate had a significant decrease of over 22 percentage points in comparison to the MWA for HEDIS MY 2022 and ranked below the 25th percentile, demonstrating an area for improvement. Multiple MHPs ranked below the LPL for this measure.

MDHHS is encouraged to conduct a root cause analysis to identify the causal factors that resulted in a rapid and significant decline of the *Persistence of Beta-Blocker Treatment After a Heart Attack* measure performance across multiple MHPs. The prevalent MHP underperformance may indicate a need for further education and awareness of measure requirements, measure specifications for meeting criteria, and knowledge of intervention types most impactful and efficacious in meeting measure standards. Medical guidelines support taking a beta-blocker after a heart attack to prevent another heart attack from occurring.¹² Additionally, MDHHS should continue to work with the MHPs to readily identify interventions and operational process changes that led to improved rates ranking at or above the 50th percentile within the Living With Illness domain, while supporting and strengthening methods that resulted in improved year-over-year performance.

Health Plan Diversity

Although measures under this domain are not performance measures and are not compared to percentiles, changes observed in the results may provide insight into how select member characteristics affect the MHPs' provision of services and care.

Utilization

For the *Ambulatory Care—Emergency Department (ED) Visits—Total* measure indicator, the Michigan Medicaid Average (MA) increased by 10.05 visits per 1,000 member years from HEDIS MY 2021 to HEDIS MY 2023. The MA for the *Outpatient Visits—Total* measure indicator decreased from HEDIS MY 2021 to HEDIS MY 2023 by 423.43 visits per 1,000 member years.¹³ Since the measure of outpatient visits is not linked to performance, the results for this measure are not comparable to percentiles. For the *Plan All-Cause Readmissions* measure, six MHPs had an O/E ratio less than 1.0, indicating that these MHPs had fewer observed readmissions than were expected based on patient mix. The remaining three MHPs had an O/E ratio greater than 1.0, indicating they had more readmissions.

¹² National Committee for Quality Assurance. Persistence of Beta-Blocker Treatment After a Heart Attack. Available at: <https://www.ncqa.org/hedis/measures/persistence-of-beta-blocker-treatment-after-a-heart-attack/>. Accessed on: Sept 17, 2024.

¹³ For the *ED Visits* indicator, awareness is advised when interpreting results for this indicator as a lower rate is a higher percentile.

Limitations and Considerations

Some behavioral health services are carved out and are not provided by the MHPs; therefore, exercise caution when interpreting rates for measures related to behavioral health.

2. How to Get the Most From This Report

Introduction

This reader's guide is designed to provide supplemental information to the reader that may aid in the interpretation and use of the results presented in this report.

Summary of Michigan Medicaid HEDIS MY 2023 Measures

Within this report, HSAG presents the Michigan MWA (i.e., statewide average rates) and MHP-specific performance on HEDIS measures selected by MDHHS for HEDIS MY 2023. These measures were grouped into the following eight domains of care: Child & Adolescent Care, Women—Adult Care, Access to Care, Obesity, Pregnancy Care, Living With Illness, Health Plan Diversity, and Utilization. While performance is reported primarily at the measure indicator level, grouping these measures into domains encourages MHPs and MDHHS to consider the measures as a whole rather than in isolation and to develop the strategic changes required to improve overall performance.

Table 2-1 shows the selected HEDIS MY 2023 measures and measure indicators as well as the corresponding domains of care and the reporting methodologies for each measure. The data collection or calculation method is specified by NCQA in the *HEDIS MY 2023 Volume 2 Technical Specifications*. Data collection methodologies are described in detail in the next section.

Table 2-1—Michigan Medicaid HEDIS MY 2023 Required Measures

Performance Measure	HEDIS Data Collection Methodology
Child & Adolescent Care	
<i>Childhood Immunization Status (CIS)</i>	
<i>Combination 3</i>	Hybrid
<i>Combination 7</i>	Hybrid
<i>Combination 10</i>	Hybrid
<i>Well-Child Visits in the First 30 Months of Life (W30)</i>	
<i>Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	Administrative
<i>Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i>	Administrative
<i>Lead Screening in Children (LSC)</i>	
<i>Lead Screening in Children</i>	Hybrid
<i>Child and Adolescent Well-Care Visits (WCV)</i>	
<i>Ages 3 to 11 Years</i>	Administrative
<i>Ages 12 to 17 Years</i>	Administrative

Performance Measure	HEDIS Data Collection Methodology
<i>Ages 18 to 21 Years</i>	Administrative
<i>Total</i>	Administrative
<i>Immunizations for Adolescents (IMA)</i>	
<i>Combination 1 (Meningococcal, Tdap)</i>	Hybrid
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	Hybrid
<i>Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)¹</i>	
<i>Initiation Phase</i>	Administrative
<i>Continuation and Maintenance Phase</i>	Administrative
Women—Adult Care	
<i>Chlamydia Screening in Women (CHL)¹</i>	
<i>Ages 16 to 20 Years</i>	Administrative
<i>Ages 21 to 24 Years</i>	Administrative
<i>Total</i>	Administrative
<i>Cervical Cancer Screening (CCS-E)</i>	
<i>Cervical Cancer Screening</i>	Administrative
<i>Breast Cancer Screening (BCS-E)</i>	
<i>Breast Cancer Screening</i>	Administrative
Access to Care	
<i>Adults' Access to Preventive/Ambulatory Health Services (AAP)</i>	
<i>Ages 20 to 44 Years</i>	Administrative
<i>Ages 45 to 64 Years</i>	Administrative
<i>Ages 65 Years and Older</i>	Administrative
<i>Total</i>	Administrative
<i>Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)</i>	
<i>Ages 3 Months to 17 Years</i>	Administrative
<i>Ages 18 to 64 Years</i>	Administrative
<i>Ages 65 Years and Older</i>	Administrative
<i>Total</i>	Administrative
<i>Appropriate Testing for Pharyngitis (CWP)</i>	
<i>Ages 3 to 17 Years</i>	Administrative
<i>Ages 18 to 64 Years</i>	Administrative
<i>Ages 65 Years and Older</i>	Administrative

Performance Measure	HEDIS Data Collection Methodology
<i>Total</i>	Administrative
<i>Appropriate Treatment for Upper Respiratory Infection (URI)</i>	
<i>Ages 3 Months to 17 Years</i>	Administrative
<i>Ages 18 to 64 Years</i>	Administrative
<i>Ages 65 Years and Older</i>	Administrative
<i>Total</i>	Administrative
Obesity	
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)</i>	
<i>Body Mass Index (BMI) Percentile—Total</i>	Hybrid
<i>Counseling for Nutrition—Total</i>	Hybrid
<i>Counseling for Physical Activity—Total</i>	Hybrid
Pregnancy Care	
<i>Prenatal and Postpartum Care (PPC)</i>¹	
<i>Timeliness of Prenatal Care</i>	Hybrid
<i>Postpartum Care</i>	Hybrid
Living With Illness	
<i>Hemoglobin A1c Control for Patients With Diabetes (HBD)</i>	
<i>HbA1c Control (<8.0%)</i>	Hybrid
<i>HbA1c Poor Control (>9.0%)*</i>	Hybrid
<i>Blood Pressure Control for Patients With Diabetes (BPD)</i>	
<i>Blood Pressure Control for Patients With Diabetes</i>	Hybrid
<i>Eye Exam for Patients With Diabetes (EED)</i>¹	
<i>Eye Exam for Patients With Diabetes</i>	Hybrid
<i>Kidney Health Evaluation for Patients With Diabetes (KED)</i>	
<i>Ages 18 to 64 Years</i>	Administrative
<i>Ages 65 to 74 Years</i>	Administrative
<i>Ages 75 to 85 Years</i>	Administrative
<i>Total</i>	Administrative
<i>Asthma Medication Ratio (AMR)</i>	
<i>Total</i>	Administrative
<i>Controlling High Blood Pressure (CBP)</i>	
<i>Controlling High Blood Pressure</i>	Hybrid
<i>Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)</i>	

Performance Measure	HEDIS Data Collection Methodology
<i>Persistence of Beta-Blocker Treatment After a Heart Attack</i>	Administrative
Cardiac Rehabilitation (CRE)	
<i>Initiation—Ages 18 to 64 Years</i>	Administrative
<i>Initiation—Ages 65 Years and Older</i>	Administrative
<i>Initiation—Total</i>	Administrative
<i>Engagement 1—Ages 18 to 64 Years</i>	Administrative
<i>Engagement 1—Ages 65 Years and Older</i>	Administrative
<i>Engagement 1—Total</i>	Administrative
<i>Engagement 2—Ages 18 to 64 Years</i>	Administrative
<i>Engagement 2—Ages 65 Years and Older</i>	Administrative
<i>Engagement 2—Total</i>	Administrative
<i>Achievement—Ages 18 to 64 Years</i>	Administrative
<i>Achievement—Ages 65 Years and Older</i>	Administrative
<i>Achievement—Total</i>	Administrative
Antidepressant Medication Management (AMM) ¹	
<i>Effective Acute Phase Treatment</i>	Administrative
<i>Effective Continuation Phase Treatment</i>	Administrative
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	
<i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</i>	Administrative
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	
<i>Diabetes Monitoring for People With Diabetes and Schizophrenia</i>	Administrative
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	
<i>Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia</i>	Administrative
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	
<i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia</i>	Administrative
Diagnosed Mental Health Disorders (DMH)	
<i>Ages 1 to 17 Years</i>	Administrative
<i>Ages 18 to 64 Years</i>	Administrative
<i>Ages 65 Years and Older</i>	Administrative
<i>Total</i>	Administrative

Performance Measure	HEDIS Data Collection Methodology
Health Plan Diversity	
<i>Race/Ethnicity Diversity of Membership (RDM)</i>	
<i>White</i>	Administrative
<i>Black or African American</i>	Administrative
<i>American Indian or Alaska Native</i>	Administrative
<i>Asian</i>	Administrative
<i>Native Hawaiian or Other Pacific Islander</i>	Administrative
<i>Some Other Race</i>	Administrative
<i>Two or More Races</i>	Administrative
<i>Ethnicity Reporting Category: Hispanic or Latino</i>	Administrative
<i>Unknown</i>	Administrative
<i>Declined</i>	Administrative
<i>Language Diversity of Membership (LDM)</i>	
<i>Spoken Language Preferred for Health Care—English</i>	Administrative
<i>Spoken Language Preferred for Health Care—Non-English</i>	Administrative
<i>Spoken Language Preferred for Health Care—Unknown</i>	Administrative
<i>Spoken Language Preferred for Health Care—Declined</i>	Administrative
<i>Language Preferred for Written Materials—English</i>	Administrative
<i>Language Preferred for Written Materials—Non-English</i>	Administrative
<i>Language Preferred for Written Materials—Unknown</i>	Administrative
<i>Language Preferred for Written Materials—Declined</i>	Administrative
<i>Other Language Needs—English</i>	Administrative
<i>Other Language Needs—Non-English</i>	Administrative
<i>Other Language Needs—Unknown</i>	Administrative
<i>Other Language Needs—Declined</i>	Administrative
Utilization	
<i>Ambulatory Care (AMB)</i>	
<i>Emergency Department Visits[±]</i>	Administrative
<i>Outpatient Visits</i>	Administrative
<i>Inpatient Utilization—General Hospital/Acute Care (IPU)</i>	
<i>Discharges—Total Inpatient—Total All Ages</i>	Administrative
<i>Average Length of Stay—Total Inpatient—Total All Ages</i>	Administrative
<i>Discharges—Maternity—Total All Ages</i>	Administrative

Performance Measure	HEDIS Data Collection Methodology
<i>Average Length of Stay—Maternity—Total All Ages</i>	Administrative
<i>Discharges—Surgery—Total All Ages</i>	Administrative
<i>Average Length of Stay—Surgery—Total All Ages</i>	Administrative
<i>Discharges—Medicine—Total All Ages</i>	Administrative
<i>Average Length of Stay—Medicine—Total All Ages</i>	Administrative
<i>Use of Opioids From Multiple Providers (UOP)*</i>	
<i>Multiple Prescribers</i>	Administrative
<i>Multiple Pharmacies</i>	Administrative
<i>Multiple Prescribers and Multiple Pharmacies</i>	Administrative
<i>Use of Opioids at High Dosage (HDO)*</i>	
<i>Use of Opioids at High Dosage</i>	Administrative
<i>Risk of Continued Opioid Use (COU)*</i>	
<i>At Least 15 Days Covered—Total</i>	Administrative
<i>At Least 31 Days Covered—Total</i>	Administrative
<i>Plan All-Cause Readmissions (PCR)</i>	
<i>Observed Readmissions—Total</i>	Administrative
<i>Expected Readmissions—Total</i>	Administrative
<i>O/E Ratio—Total</i>	Administrative

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

¹ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

[±] Awareness is advised when interpreting results for this indicator as a lower rate is a higher percentile.

Data Collection Methods

Administrative Method

The administrative method requires that MHPs identify the eligible population (i.e., the denominator) using administrative data, derived from claims and encounters. In addition, the numerator(s), or services provided to the members in the eligible population, are derived solely using administrative data collected during the reporting year. Medical record review (MRR) data from the prior year may be used as supplemental data. Medical records collected during the current year cannot be used to retrieve information. When using the administrative method, the entire eligible population becomes the denominator, and sampling is not allowed.

Hybrid Method

The hybrid method requires that MHPs identify the eligible population using administrative data and then extract a systematic sample of members from the eligible population, which becomes the denominator. Administrative data are used to identify services provided to those members. Medical records must then be reviewed for those members who do not have evidence of a service being provided using administrative data.

The hybrid method generally produces higher rates because the completeness of documentation in the medical record exceeds what is typically captured in administrative data; however, the MRR component of the hybrid method is considered more labor intensive. For example, the MHP has 10,000 members who qualify for the *Prenatal and Postpartum Care* measure and chooses to use the hybrid method. After randomly selecting 411 eligible members, the MHP finds that 161 members had evidence of a postpartum visit using administrative data. The MHP then obtains and reviews medical records for the 250 members who did not have evidence of a postpartum visit using administrative data. Of those 250 members, 54 were found to have a postpartum visit recorded in the MRR. Therefore, the final rate for this measure, using the hybrid method, would be $(161 + 54)/411$, or 52.3 percent, a 13.1 percentage point increase from the administrative only rate of 39.2 percent.

Understanding Sampling Error

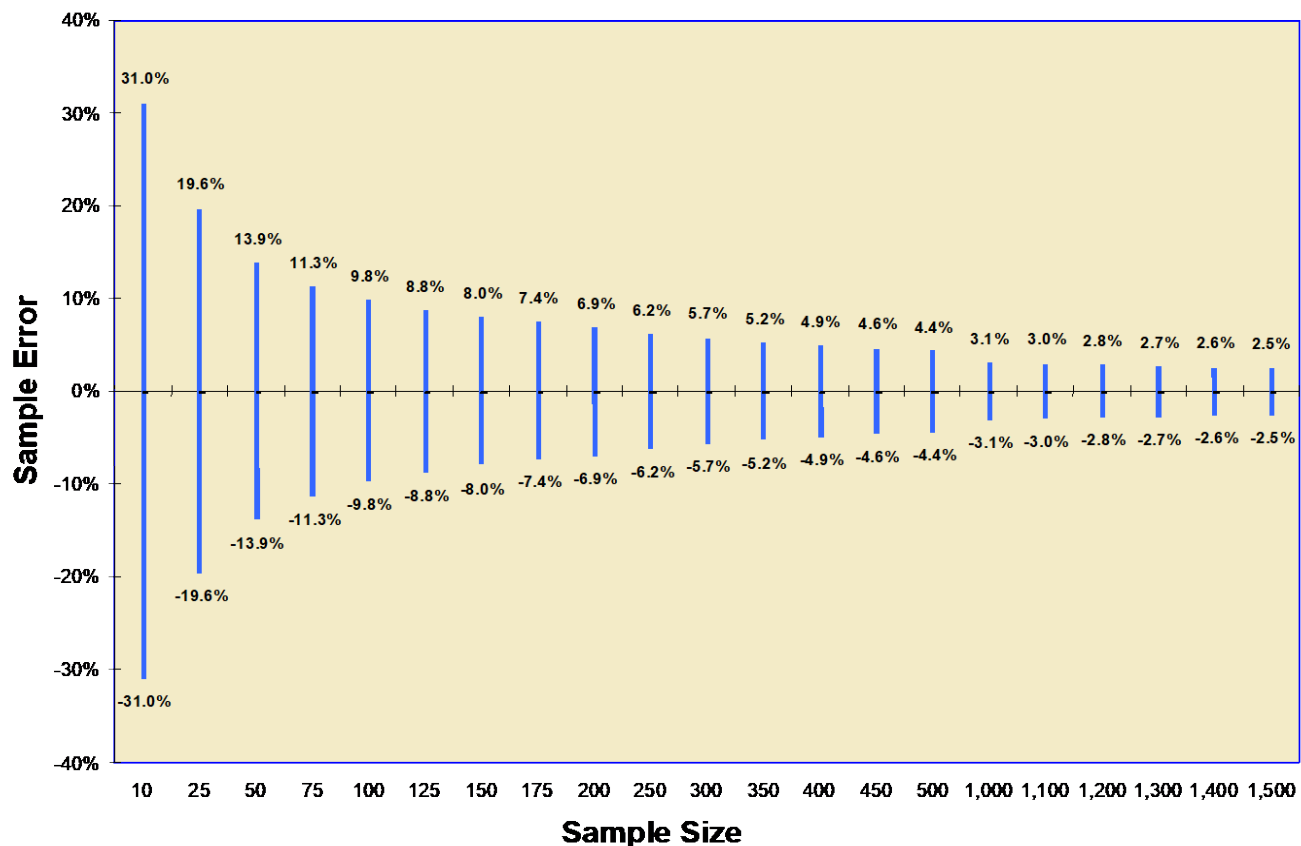
Correct interpretation of results for measures collected using HEDIS hybrid methodology requires an understanding of sampling error. It is rarely possible, logistically or financially, to complete MRR for the entire eligible population for a given measure. Measures collected using the HEDIS hybrid method include only a sample from the eligible population, and statistical techniques are used to maximize the probability that the sample results reflect the experience of the entire eligible population.

For results to be generalized to the entire eligible population, the process of sample selection must be such that everyone in the eligible population has an equal chance of being selected. The HEDIS hybrid method prescribes a systematic sampling process selecting at least 411 members of the eligible

population. MHP may use a 5 percent, 10 percent, 15 percent, or 20 percent oversample to replace invalid cases (e.g., a male selected for *Postpartum Care*).

Figure 2-1 shows that if 411 members are included in a measure, the margin of error is approximately ± 4.9 percentage points. Note that the data in this figure are based on the assumption that the size of the eligible population is greater than 2,000. The smaller the sample included in the measure, the larger the sampling error.

Figure 2-1—Relationship of Sample Size to Sample Error



As Figure 2-1 shows, sample error decreases as the sample size gets larger. Consequently, when sample sizes are very large and sampling errors are very small, almost any difference is statistically significant. This does not mean that all such differences are important. On the other hand, the difference between two measured rates may not be statistically significant but may, nevertheless, be important. The judgment of the reviewer is always a requisite for meaningful data interpretation.

Data Sources and Measure Audit Results

MHP-specific performance displayed in this report was based on data elements obtained from the Interactive Data Submission System (IDSS) files supplied by the MHPs. Prior to HSAG's receipt of the MHPs' IDSS files, all the MHPs were required by MDHHS to have their HEDIS MY 2023 results examined and verified through an NCQA HEDIS Compliance Audit.¹⁴

Through the audit process, each measure indicator rate reported by an MHP was assigned an NCQA-defined audit result. HEDIS MY 2023 measure indicator rates received one of seven predefined audit results: *Reportable (R)*, *Small Denominator (NA)*, *Biased Rate (BR)*, *No Benefit (NB)*, *Not Required (NQ)*, *Un-Audited (UN)*, and *Not Reported (NR)*. The audit results are defined in Section 12.

Rates designated as *NA*, *BR*, *NB*, *NQ*, *UN*, or *NR* are not presented in this report. All measure indicator rates that are presented in this report have been verified as an unbiased estimate of the measure. Please see Section 11 for additional information on NCQA's Information System (IS) standards and the audit findings for the MHPs.

Calculation of Statewide Averages

For all measures, HSAG collected the audited results, numerator, denominator, rate, and eligible population elements reported in the files submitted by MHPs to calculate the MWA rate. Given that the MHPs varied in membership size, the MWA rate was calculated for most of the measures based on MHPs' eligible populations. Weighting the rates by the eligible population sizes ensured that a rate for an MHP with 125,000 members, for example, had a greater impact on the overall MWA rate than a rate for the MHP with only 10,000 members. For MHPs' rates reported as *NA*, the numerators, denominators, and eligible populations were included in the calculations of the MWA rate. MHP rates reported as *BR*, *NB*, *NQ*, *UN*, or *NR* were excluded from the MWA rate calculation. However, traditional unweighted statewide Medicaid average rates were calculated for some utilization-based measures to align with calculations from prior years' deliverables.

¹⁴ NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.

Evaluating Measure Results

National Benchmark Comparisons

Benchmark Data

HEDIS MY 2023 MHP and MWA rates were compared to the corresponding national HEDIS benchmarks, which are expressed in percentiles of national performance for different measures. For comparison, HSAG used the most recent data available from NCQA at the time of the publication of this report to evaluate the HEDIS MY 2023 rates: NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS MY 2022 MWA, which are referred to as "percentiles" throughout this report.

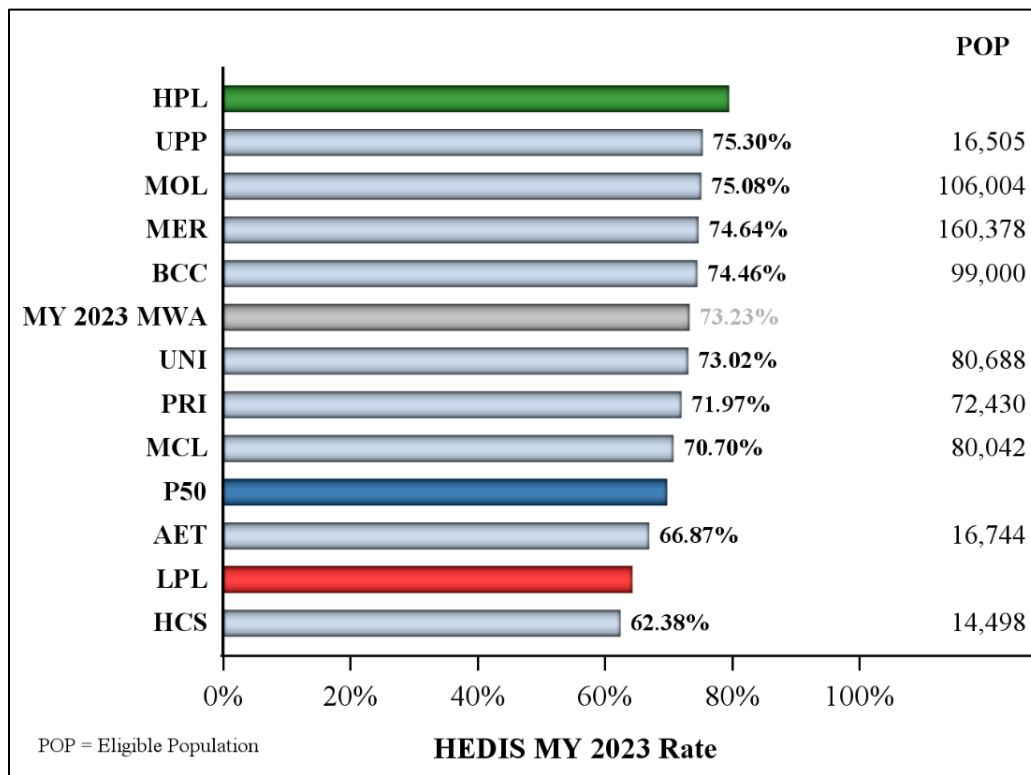
Additionally, benchmarking data (i.e., NCQA's Quality Compass and NCQA's Audit Means and Percentiles) are the proprietary intellectual property of NCQA; therefore, this report does not display any actual percentile values. As a result, rate comparisons to benchmarks are illustrated within this report using proxy displays.

Figure Interpretation

For each performance measure indicator presented in Sections 3 through 8 of this report, the horizontal bar graph figure positioned on the right side of the page presents each MHP's performance against the HEDIS MY 2023 MWA (i.e., the bar shaded gray); the HPL (i.e., the green shaded bar), representing the 90th percentile; the P50 bar (i.e., the blue shaded bar), representing the 50th percentile; and the LPL (i.e., the red shaded bar), representing the 25th percentile.

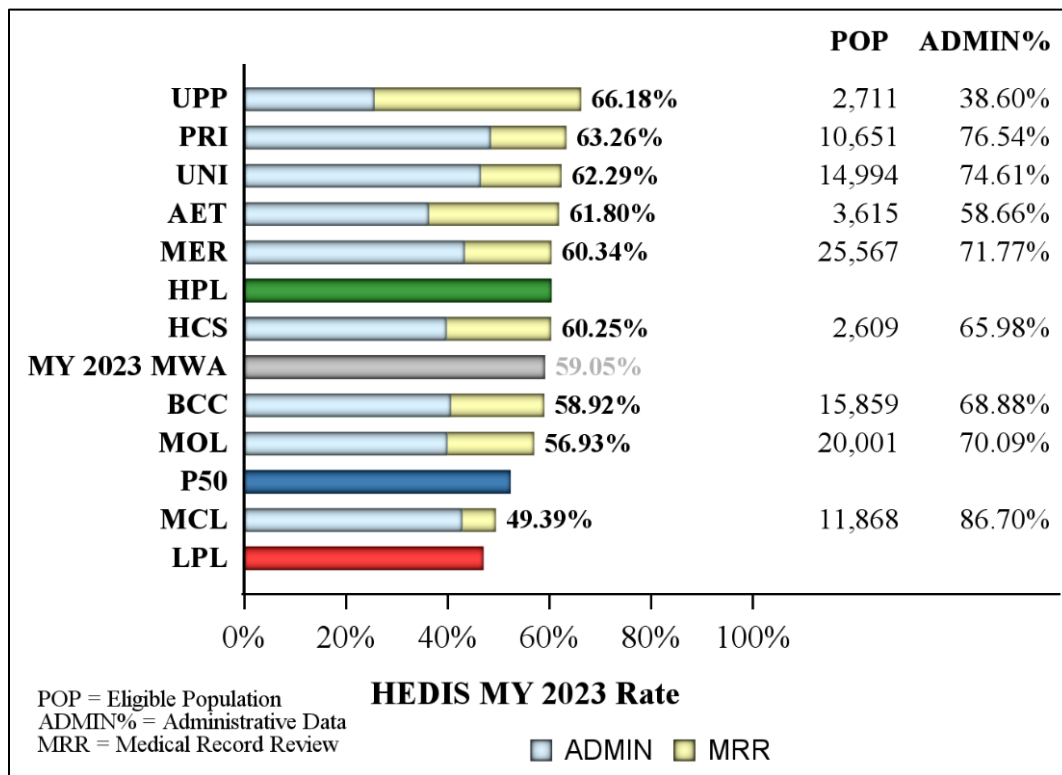
For measures for which lower rates indicate better performance, the 10th percentile (rather than the 90th percentile) and the 75th percentile (rather than the 25th percentile) are considered the HPL and LPL, respectively. An example of the horizontal bar graph figure for measure indicators reported administratively is shown below in Figure 2-2.

Figure 2-2—Sample Horizontal Bar Graph Figure for Administrative Measures



For performance measure rates that were reported using the hybrid method, the “ADMIN%” column presented with each horizontal bar graph figure displays the percentage of the rate derived from administrative data (e.g., claims data and supplemental data). The portion of the bar shaded yellow represents the proportion of the total measure rate attributed to MRR, while the portion of the bar shaded light blue indicates the proportion of the measure rate that was derived using the administrative method. This percentage describes the level of claims/encounter data completeness of the MHP data for calculating a particular performance measure. A low administrative data percentage suggests that the MHP relied heavily on medical records to report the rate. Conversely, a high administrative data percentage indicates that the MHP’s claims/encounter data were relatively complete for use in calculating the performance measure indicator rate. An administrative percentage of 100 percent indicates that the MHP did not report the measure indicator rate using the hybrid method. An example of the horizontal bar graph figure for measure indicators reported using the hybrid method is shown in Figure 2-3.

Figure 2-3—Sample Horizontal Bar Graph Figure for Hybrid Measures



Percentile Rankings and Star Ratings

In addition to illustrating MHP and statewide performance via side-by-side comparisons to national percentiles, benchmark comparisons are denoted within Appendix B of this report using the percentile ranking performance levels and star ratings defined below in Table 2-2.

Table 2-2—Percentile Ranking Performance Levels

Star Rating	Performance Level
★★★★★	At or above the 90th percentile
★★★★	At or above the 75th percentile but below the 90th percentile
★★★	At or above the 50th percentile but below the 75th percentile
★★	At or above the 25th percentile but below the 50th percentile
★	Below the 25th percentile
NA	NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.
NB	NB indicates that the MHP did not offer the health benefit required by the measure.

Measures in the Health Plan Diversity and Utilization measure domains are designed to capture the frequency of services provided and characteristics of the populations served. Excluding the *Ambulatory Care—Total—ED Visits*, *Use of Opioids From Multiple Providers*, *Use of Opioids at High Dosage*, *Risk of Continued Opioid Use*, and *Plan All-Cause Readmissions* measures, higher or lower rates in these domains do not necessarily indicate better or worse performance. A lower rate for *Ambulatory Care—Total—ED Visits* may indicate a more favorable performance since lower rates of ED services may indicate better utilization of services. Further, measures under the Health Plan Diversity measure domain provide insight into how member race/ethnicity or language characteristics are compared to national distributions and are not suggestive of plan performance.

For the *Ambulatory Care—Total—ED Visits*, *Use of Opioids From Multiple Providers*, *Use of Opioids at High Dosage*, *Risk of Continued Opioid Use*, and *Plan All-Cause Readmissions* measure indicators, HSAG inverted the star ratings to be consistently applied to these measures as with the other HEDIS measures. For example, the 10th percentile (a lower rate) was inverted to become the 90th percentile, indicating better performance.

Of note, MHP and statewide average rates were rounded to the second decimal place before performance levels were determined. As HSAG assigned star ratings, an em dash (—) was presented to indicate that the measure indicator was not required and not presented in previous years' HEDIS deliverables; or that a performance level was not presented in this report either because the measure did not have an applicable benchmark or a comparison to benchmarks was not appropriate.

Performance Trend Analysis

In addition to the star rating results, HSAG also compared HEDIS MY 2023 MWA and MHP rates to the corresponding HEDIS MY 2022 MWA rates. HSAG also evaluated the extent of changes observed in the rates between years. Year-over-year performance comparisons are based on the Chi-square test of statistical significance with a p value <0.05 for MHP rate comparisons and a p value <0.01 for MWA rate comparisons. Note that statistical testing could not be performed on the utilization-based measures domain given that variances were not available in the IDSS files for HSAG to use for statistical testing. Further statistical testing was not performed on the health plan diversity measures because these measures are for information only.

In general, results from statistical significance testing provide information on whether a change in the rate may suggest improvement or decline in performance. Throughout the report, references to “significant” changes in performance are noted; these instances refer to statistically significant differences between performance from HEDIS MY 2022 MWA to HEDIS MY 2023. At the statewide level, if the number of MHPs reporting *NR* or *BR* differs vastly from year to year, the statewide performance may not represent all of the contracted MHPs, and any changes observed across years may need to take this factor into consideration. Nonetheless, changes (regardless of whether they are significant) could be related to the following factors independent of any effective interventions designed to improve the quality of care:

- Substantial changes in measure specifications. The “Measure Changes Between HEDIS MY 2022 MWA and HEDIS MY 2023” section below lists measures with specification changes made by NCQA.
- Substantial changes in membership composition within the MHP.

Table and Figure Interpretation

Within Sections 3 through 8 and Appendix B of this report, performance measure indicator rates and results of significance testing between HEDIS MY 2022 MWA and HEDIS MY 2023 are presented in tabular format. HEDIS MY 2023 rates shaded green with one cross (+) indicate a significant improvement in performance from the previous year. HEDIS MY 2023 rates shaded red with two crosses (++) indicate a significant decline in performance from the previous year. The colors used are provided below for reference:

 Indicates that the HEDIS MY 2023 MWA demonstrated a significant improvement from the HEDIS MY 2022 MWA.

 Indicates that the HEDIS MY 2023 MWA demonstrated a significant decline from the HEDIS MY 2022 MWA.

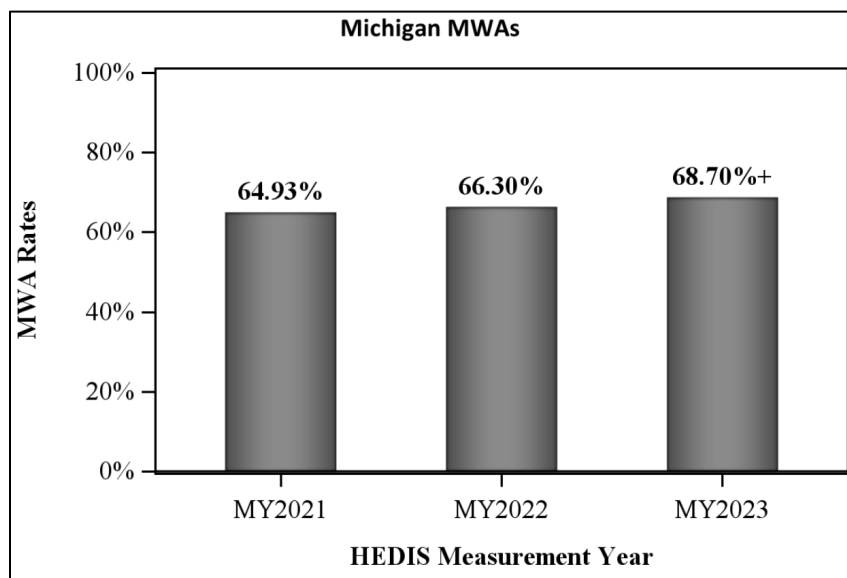
Additionally, benchmark comparisons are denoted within Sections 3 through 8. Performance levels are represented using the following percentile rankings:

Table 2-3—Percentile Ranking Performance Levels

Percentile Ranking and Shading	Performance Level
≥90th	At or above the 90th percentile
≥75th and ≤89th	At or above the 75th percentile but below the 90th percentile
≥50th and ≤74th	At or above the 50th percentile but below the 75th percentile
≥25th and ≤49th	At or above the 25th percentile but below the 50th percentile
<25th	Below the 25th percentile

For each performance measure indicator presented in Sections 3 through 8 of this report, the vertical bar graph figure positioned on the left side of the page presents the HEDIS MY 2021, HEDIS MY 2022 MWA, and HEDIS MY 2023 MWAs with significance testing performed between the HEDIS MY 2022 MWA and HEDIS MY 2023 MWAs. Within these figures, HEDIS MY 2023 rates with one cross (+) indicate a significant improvement in performance from HEDIS MY 2022 MWA. HEDIS MY 2023 rates with two crosses (++) indicate a significant decline in performance from HEDIS MY 2022 MWA. An example of the vertical bar graph figure for measure indicators reported is included in Figure 2-4.

Figure 2-4—Sample Vertical Bar Graph Figure Showing Significant Improvement



Interpreting Results Presented in This Report

HEDIS results can differ among MHPs and even across measures for the same MHP.

The following questions should be asked when examining these data:

How accurate are the results?

All Michigan MHPs are required by MDHHS to have their HEDIS results confirmed through an NCQA HEDIS Compliance Audit. As a result, any rate included in this report has been verified as an unbiased estimate of the measure. NCQA’s HEDIS protocol is designed so that the hybrid method produces results with a sampling error of ± 5 percent at a 95 percent confidence level.

To show how sampling error affects the accuracy of results, an example was provided in the “Data Collection Methods” section above. When an MHP uses the hybrid method to derive a *Postpartum Care* rate of 52 percent, the true rate is actually within ± 5 percentage points of this rate, due to sampling error. For a 95 percent confidence level, the rate would be between 47 percent and 57 percent. If the target is a rate of 55 percent, it cannot be said with certainty whether the true rate between 47 percent and 57 percent meets or does not meet the target level.

To prevent such ambiguity, this report uses a standardized methodology that requires the reported rate to be at or above the threshold level to be considered as meeting the target. Michigan MHPs are advised to understand and consider the issue of sampling error when evaluating HEDIS results.

How do Michigan Medicaid rates compare to national percentiles?

For each measure, an MHP ranking presents the reported rate in order from highest to lowest, with bars representing the established HPL, LPL, and the national HEDIS MY 2022 MWA Medicaid 50th percentile. In addition, the HEDIS MY 2021, MY 2022, and MY 2023 MWA rates are presented for comparison.

Michigan MHPs with reported rates above the 90th percentile (HPL) rank in the top 10 percent of all MHPs nationally. Similarly, MHPs reporting rates below the 25th percentile (LPL) rank in the bottom 25 percent nationally for that measure.

How are Michigan MHPs performing overall?

For each domain of care, a performance profile analysis compares the MY 2023 MWA for each rate with the MY 2021 and MY 2022 MWA and the 50th percentile.

Measure Changes Between HEDIS MY 2022 and HEDIS MY 2023

The following is a list of measures with technical specification changes that NCQA announced for HEDIS MY 2023.¹⁵ These changes may have an effect on the HEDIS MY 2023 rates that are presented in this report.

Chlamydia Screening in Women (CHL)

- Revised the optional exclusions for a pregnancy test to be Step 2 of the event/diagnosis criteria.

Eye Exam for Patients With Diabetes (EED)

- Updated General Guideline 37 to allow use of automated eye exams from laboratory claims and data. This edit could result in increased performance among plans.

Antidepressant Medication Management (AMM)

- Revised the age criterion to 18 years and older as of the index prescription start date.

¹⁵ National Committee for Quality Assurance. *HEDIS® MY 2023, Volume 2: Technical Specifications for Health Plans*. Washington, DC: NCQA Publication, 2022.

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

- Added instructions for calculating covered days.
- Replaced “discharge date” with “admission date” in Step 4 of the event/diagnosis in both Rate 1 and Rate 2.

Prenatal and Postpartum Care (PPC)

- Clarified continuous enrollment requirements for Step 2 of the *Timeliness of Prenatal Care* numerator.

3. Child & Adolescent Care

Introduction

The Child & Adolescent Care domain encompasses the following HEDIS measures:

- *Childhood Immunization Status (CIS)—Combinations 3, 7, and 10*
- *Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits and Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*
- *Lead Screening in Children (LSC)*
- *Child and Adolescent Well-Care Visits (WCV)—Ages 3 to 11 Years, Ages 12 to 17 Years, Ages 18 to 21 Years, and Total*
- *Immunizations for Adolescents (IMA)—Combinations 1 and 2*
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase and Continuation and Maintenance Phase*

Please see the “How to Get the Most From This Report” section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendices A, B, and C.

Summary of Findings

Table 3-1 presents the Michigan MWA performance for the measure indicators under the Child & Adolescent Care domain. The table lists the HEDIS MY 2023 MWA rates and performance levels, a comparison of the HEDIS MY 2022 MWA to the HEDIS MY 2023 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating significant changes from HEDIS MY 2022 to HEDIS MY 2023.

Table 3-1—HEDIS MY 2023 MWA Performance Levels and Trend Results for Child & Adolescent Care

	HEDIS MY 2023 MWA and Performance Level ¹	HEDIS MY 2022 MWA— HEDIS MY 2023 MWA Comparison ²	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2023	Number of MHPs With Statistically Significant Decline in HEDIS MY 2023
<i>Childhood Immunization Status (CIS)</i>				
<i>Combination 3</i>	58.72%	+1.10 ⁺	0	0
<i>Combination 7</i>	50.19%	+0.59	0	0

	HEDIS MY 2023 MWA and Performance Level ¹	HEDIS MY 2022 MWA– HEDIS MY 2023 MWA Comparison ²	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2023	Number of MHPs With Statistically Significant Decline in HEDIS MY 2023
<i>Combination 10</i>	23.67%	-1.62 ⁺⁺	0	1
Well-Child Visits in the First 30 Months of Life (W30)				
<i>Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	64.33%	+4.27 ⁺	2	0
<i>Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i>	66.19%	+5.34 ⁺	8	0
Lead Screening in Children (LSC)				
<i>Lead Screening in Children</i>	58.40%	+3.62 ⁺	4	0
Child and Adolescent Well-Care Visits (WCV)				
<i>Ages 3 to 11 Years</i>	61.33%	+2.13 ⁺	8	0
<i>Ages 12 to 17 Years</i>	52.14%	+1.76 ⁺	4	0
<i>Ages 18 to 21 Years</i>	30.51%	+2.20 ⁺	7	0
<i>Total</i>	53.31%	+2.41 ⁺	9	0
Immunizations for Adolescents (IMA)				
<i>Combination 1 (Meningococcal, Tdap)</i>	79.43%	+2.47 ⁺	2	0
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	32.73%	+3.37 ⁺	2	0
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)³				
<i>Initiation Phase</i>	44.77%	+2.29 ⁺	3	0
<i>Continuation and Maintenance Phase</i>	48.46%	+0.53	1	0

¹ HEDIS MY 2023 performance levels were based on comparisons of the HEDIS MY 2023 MWA rates to national Medicaid Quality Compass HEDIS MY 2022 MWA benchmarks. HEDIS MY 2023 performance levels represent the following percentile comparisons:

<25th	≥25th and ≤49th	≥50th and ≤74th	≥75th and ≤89th	≥90th
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² HEDIS MY 2022 MWA to HEDIS MY 2023 MWA comparisons were based on a Chi-square test of statistical significance with a p-value <0.01 due to large denominators.

Green Shading⁺ Indicates that the HEDIS MY 2023 MWA demonstrated a significant improvement from the HEDIS MY 2022 MWA.

Red Shading⁺⁺ Indicates that the HEDIS MY 2023 MWA demonstrated a significant decline from the HEDIS MY 2022 MWA.

³ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

Table 3-1 shows that for the Child & Adolescent Care domain, the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*; *Child and Adolescent Well-Care Visits—Ages 3 to 11 Years, Ages 12 to 17 Years, Ages 18 to 21 Years, and Total*; and *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure indicators were an area of strength. All measure indicators ranked at or above the 50th percentile and demonstrated significant improvement from the HEDIS MY 2022 MWA. **BCC**, **MOL**, **PRI**, and **UPP** ranked above the 50th percentile for the most measure indicators within the Child & Adolescent Care domain. **UPP** ranked above the HPL for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator.

The MWA demonstrated a significant decline for the *Childhood Immunization Status—Combination 10* indicator, had an MWA decrease of over 1 percentage point from HEDIS MY 2022, and ranked below the 25th percentile. The *Childhood Immunization Status—Combination 7* and *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* indicators also ranked below the 25th percentile.

MDHHS should continue to monitor the MHPs' performance on the *Childhood Immunization Status—Combination 7* and *Combination 10*, and *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure indicators to ensure that the MHPs' performance does not continue to decline, while working with the MHPs and providers to target improving child vaccination rates and monitoring of ADHD medication. Immunizations are essential for disease prevention and are a critical aspect of preventable care for children. Vaccination coverage must be maintained in order to prevent a resurgence of vaccine-preventable diseases.¹⁶ When managed appropriately, ADHD medication can control symptoms of hyperactivity, impulsiveness and inability to sustain concentration. To ensure that medication is prescribed and managed correctly, it is important that children be monitored by a pediatrician with prescribing authority.¹⁷

Additionally, MDHHS should work with the MHPs and providers to identify potential root causes for the significant rate decline for the *Childhood Immunization Status—Combination 10* measure indicator.

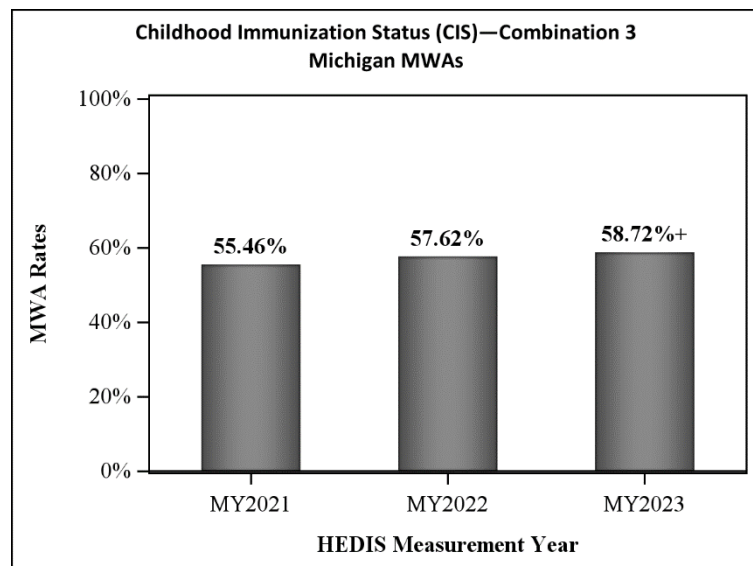
¹⁶ National Committee for Quality Assurance. Childhood Immunization Status. Available at: <https://www.ncqa.org/hedis/measures/childhood-immunization-status/>. Accessed on: Sept 17, 2024.

¹⁷ National Committee for Quality Assurance. Follow-Up Care for Children Prescribed ADHD Medication. Available at: <https://www.ncqa.org/hedis/measures/follow-up-care-for-children-prescribed-adhd-medication/>. Accessed on: Sept 17, 2024.

Measure-Specific Findings

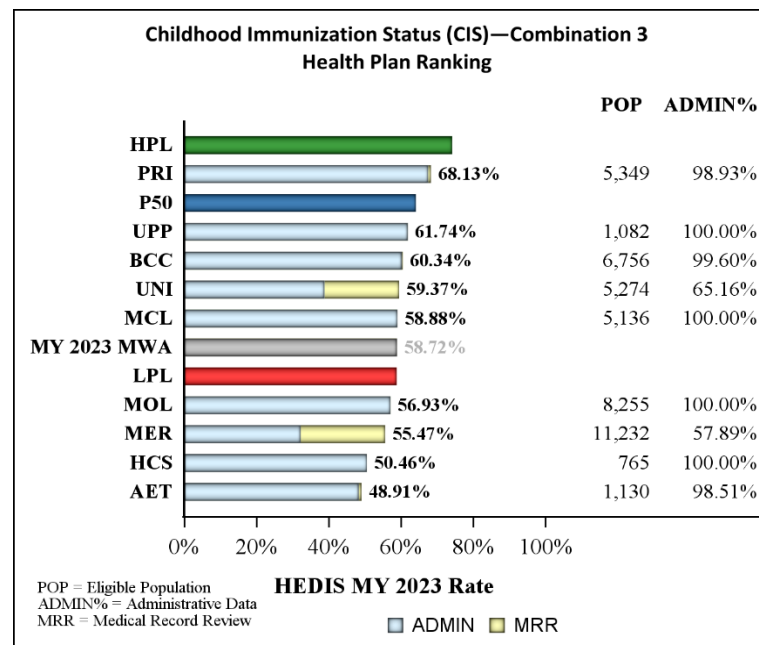
Childhood Immunization Status (CIS)—Combination 3

Childhood Immunization Status (CIS)—Combination 3 assesses the percentage of children 2 years of age who received the following vaccines by their second birthday: four diphtheria, tetanus, and acellular pertussis (DTaP), three polio (IPV), one measles, mumps and rubella (MMR), three haemophilus influenza type B (HiB), three hepatitis B (HepB), one chicken pox (VZV), and four pneumococcal conjugate (PCV).



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

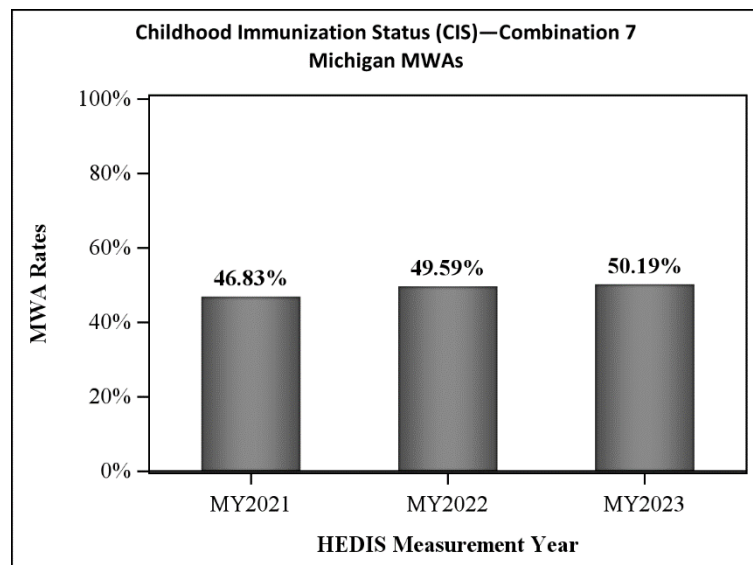
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



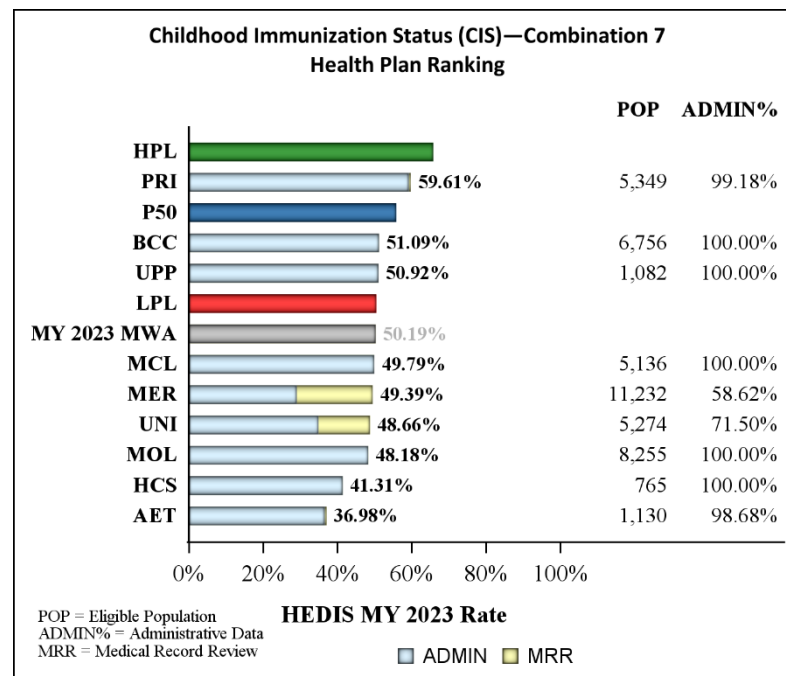
One MHP ranked above the 50th percentile but fell below the HPL. Four MHPs and the MWA ranked above the LPL but fell below the 50th percentile. Four MHPs fell below the LPL. MHP performance varied by over 19 percentage points.

Childhood Immunization Status (CIS)—Combination 7

Childhood Immunization Status (CIS)—Combination 7 assesses the percentage of children 2 years of age who received the following vaccines by their second birthday: four DTaP, three IPV, one MMR, three HiB, three HepB, one VZV, four PCV, one HepA, and two or three rotavirus (RV).



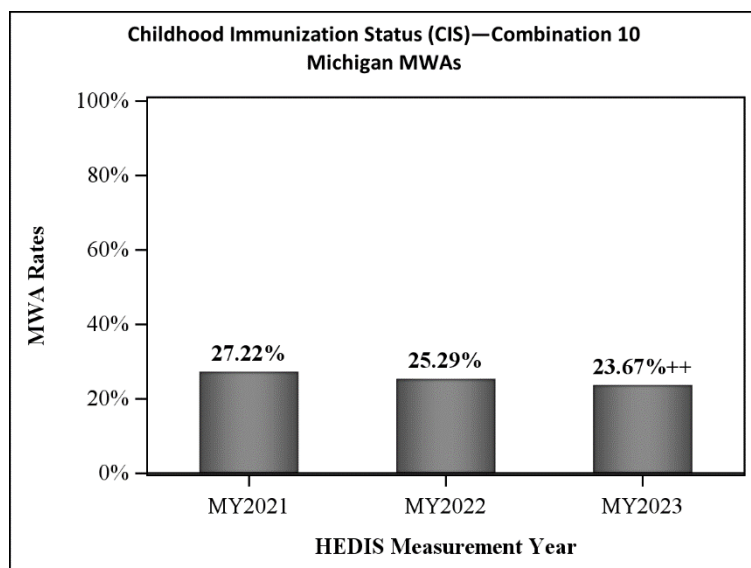
The HEDIS MY 2023 MWA rate did not demonstrate a significant change from HEDIS MY 2022.



One MHP ranked above the 50th percentile but fell below the HPL. Two MHPs ranked above the LPL but fell below the 50th percentile. Six MHPs and the MWA fell below the LPL. MHP performance varied by over 22 percentage points.

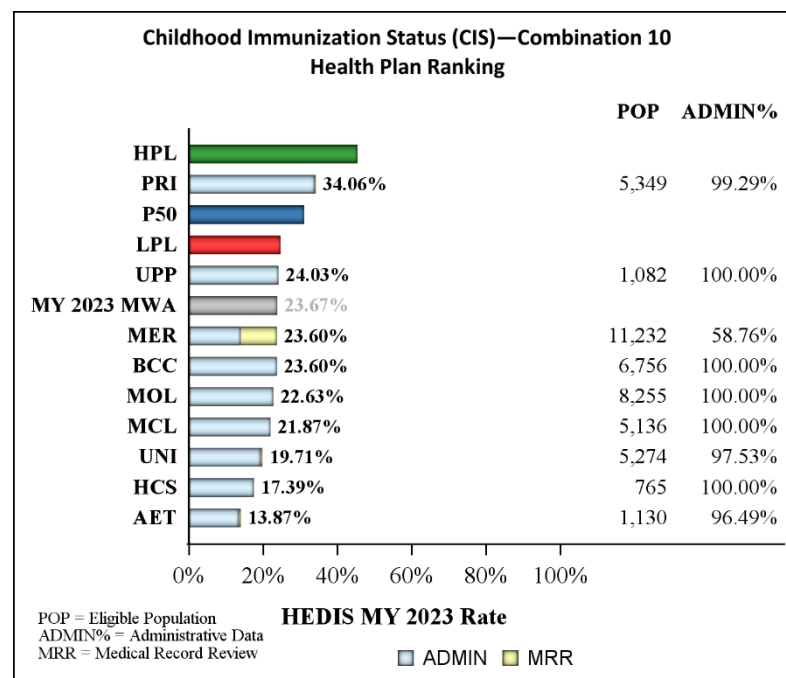
Childhood Immunization Status (CIS)—Combination 10

Childhood Immunization Status (CIS)—Combination 10 assesses the percentage of children 2 years of age who received the following vaccines by their second birthday: four DTaP, three IPV, one MMR, three HiB, three HepB, one VZV, four PCV, one HepA, two or three RV, and two influenza.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

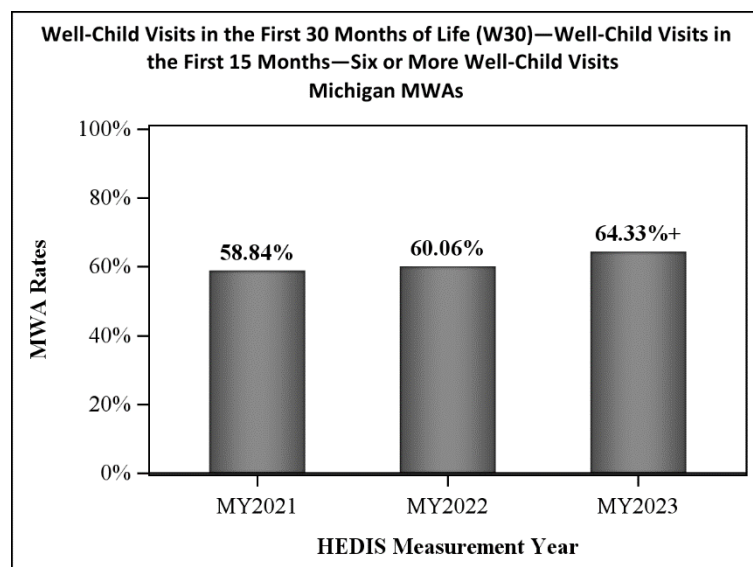
The HEDIS MY 2023 MWA rate significantly declined from HEDIS MY 2022.



One MHP ranked above the 50th percentile but fell below the HPL. Eight MHPs and the MWA fell below the LPL. MHP performance varied by over 20 percentage points.

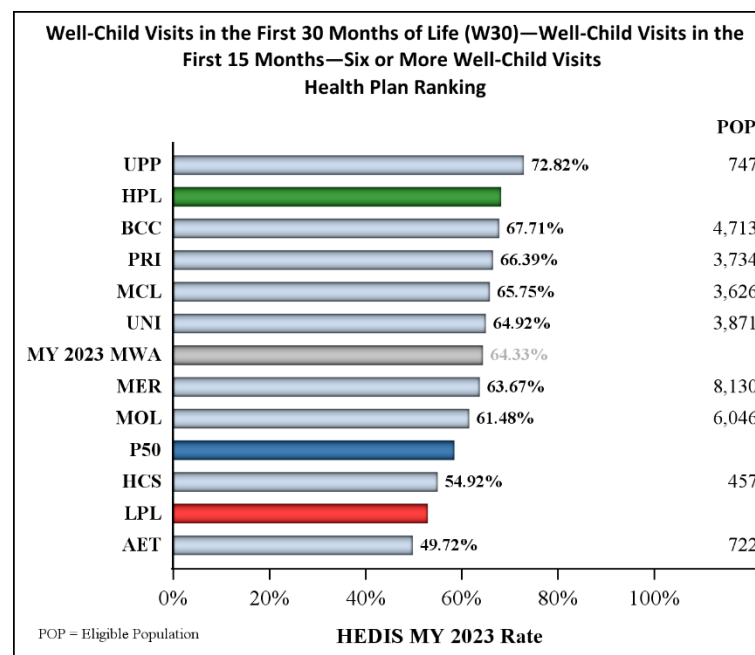
Well-Child Visits in the First 30 Months of Life (W30)—Well Child Visits in the First 15 Months—Six or More Well-Child Visits

Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits assesses the percentage of members who turned 15 months old during the MY who received six or more well-child visits with a PCP during their first 15 months of life.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

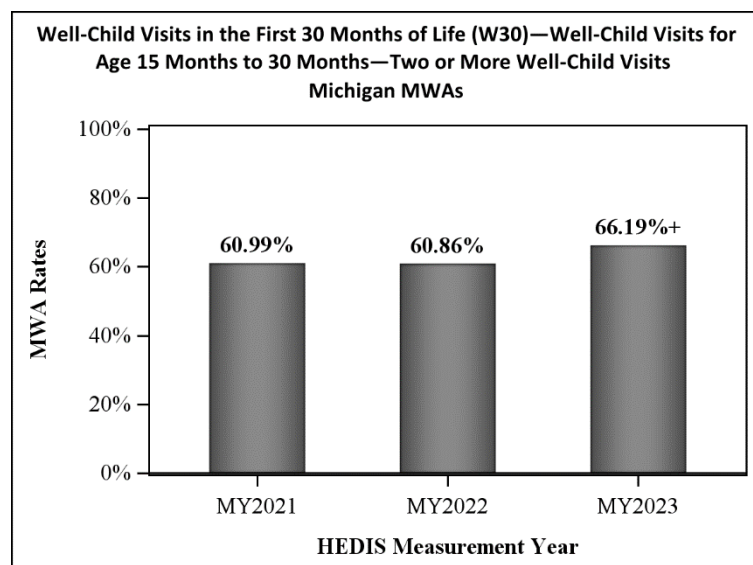
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



One MHP ranked above the HPL. Six MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 23 percentage points.

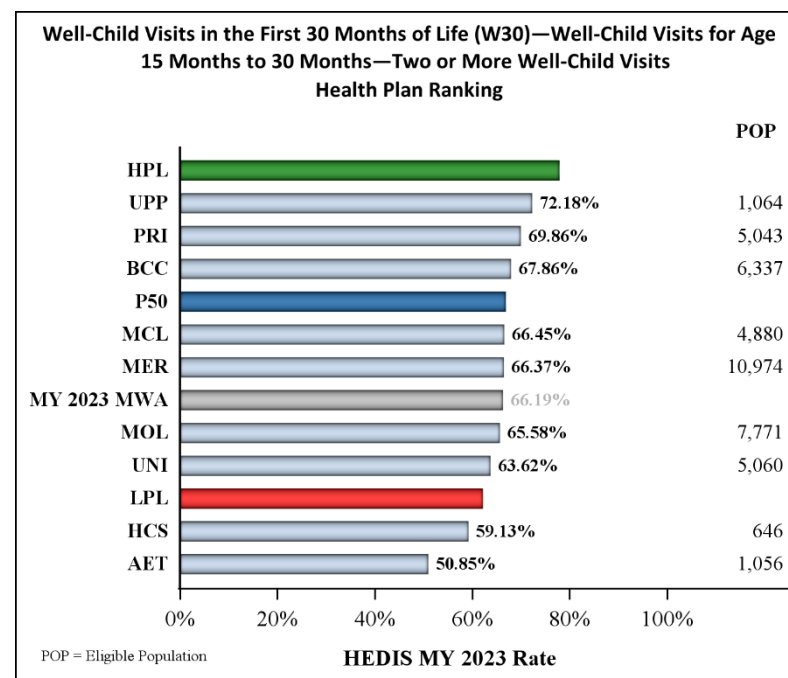
Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits

Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits assesses the percentage of members who turned 30 months old during the MY who received two or more well-child visits with a PCP during their first 15 months of life.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

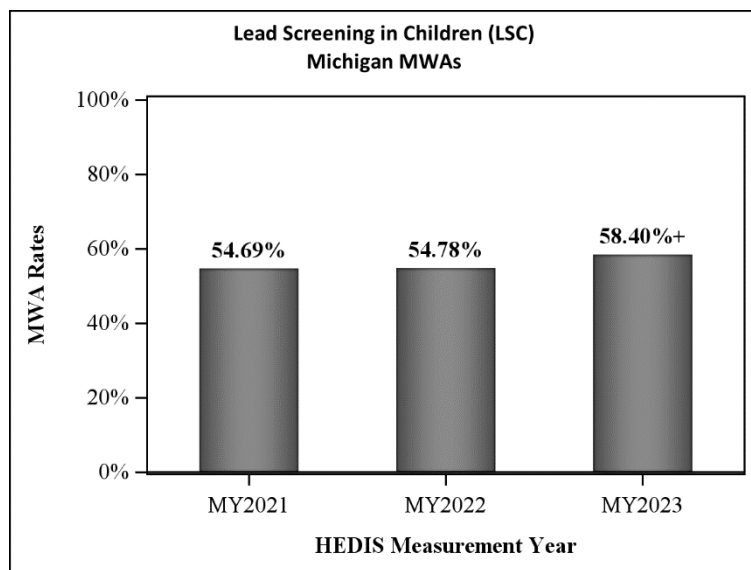
The HEDIS MY 2023 MWA significantly improved from HEDIS MY 2022.



Three MHPs ranked above the 50th percentile but fell below the HPL. Four MHPs and the MWA ranked above the LPL but fell below the 50th percentile. Two MHPs fell below the LPL. MHP performance varied by over 21 percentage points.

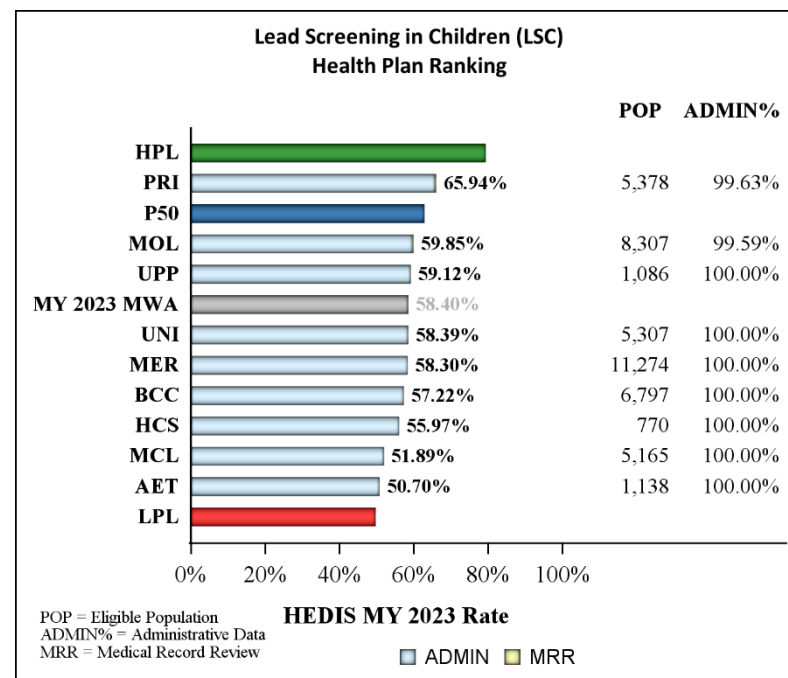
Lead Screening in Children (LSC)

Lead Screening in Children (LSC) assesses the percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

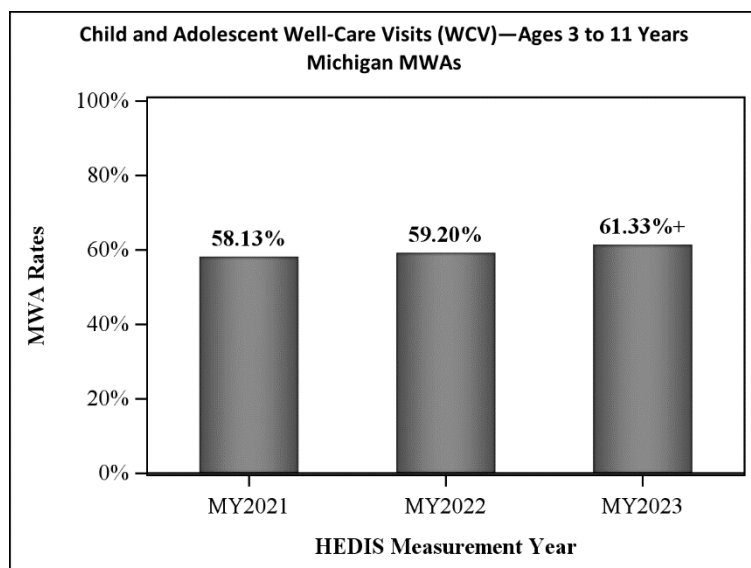
The HEDIS MY 2023 MWA significantly improved from HEDIS MY 2022.



One MHP ranked above the 50th percentile but fell below the HPL. Eight MHPs and the MWA ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 15 percentage points.

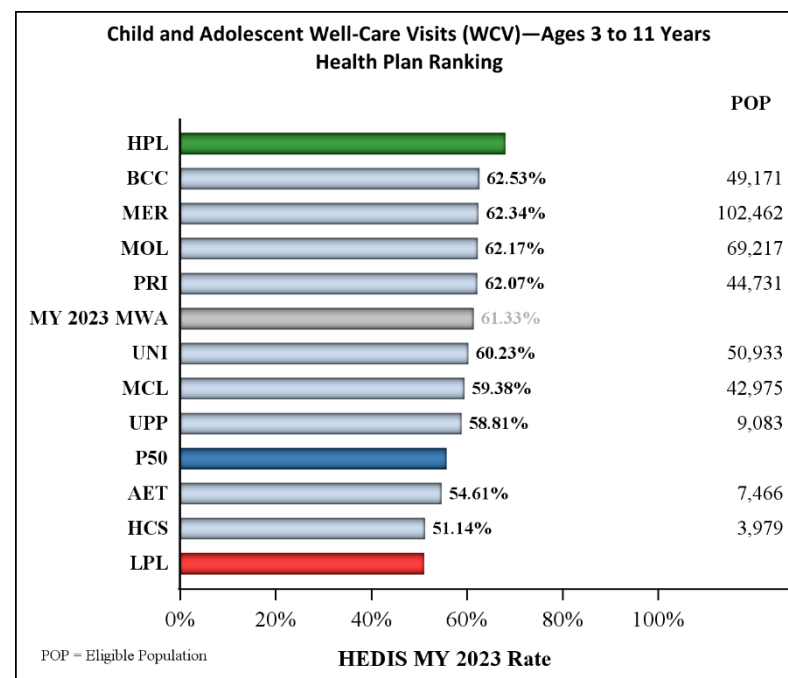
Child and Adolescent Well-Care Visits (WCV)—Ages 3 to 11 Years

Child and Adolescent Well-Care Visits (WCV)—Ages 3 to 11 Years assesses the percentage of members who were 3 to 11 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

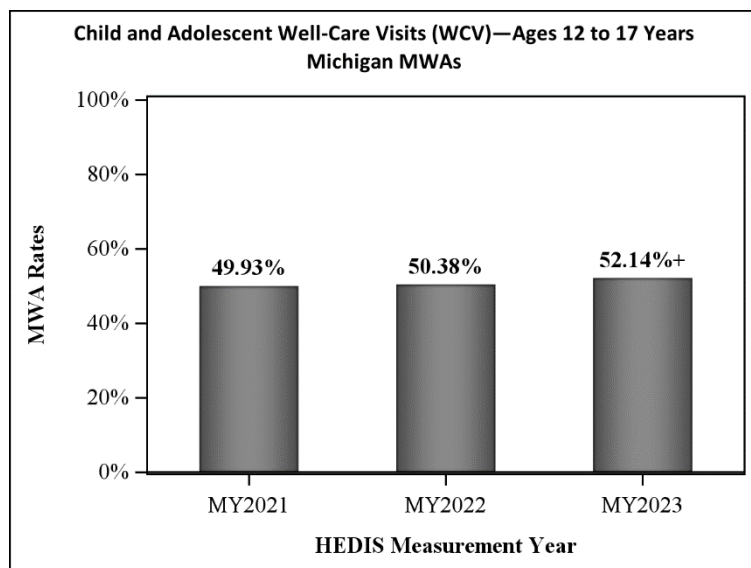
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



Seven MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Two MHPs ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 11 percentage points.

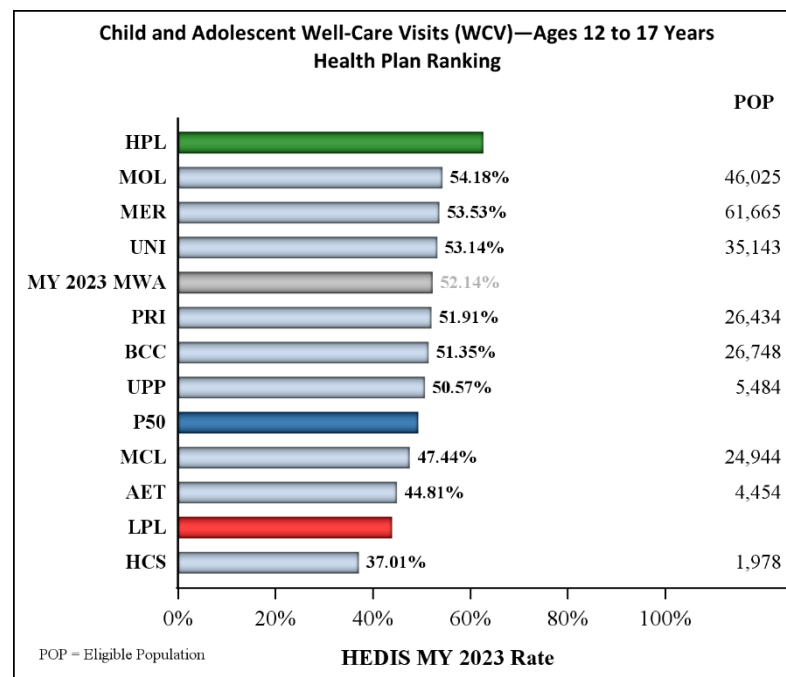
Child and Adolescent Well-Care Visits (WCV)—Ages 12 to 17 Years

Child and Adolescent Well-Care Visits (WCV)—Ages 12 to 17 Years assesses the percentage of members who were 12 to 17 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

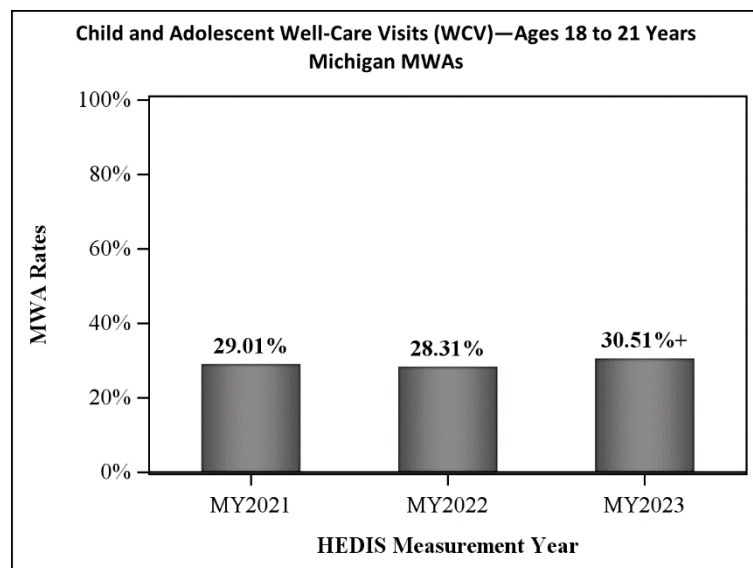
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



Six MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Two MHPs ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 17 percentage points.

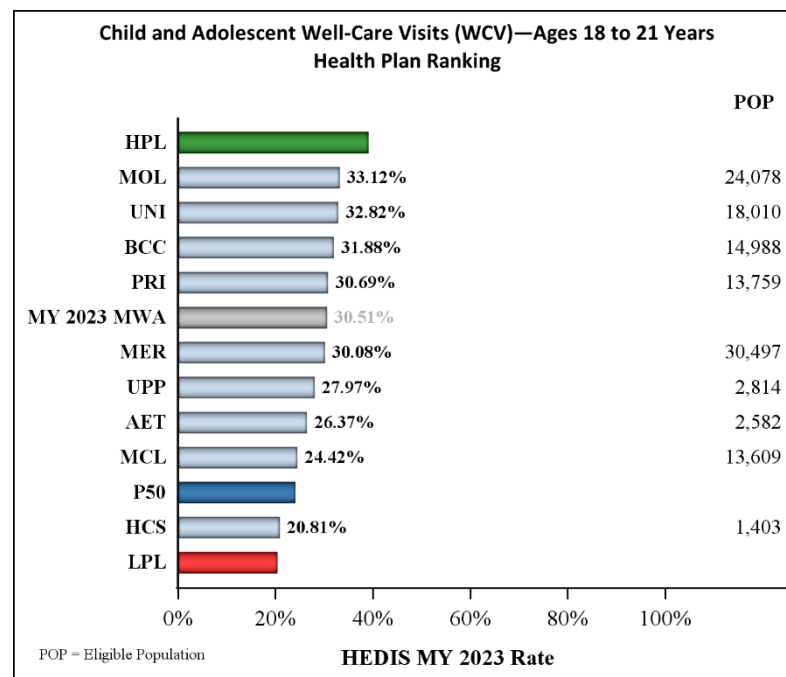
Child and Adolescent Well-Care Visits (WCV)—Ages 18 to 21 Years

Child and Adolescent Well-Care Visits (WCV)—Ages 18 to 21 Years assesses the percentage of members who were 18 to 21 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

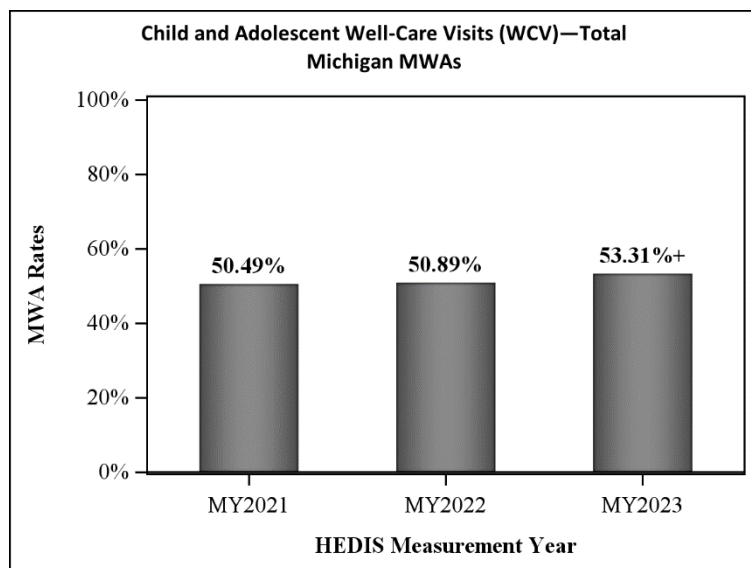
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



Eight MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 12 percentage points.

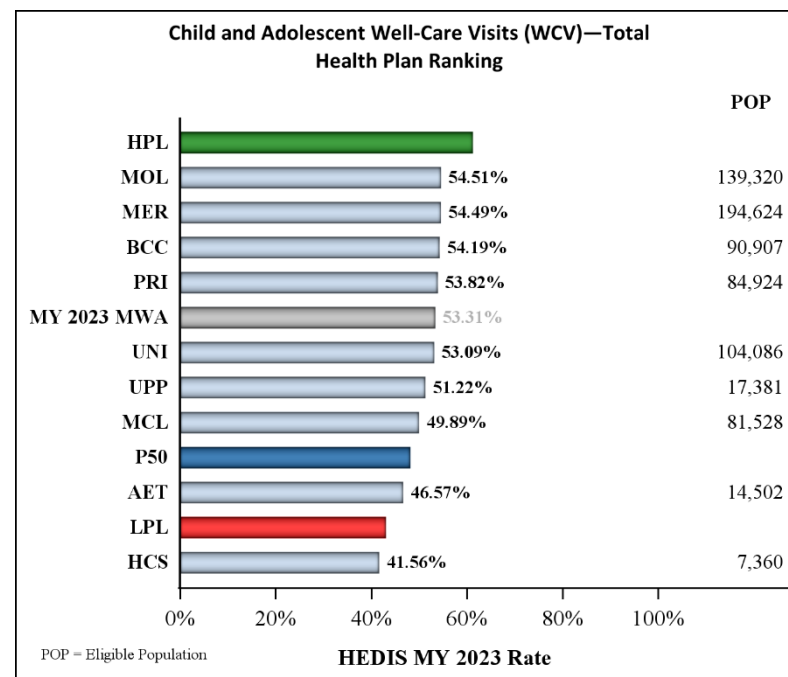
Child and Adolescent Well-Care Visits (WCV)—Total

Child and Adolescent Well-Care Visits (WCV)—Total assesses the percentage of members who were 3 to 21 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

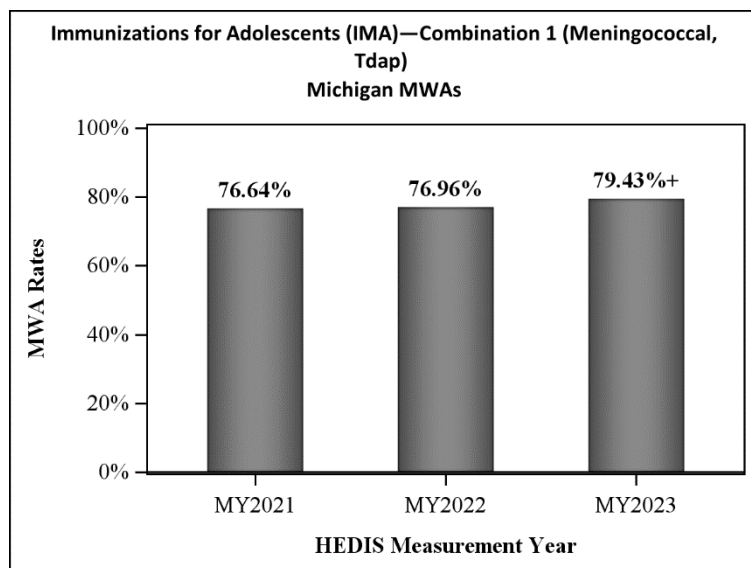
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



Seven MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 12 percentage points.

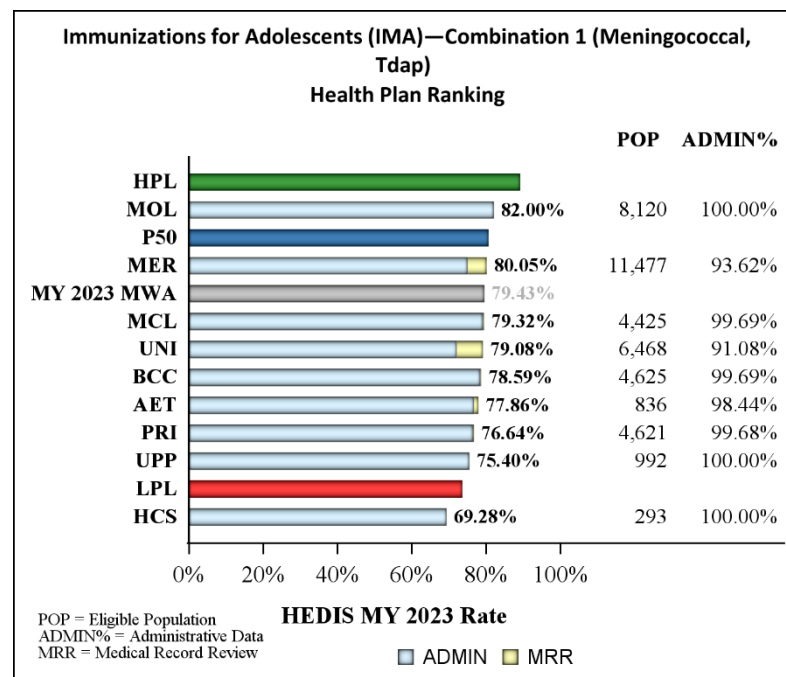
Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap)

Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap) assesses the percentage of adolescents 13 years of age who had the following by their 13th birthday: one dose of meningococcal vaccine and one Tdap vaccine.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

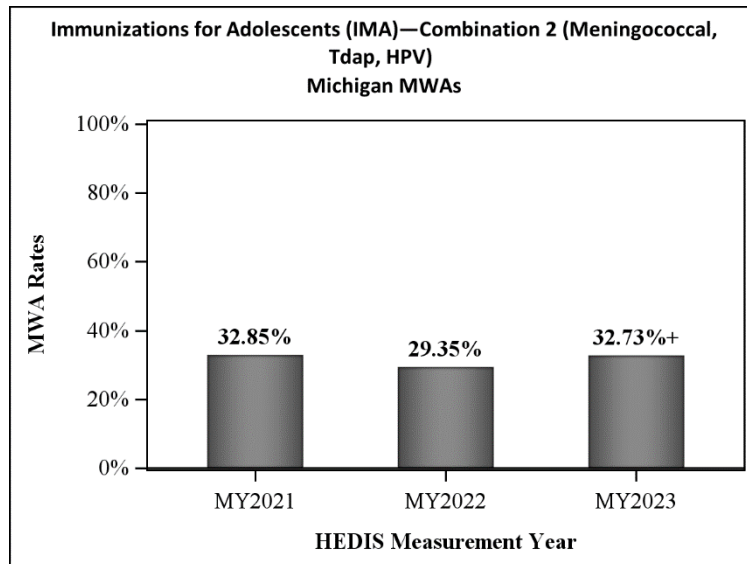
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



One MHP ranked above the 50th percentile but fell below the HPL. Seven MHPs and the MWA ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 12 percentage points.

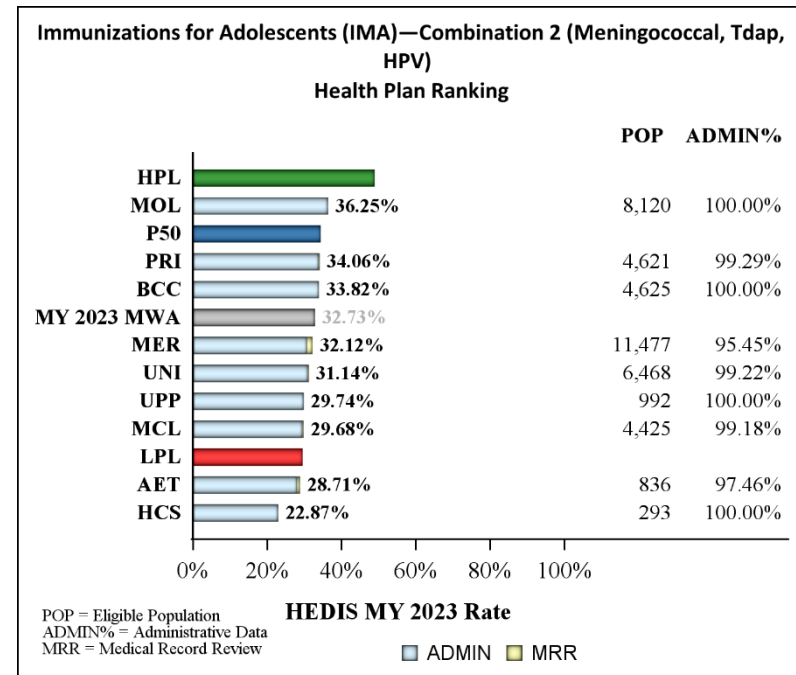
Immunizations for Adolescents (IMA)—Combination 2 (Meningococcal, Tdap, HPV)

Immunizations for Adolescents (IMA)—Combination 2 (Meningococcal, Tdap, HPV) assesses the percentage of adolescents 13 years of age who had the following by their 13th birthday: one dose of meningococcal vaccine, one Tdap vaccine, and two HPV.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

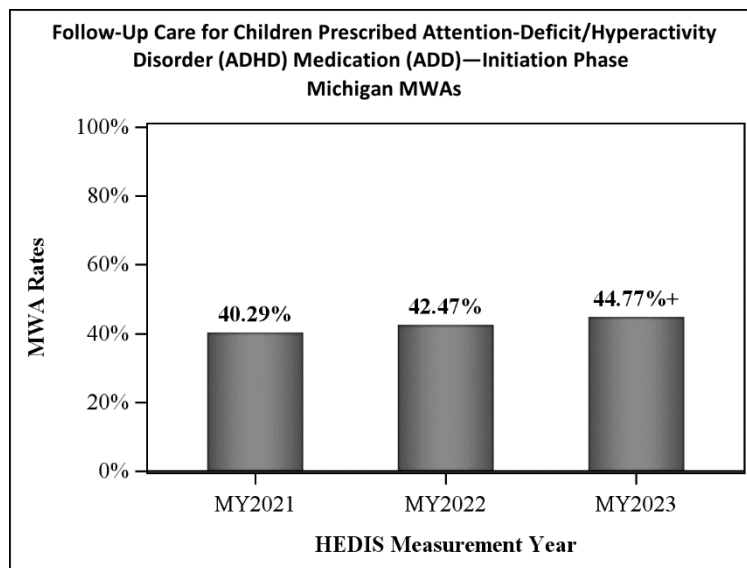
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



One MHP ranked above the 50th percentile but fell below the HPL. Six MHPs and the MWA ranked above the LPL but fell below the 50th percentile. Two MHPs fell below the LPL. MHP performance varied by over 13 percentage points.

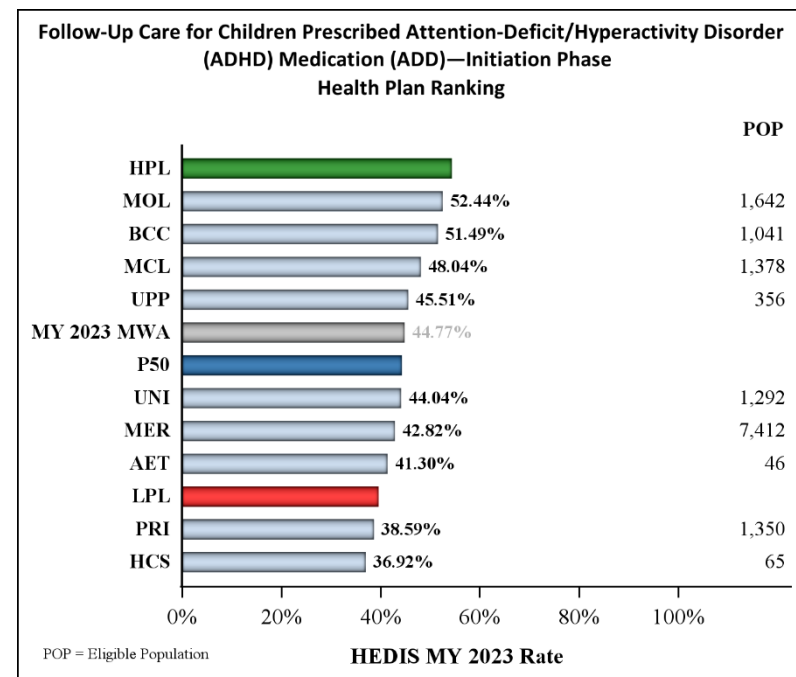
Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase

Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase assesses the percentage of children 6 to 12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase. *Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.*



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

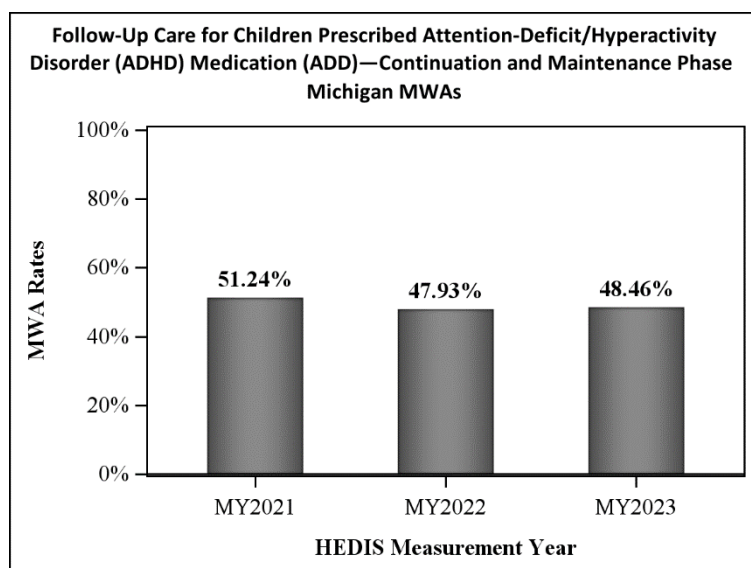
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



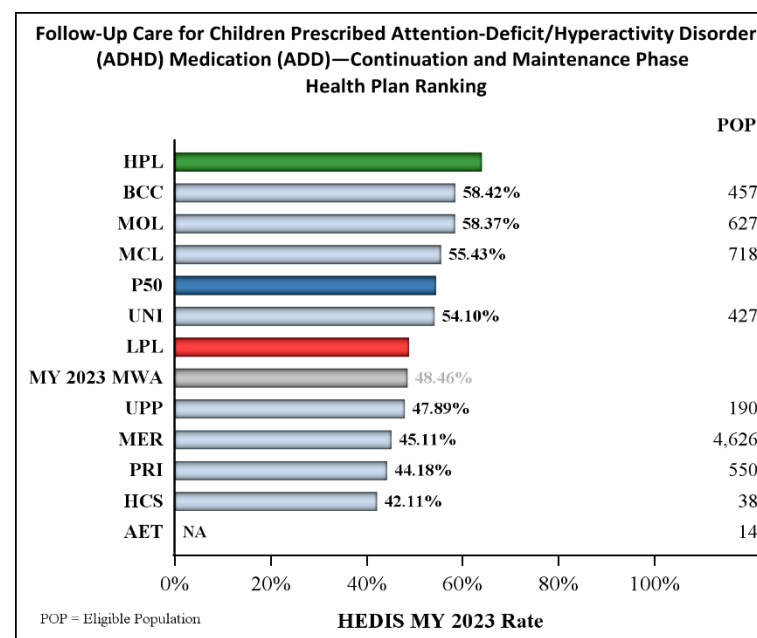
Four MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Three MHPs ranked above the LPL but fell below the 50th percentile. Two MHPs fell below the LPL. MHP performance varied by over 15 percentage points.

Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Continuation and Maintenance Phase

Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Continuation and Maintenance Phase assesses the percentage of children 6 to 12 years with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended. *Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.*



The HEDIS MY 2023 MWA rate did not demonstrate a significant change from HEDIS MY 2022.



NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Three MHPs ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. Four MHPs and the MWA fell below the LPL. MHP performance varied by over 16 percentage points.

4. Women—Adult Care

Introduction

The Women—Adult Care domain encompasses the following HEDIS measures:

- *Chlamydia Screening in Women (CHL)—Ages 16 to 20 Years, Ages 21 to 24 Years, and Total*
- *Cervical Cancer Screening (CCS-E)*
- *Breast Cancer Screening (BCS-E)*

Please see the “How to Get the Most From This Report” section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendices A, B, and C.

Summary of Findings

Table 4-1 presents the Michigan MWA performance for the measure indicators under the Women—Adult Care domain. The table lists the HEDIS MY 2023 MWA rates and performance levels, a comparison of the HEDIS MY 2022 MWA to the HEDIS MY 2023 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating significant changes from HEDIS MY 2022 MWA to HEDIS MY 2023 MWA.

Table 4-1—HEDIS MY 2023 MWA Performance Levels and Trend Results for Women—Adult Care

	HEDIS MY 2023 MWA and Performance Level ¹	HEDIS MY 2022 MWA— HEDIS MY 2023 MWA Comparison ²	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2023	Number of MHPs With Statistically Significant Decline in HEDIS MY 2023
<i>Chlamydia Screening in Women (CHL)</i>³				
<i>Ages 16 to 20 Years</i>	57.65%	-1.71 ⁺⁺	0	2
<i>Ages 21 to 24 Years</i>	64.80%	-1.54 ⁺⁺	0	2
<i>Total</i>	61.06%	-1.70 ⁺⁺	0	2
<i>Cervical Cancer Screening (CCS-E)</i>				
<i>Cervical Cancer Screening</i>	54.97%	-4.19 ⁺⁺	0	4
<i>Breast Cancer Screening (BCS-E)</i>				
<i>Breast Cancer Screening</i>	55.00%	+1.39 ⁺	2	0

¹ HEDIS MY 2023 performance levels were based on comparisons of the HEDIS MY 2023 MWA rates to national Medicaid Quality Compass HEDIS MY 2022 MWA benchmarks. HEDIS MY 2023 performance levels represent the following percentile comparisons:

<25th	≥25th and ≤49th	≥50th and ≤74th	≥75th and ≤89th	≥90th
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² HEDIS MY 2022 MWA to HEDIS MY 2023 MWA comparisons were based on a Chi-square test of statistical significance with a p-value <0.01 due to large denominators.

Green Shading⁺ Indicates that the HEDIS MY 2023 MWA demonstrated a significant improvement from the HEDIS MY 2022 MWA.

Red Shading⁺ Indicates that the HEDIS MY 2023 MWA demonstrated a significant decline from the HEDIS MY 2022 MWA.

³ Due to changes in the technical specifications for this measure, NCQA recommends trending between MY 2023 and prior years be considered with caution.

Table 4-1 shows that for the Women—Adult Care domain, the *Breast Cancer Screening* measure indicator was an area of strength, as the measure indicator ranked at or above the 50th percentile. Additionally, the *Breast Cancer Screening* measure indicator demonstrated significant improvement from the HEDIS MY 2022 MWA. **BCC**, **MCL**, **MER**, **MOL**, **PRI**, and **UNI** ranked above the 50th percentile for the most measure indicators within the Women—Adult Care domain. In addition, **AET** ranked above the HPL for the *Chlamydia Screening in Women—16 to 20 Years* and *Total* measure indicators.

The MWA demonstrated a significant decline for the *Chlamydia Screening in Women—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total* indicators, with the MWA for each declining more than 1 percentage point from HEDIS MY 2022; similarly, the MWA for the *Cervical Cancer Screening* indicator also demonstrated a significant decline, with the MWA declining more than 4 percentage points. The *Cervical Cancer Screening* indicator also ranked below the 50th percentile.

MDHHS should continue to monitor the MHPs' performance related to the *Chlamydia Screening in Women—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total*; and *Cervical Cancer Screening* measure indicators within the Women—Adult Care domain to further improve performance. Untreated chlamydia infections can lead to serious and irreversible complications. Screening is important, as infections can be asymptomatic. This results in delayed medical care and treatment.¹⁸ Each year in the United States, about 11,500 new cases of cervical cancer are diagnosed and about 4,000 women die of this cancer.¹⁹ Effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate.²⁰ MDHHS should consider promoting the integration of targeted outreach interventions that MHPs could employ to increase adherence to *Chlamydia Screening in Women* and *Cervical Cancer Screening* such as sending automated text messages, distributing pamphlets or brochures further educating members on the importance of timely screenings, and imbedding health screening reminders into routine case management touch points with members.

¹⁸ National Committee for Quality Assurance. Chlamydia Screening in Women. Available at: <https://www.ncqa.org/hedis/measures/chlamydia-screening-in-women/>. Accessed on: Sept 17, 2024.

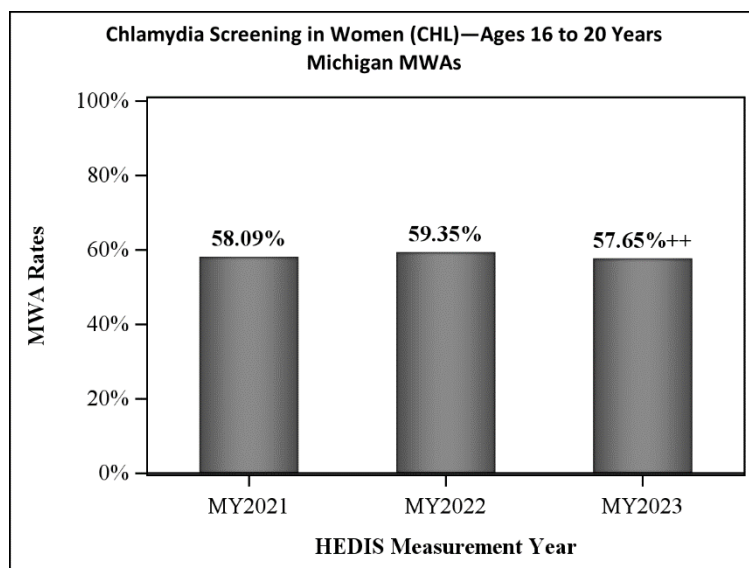
¹⁹ Centers for Disease Control and Prevention. Cervical Cancer Statistics. Available at: <https://www.cdc.gov/cervical-cancer/statistics/index.html>. Accessed on: Sept 17, 2024.

²⁰ National Committee for Quality Assurance. Cervical Cancer Screening. Available at: <https://www.ncqa.org/hedis/measures/cervical-cancer-screening/>. Accessed on: Sept 17, 2024.

Measure-Specific Findings

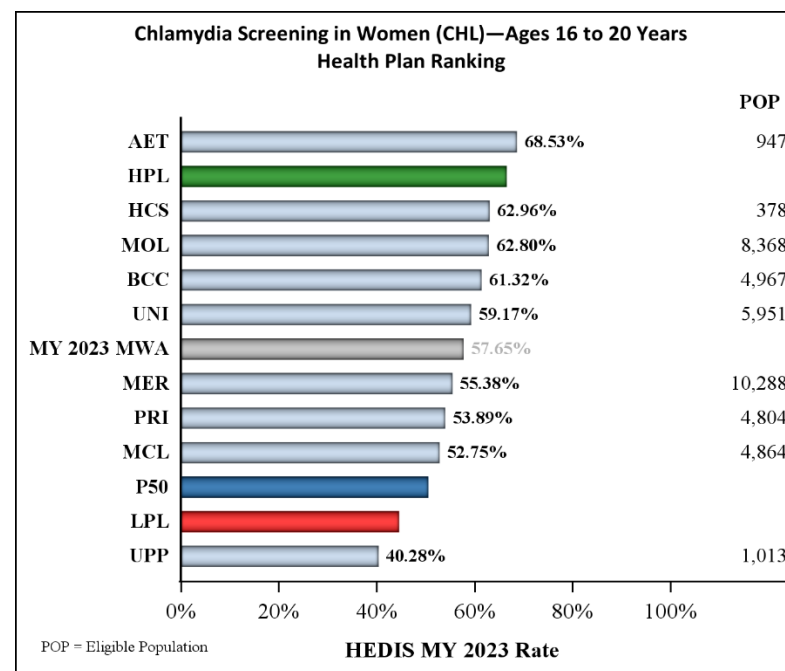
Chlamydia Screening in Women (CHL)—Ages 16 to 20 Years

Chlamydia Screening in Women (CHL)—Ages 16 to 20 Years assesses the percentage of women 16 to 20 years of age who were identified as sexually active and had at least one test for chlamydia during the MY. *Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.*



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

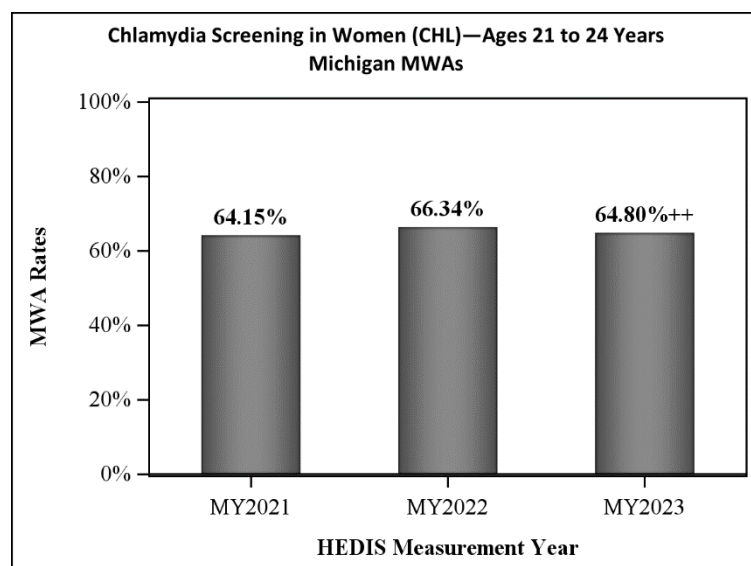
The HEDIS MY 2023 MWA rate significantly declined from HEDIS MY 2022.



One MHP ranked above the HPL. Seven MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP fell below the LPL. MHP performance varied by over 28 percentage points.

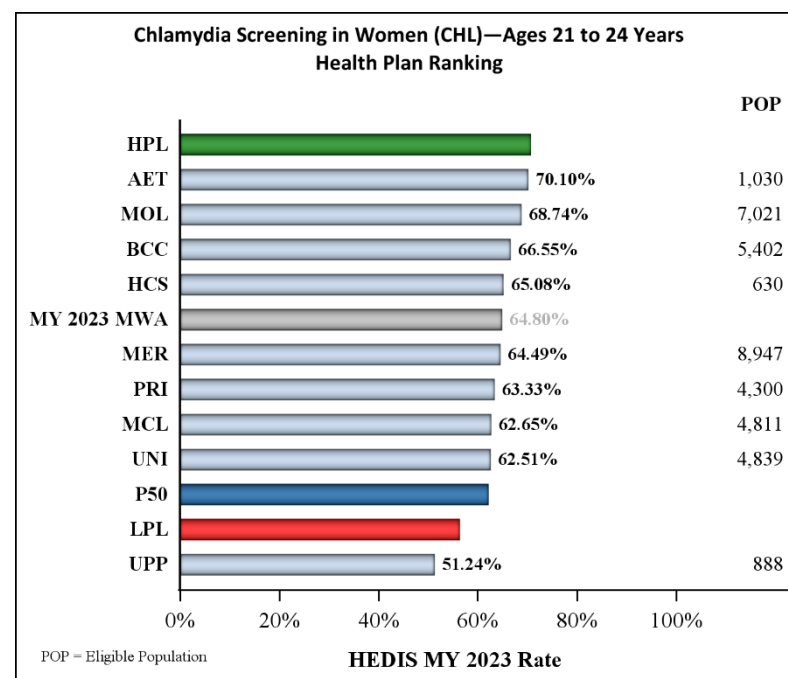
Chlamydia Screening in Women (CHL)—Ages 21 to 24 Years

Chlamydia Screening in Women (CHL)—21 to 24 Years assesses the percentage of women 21 to 24 years of age who were identified as sexually active and had at least one test for chlamydia during the MY. Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

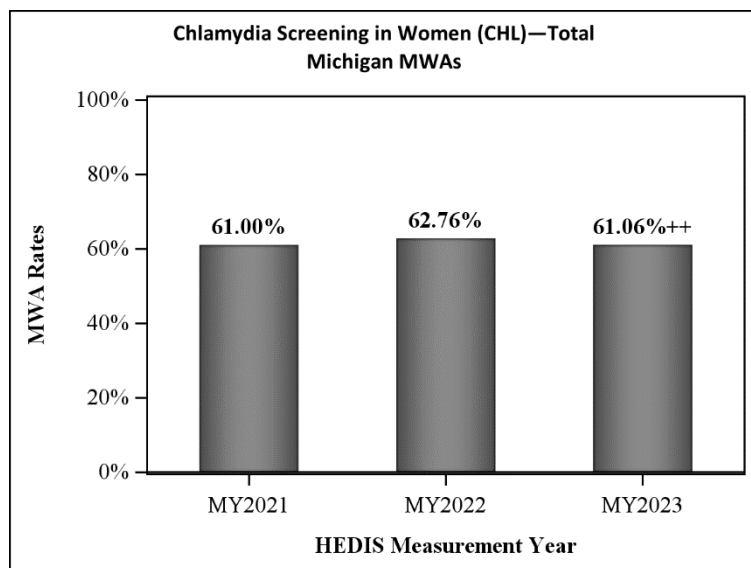
The HEDIS MY 2023 MWA rate significantly declined from HEDIS MY 2022.



Eight MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP fell below the LPL. MHP performance varied by over 18 percentage points.

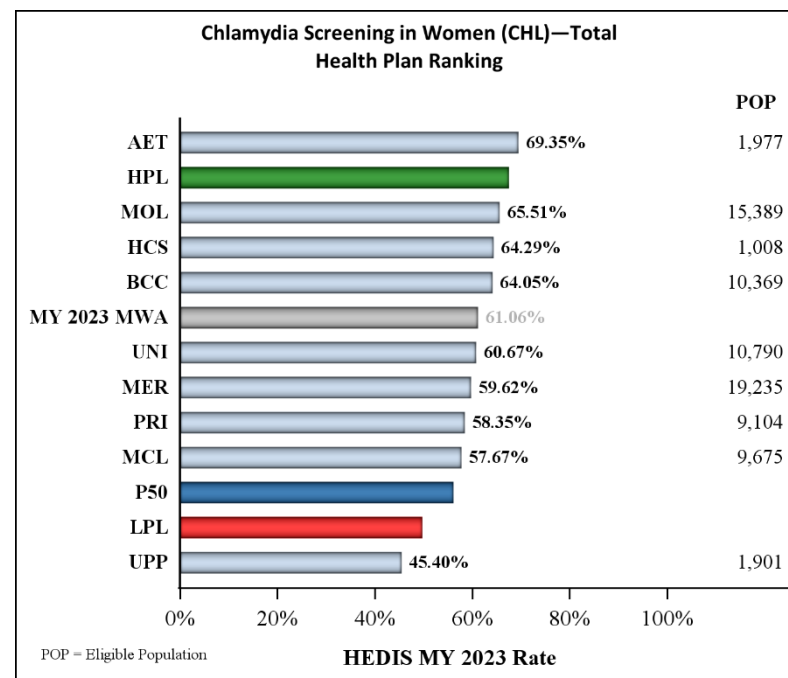
Chlamydia Screening in Women (CHL)—Total

Chlamydia Screening in Women (CHL)—Total assesses the percentage of women 16 to 24 years of age who were identified as sexually active and had at least one test for chlamydia during the MY. Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The HEDIS MY 2023 MWA rate significantly declined from HEDIS MY 2022.

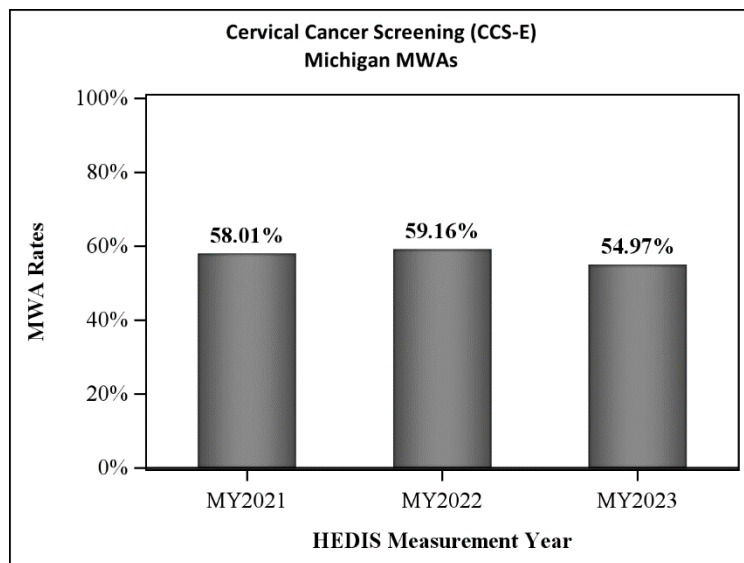


One MHP ranked above the HPL. Seven MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP fell below the LPL. MHP performance varied by over 23 percentage points.

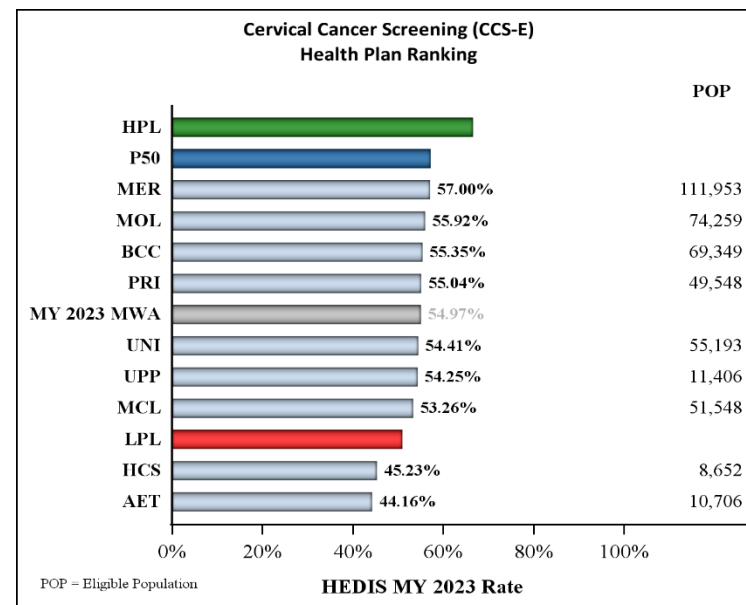
Cervical Cancer Screening (CCS-E)

Cervical Cancer Screening (CCS-E) assesses the percentage of women 21 to 64 years of age who were screened for cervical cancer using either of the following criteria:

- Women 21 to 64 years of age who had cervical cytology performed within the last 3 years.
- Women 30 to 64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Women 30 to 64 years of age who had cervical cytology/hrHPV co-testing within the last 5 years.



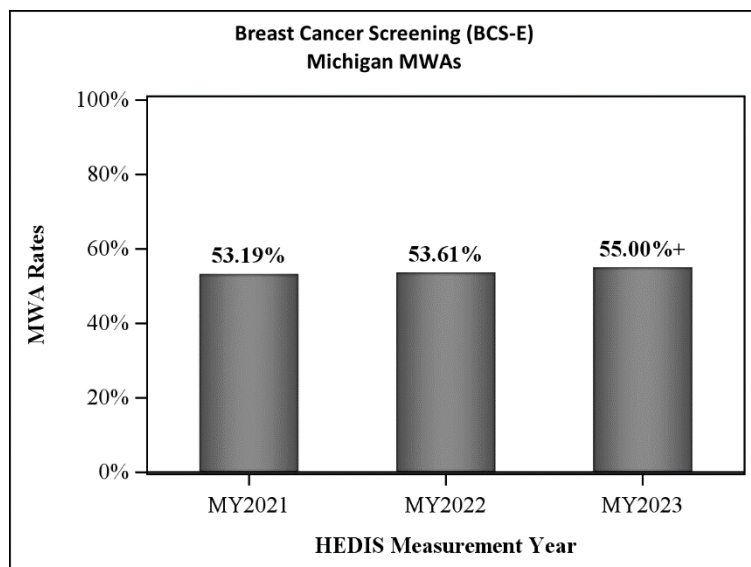
The HEDIS MY 2023 MWA rate did not demonstrate a significant change from HEDIS MY 2022.



Seven MHPs and the MWA ranked above the LPL but fell below the 50th percentile. Two MHPs fell below the LPL. MHP performance varied by over 12 percentage points.

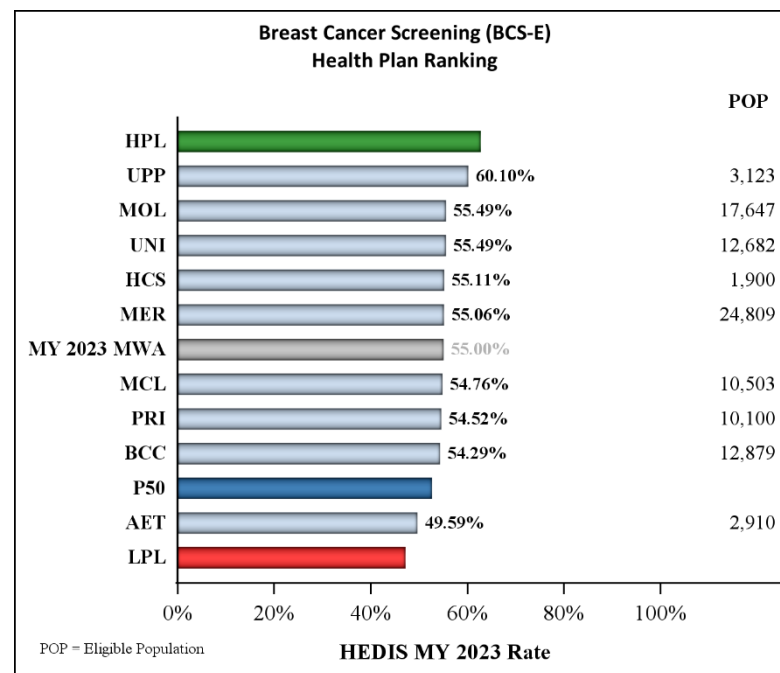
Breast Cancer Screening (BCS-E)

Breast Cancer Screening (BCS-E) assesses the percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



Eight MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 10 percentage points.

5. Access to Care

Introduction

The Access to Care domain encompasses the following HEDIS measures:

- *Adults' Access to Preventive/Ambulatory Health Services (AAP)—Ages 20 to 44 Years, Ages 45 to 64 Years, Ages 65 Years and Older, and Total*
- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)—Ages 3 Months to 17 Years, Ages 18 to 64 Years, Ages 65 Years and Older, and Total*
- *Appropriate Testing for Pharyngitis (CWP)—Ages 3 to 17 Years, Ages 18 to 64 Years, Ages 65 Years and Older, and Total*
- *Appropriate Treatment for Upper Respiratory Infection (URI)—Ages 3 Months to 17 Years, Ages 18 to 64 Years, Ages 65 Years and Older, and Total*

Please see the “How to Get the Most From This Report” section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendices A, B, and C.

Summary of Findings

Table 5-1 presents the Michigan MWA performance for the measure indicators under the Access to Care domain. The table lists the HEDIS MY 2023 MWA rates and performance levels, a comparison of the HEDIS MY 2022 MWA to the HEDIS MY 2023 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating significant changes from HEDIS MY 2022 MWA to HEDIS MY 2023 MWA.

Table 5-1—HEDIS MY 2023 MWA Performance Levels and Trend Results for Access to Care

	HEDIS MY 2023 MWA and Performance Level ¹	HEDIS MY 2022 MWA— HEDIS MY 2023 MWA Comparison ²	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2023	Number of MHPs With Statistically Significant Decline in HEDIS MY 2023
<i>Adults' Access to Preventive/Ambulatory Health Services (AAP)</i>				
<i>Ages 20 to 44 Years</i>	73.23%	+0.37 ⁺	4	0
<i>Ages 45 to 64 Years</i>	82.76%	+0.17	1	0
<i>Ages 65 Years and Older</i>	89.13%	-0.39	0	1
<i>Total</i>	76.80%	+0.37 ⁺	4	0

	HEDIS MY 2023 MWA and Performance Level ¹	HEDIS MY 2022 MWA– HEDIS MY 2023 MWA Comparison ²	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2023	Number of MHPs With Statistically Significant Decline in HEDIS MY 2023
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)				
<i>Ages 3 Months to 17 Years</i>	68.70%	+2.40 ⁺	4	1
<i>Ages 18 to 64 Years</i>	40.29%	-0.33	0	0
<i>Ages 65 Years and Older</i>	32.94%	+0.71	0	0
<i>Total</i>	55.59%	+1.19 ⁺	2	1
Appropriate Testing for Pharyngitis (CWP)				
<i>Ages 3 to 17 Years</i>	78.56%	+8.72 ⁺	9	0
<i>Ages 18 to 64 Years</i>	65.73%	+11.30 ⁺	9	0
<i>Ages 65 Years and Older</i>	27.94%	+5.43	0	0
<i>Total</i>	73.79%	+11.16 ⁺	9	0
Appropriate Treatment for Upper Respiratory Infection (URI)				
<i>Ages 3 Months to 17 Years</i>	90.69%	-1.79 ⁺⁺	0	7
<i>Ages 18 to 64 Years</i>	78.32%	-3.10 ⁺⁺	0	7
<i>Ages 65 Years and Older</i>	67.09%	-3.09	0	0
<i>Total</i>	86.78%	-2.21 ⁺⁺	0	8

¹ 2023 performance levels were based on comparisons of the HEDIS MY 2023 MWA rates to national Medicaid Quality Compass HEDIS MY 2022 MWA benchmarks. 2023 performance levels represent the following percentile comparisons:

<25th	≥25th and ≤49th	≥50th and ≤74th	≥75th and ≤89th	≥90th
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² HEDIS MY 2022 MWA to HEDIS MY 2023 MWA comparisons were based on a Chi-square test of statistical significance with a p-value <0.01 due to large denominators.

Green Shading⁺ Indicates that the HEDIS MY 2023 MWA demonstrated a significant improvement from the HEDIS MY 2022 MWA.

Red Shading⁺⁺ Indicates that the HEDIS MY 2023 MWA demonstrated a significant decline from the HEDIS MY 2022 MWA.

Table 5-1 shows that for the Access to Care domain, the *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years and Total*; *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years and Total*; and *Appropriate Testing for Pharyngitis—Ages 3 to 17 Years, Ages 18 to 64 Years, and Total* measure indicators demonstrated significant improvement from the HEDIS MY 2022 MWA. **MER**, **PRI**, and **UPP** ranked above the 50th percentile for the most measure indicators within the Access to Care domain. In addition, **UPP** ranked above the HPL for *Adults' Access to Preventive/Ambulatory Health Services—Ages 65 Years and Older*; and *Appropriate Testing for Pharyngitis—Ages 3–17 Years, Ages 18–64 Years, and Total* measure indicators. **PRI** ranked above the HPL for *Appropriate Testing for Pharyngitis—Ages 18–64 Years and Total* measure indicators.

The MWA demonstrated a significant decline for the *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years, Ages 18 to 64 Years, and Total* measure indicators, each with an MWA decrease of over 1 percentage point from HEDIS MY 2022. Additionally, the MWA ranked below the 25th percentile for the *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years and Total* measure indicators.

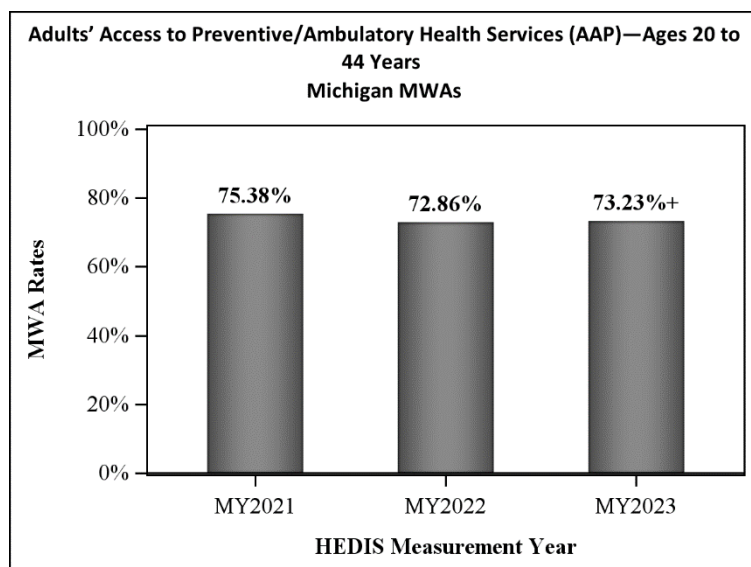
MDHHS should conduct ongoing monitoring of the MHPs' performance and declining rates for the *Appropriate Treatment for Upper Respiratory Infection* measure indicators in the Access to Care domain. MDHHS could consider conducting a causal factor analysis to identify potential reasons that contribute to declining rates and assist MHPs in developing targeted interventions. Underperforming MHPs should be given suggested interventions, based on MHP-specific capabilities, to improve rates. Too often antibiotics are prescribed inappropriately. Efforts to use antibiotics judiciously can result in fewer inappropriate antibiotics prescribed. Additionally, increased education and awareness of appropriate treatment for upper respiratory infections can reduce the danger of antibiotic-resistant bacteria.²¹

²¹ National Committee for Quality Assurance. *Appropriate Treatment for Upper Respiratory Infection*. Available at: <https://www.ncqa.org/hedis/measures/appropriate-treatment-for-upper-respiratory-infection/>. Accessed on: Sept 17, 2024.

Measure-Specific Findings

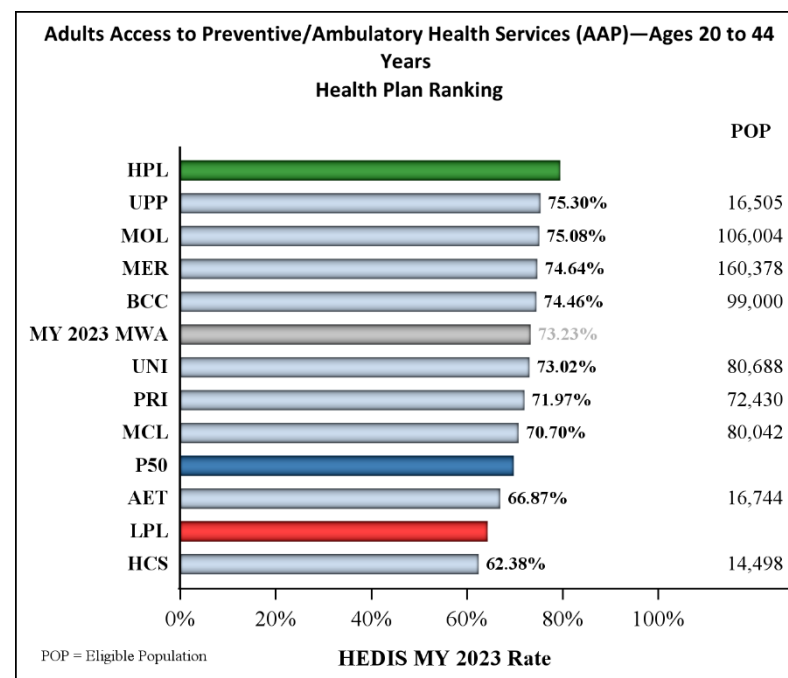
Adults' Access to Preventive/Ambulatory Health Services (AAP)—Ages 20 to 44 Years

Adults' Access to Preventive/Ambulatory Health Services (AAP)—Ages 20 to 44 Years assesses the percentage of members 20 to 44 years of age who had an ambulatory or preventive care visit during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

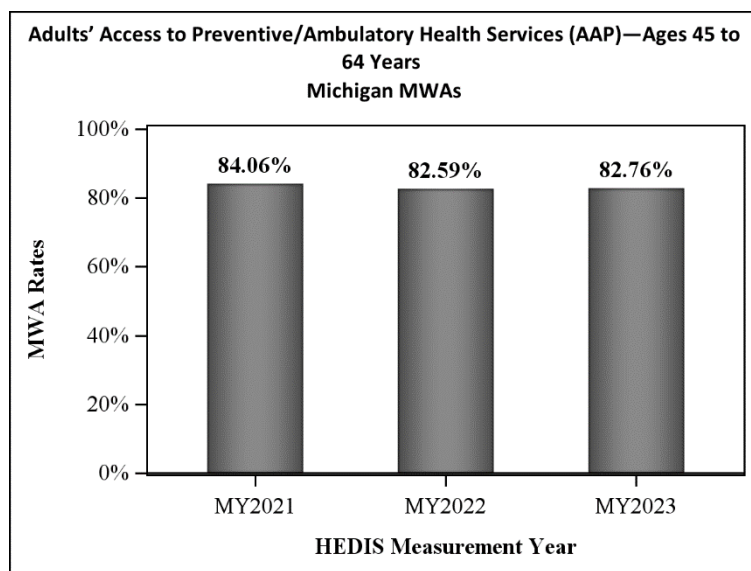
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



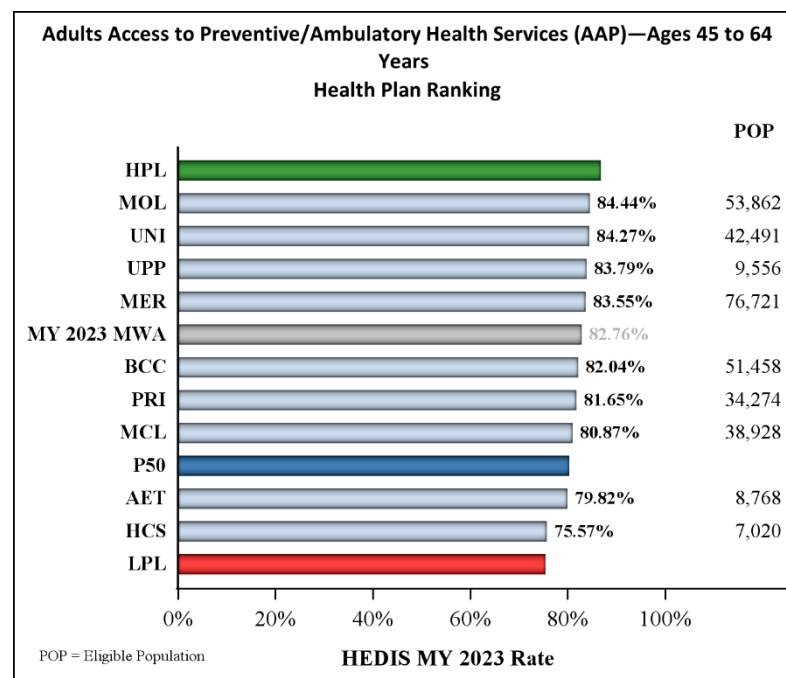
Seven MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 12 percentage points.

Adults' Access to Preventive/Ambulatory Health Services (AAP)—Ages 45 to 64 Years

Adults' Access to Preventive/Ambulatory Health Services (AAP)—Ages 45 to 64 Years assesses the percentage of members 45 to 64 years of age who had an ambulatory or preventive care visit during the MY.



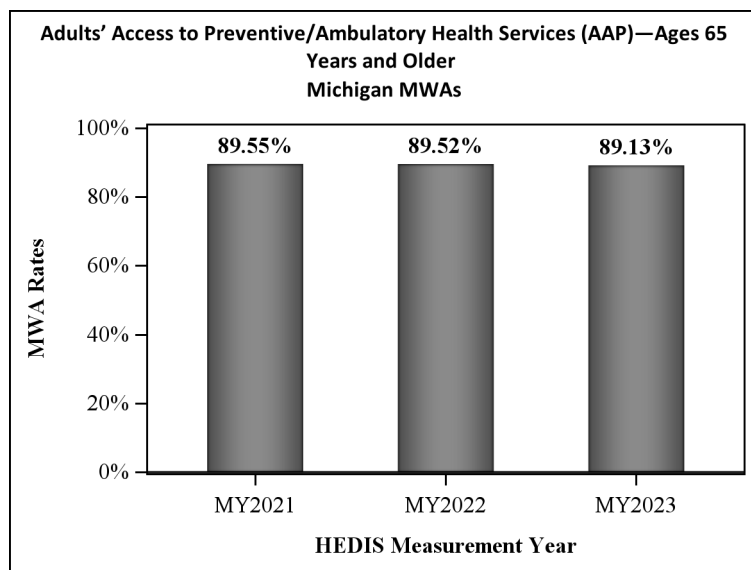
The HEDIS MY 2023 MWA rate did not demonstrate a significant change from HEDIS MY 2022.



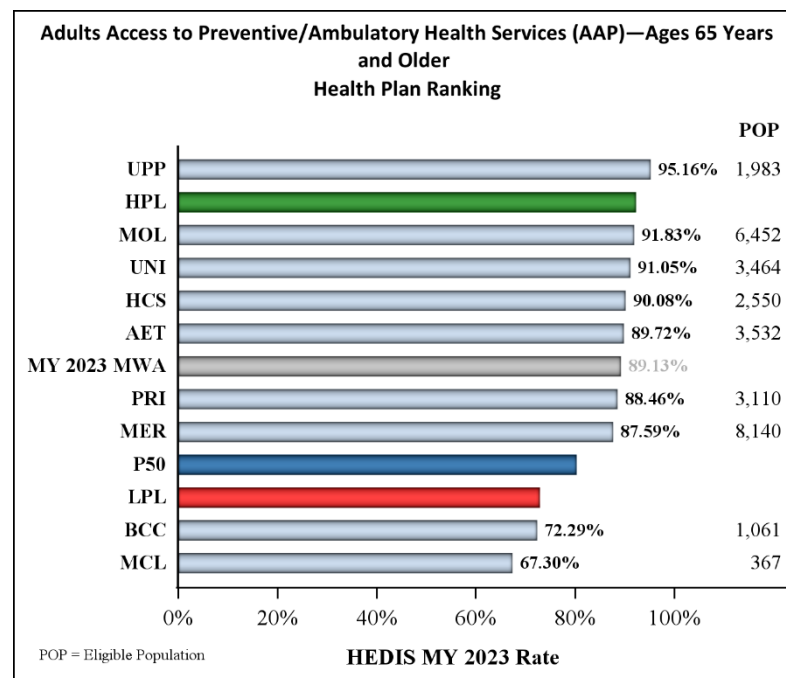
Seven MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Two MHPs ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 8 percentage points.

Adults' Access to Preventive/Ambulatory Health Services (AAP)—Ages 65 Years and Older

Adults' Access to Preventive/Ambulatory Health Services (AAP)—Ages 65 Years and Older assesses the percentage of members 65 years of age and older who had an ambulatory or preventive care visit during the MY.



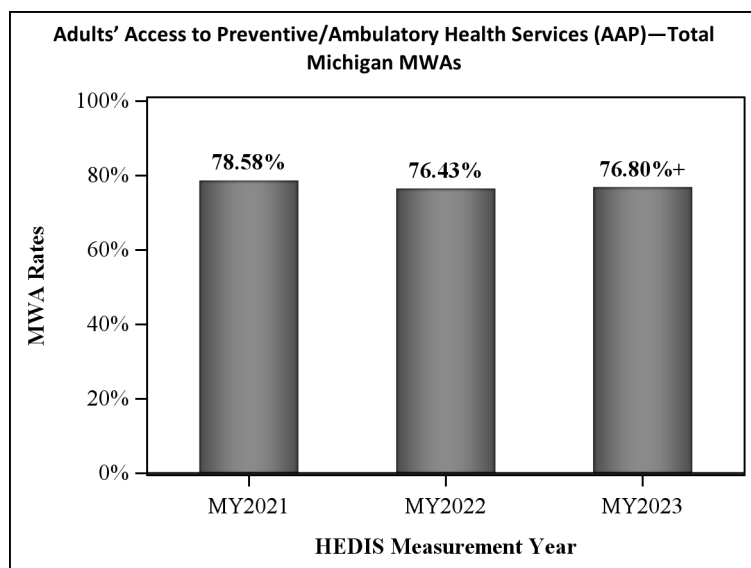
The HEDIS MY 2023 MWA rate did not demonstrate a significant change from HEDIS MY 2022.



One MHP ranked above the HPL. Six MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Two MHPs fell below the LPL. MHP performance varied by over 27 percentage points.

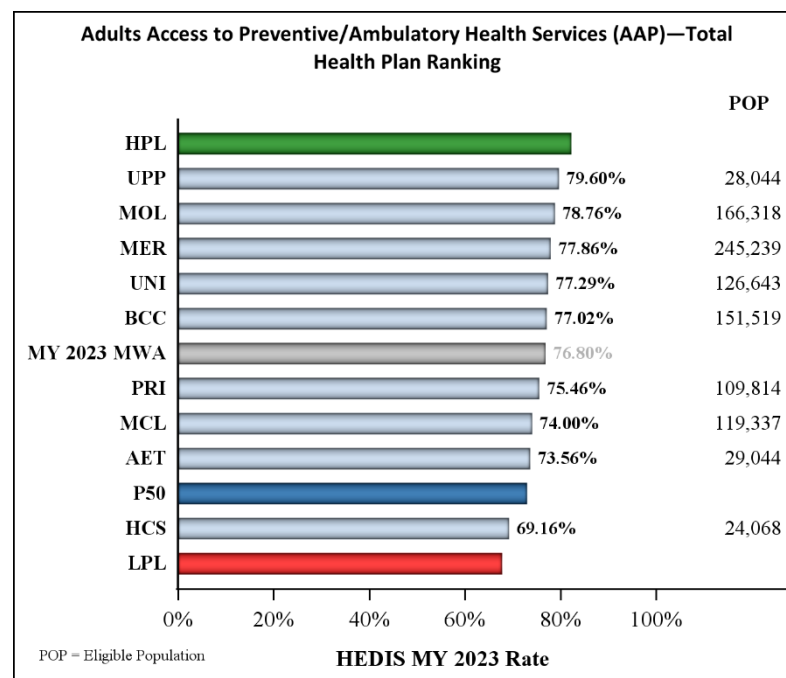
Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total

Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total assesses the percentage of members 20 years of age and older who had an ambulatory or preventive care visit during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

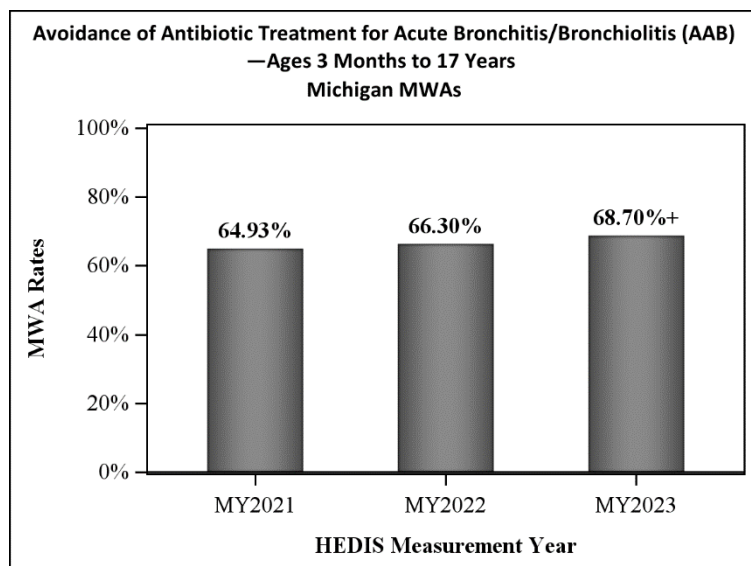
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



Eight MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 10 percentage points.

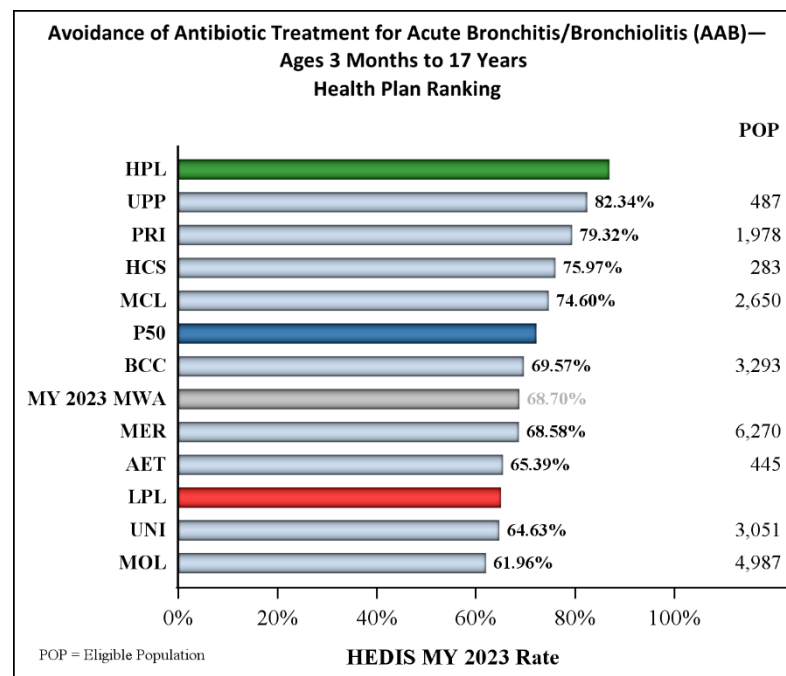
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)—Ages 3 Months to 17 Years

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)—Ages 3 Months to 17 Years assesses the percentage of members 3 months to 17 years of age with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

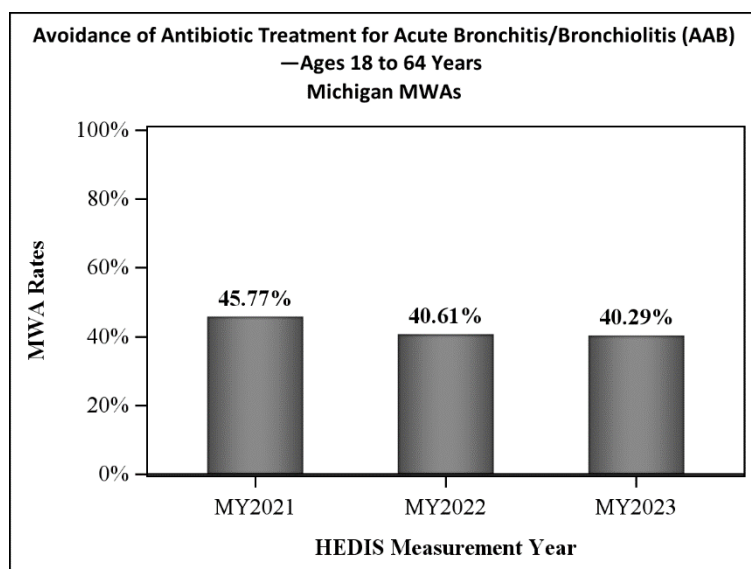
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



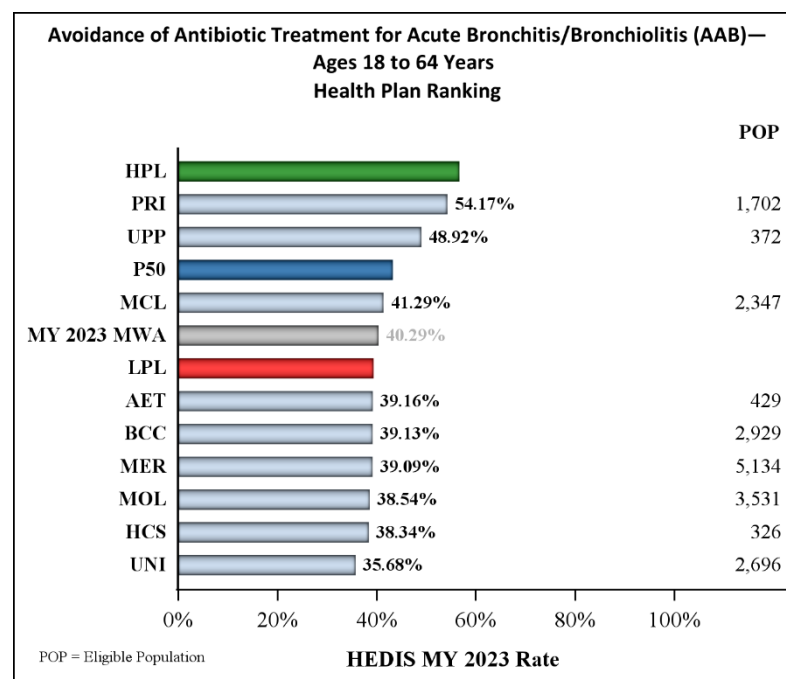
Four MHPs ranked above the 50th percentile but fell below the HPL. Three MHPs and the MWA ranked above the LPL but fell below the 50th percentile. Two MHPs fell below the LPL. MHP performance varied by over 20 percentage points.

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)—Ages 18 to 64 Years

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)—Ages 18 to 64 Years assesses the percentage of members 18 to 64 years of age with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.



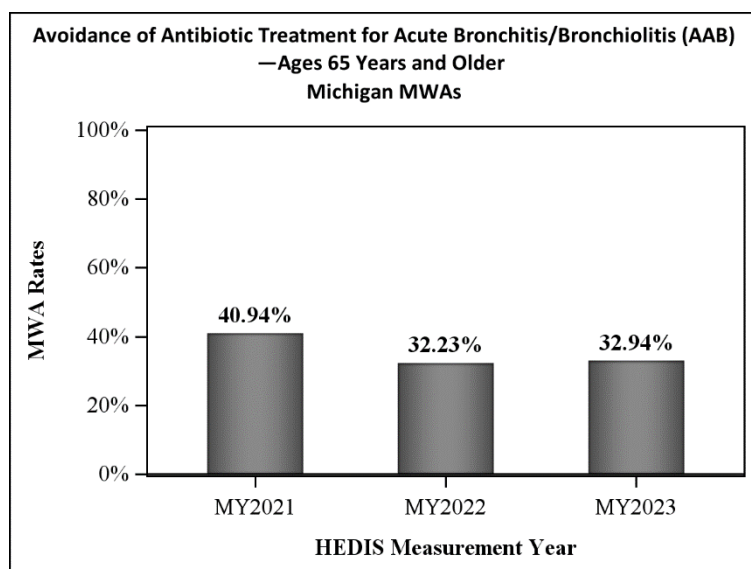
The HEDIS MY 2023 MWA rate did not demonstrate a significant change from HEDIS MY 2022.



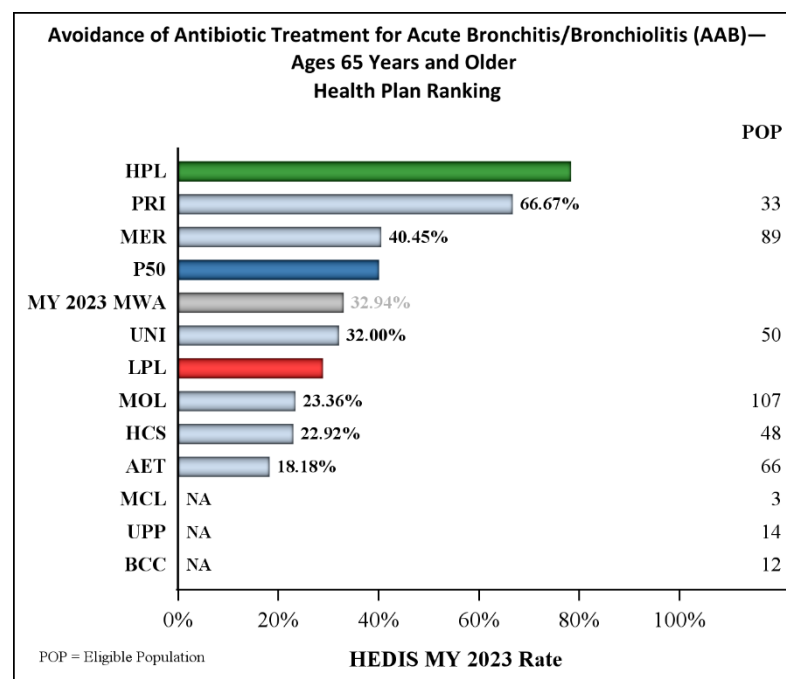
Two MHPs ranked above the 50th percentile but fell below the HPL. One MHP and the MWA ranked above the LPL but fell below the 50th percentile. Six MHPs fell below the LPL. MHP performance varied by over 18 percentage points.

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)—Ages 65 Years and Older

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)—Ages 65 Years and Older assesses the percentage of members 65 years of age and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.



The HEDIS MY 2023 MWA rate did not demonstrate a significant change from HEDIS MY 2022.

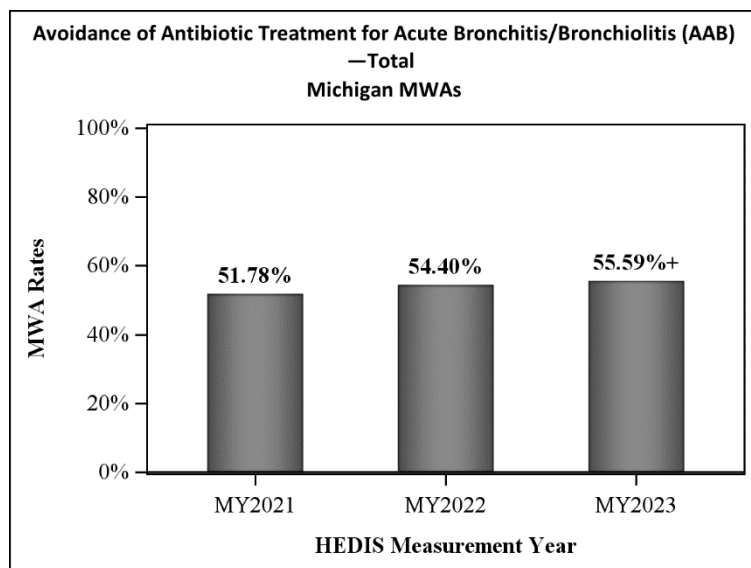


NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Two MHPs ranked above the 50th percentile but fell below the HPL. One MHP and the MWA ranked above the LPL but fell below the 50th percentile. Three MHPs fell below the LPL. MHP performance varied by over 48 percentage points.

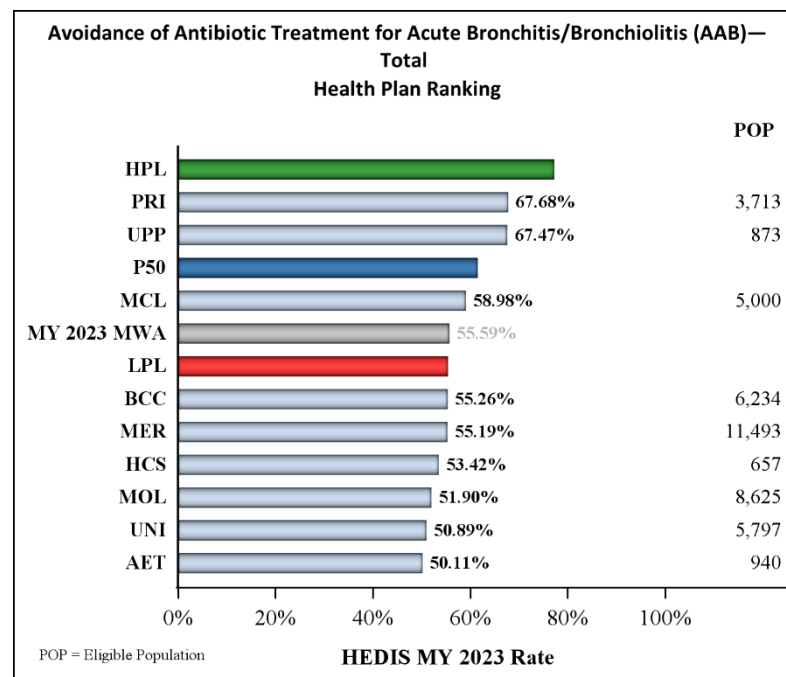
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)—Total

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)—Total assesses the percentage of members 3 months of age or older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

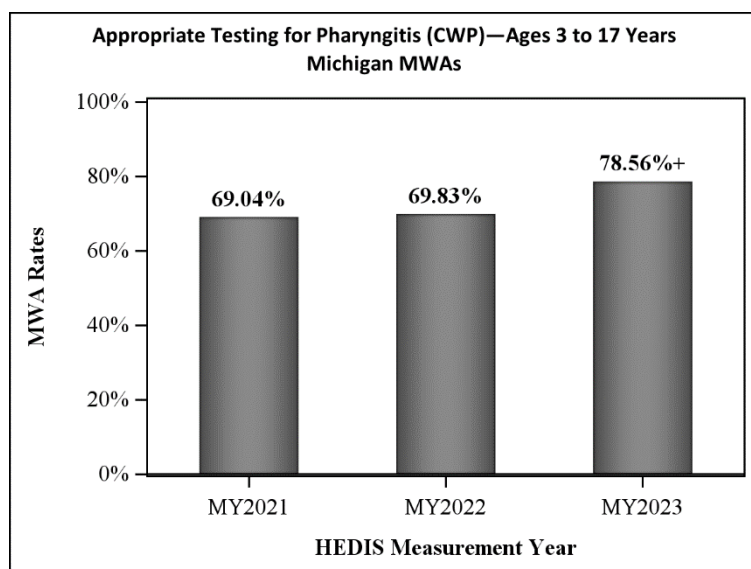
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



Two MHPs ranked above the 50th percentile but fell below the HPL. One MHP and the MWA ranked above the LPL but fell below the 50th percentile. Six MHPs fell below the LPL. MHP performance varied by over 17 percentage points.

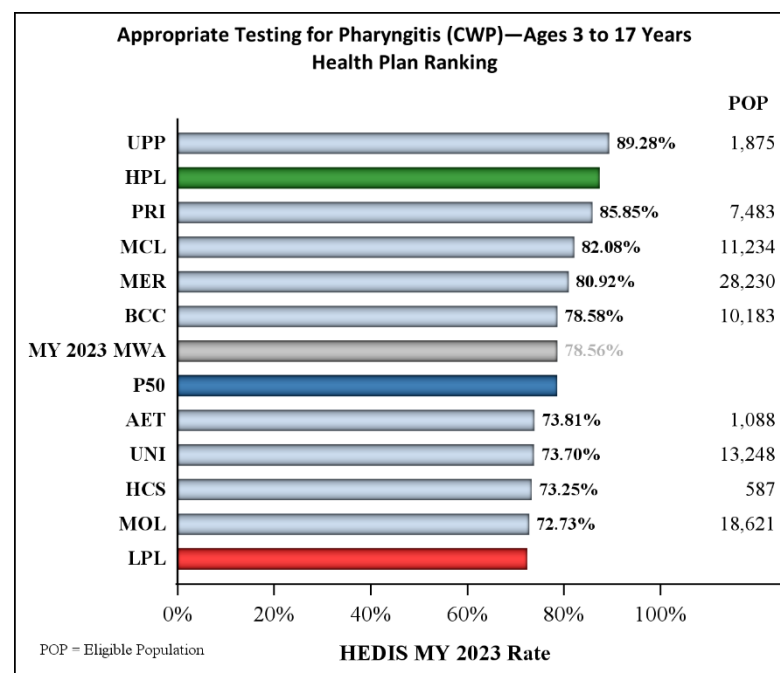
Appropriate Testing for Pharyngitis (CWP)—Ages 3 to 17 Years

Appropriate Testing for Pharyngitis (CWP)—Ages 3 to 17 Years assesses the percentage of episodes for members 3 to 17 years where the member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

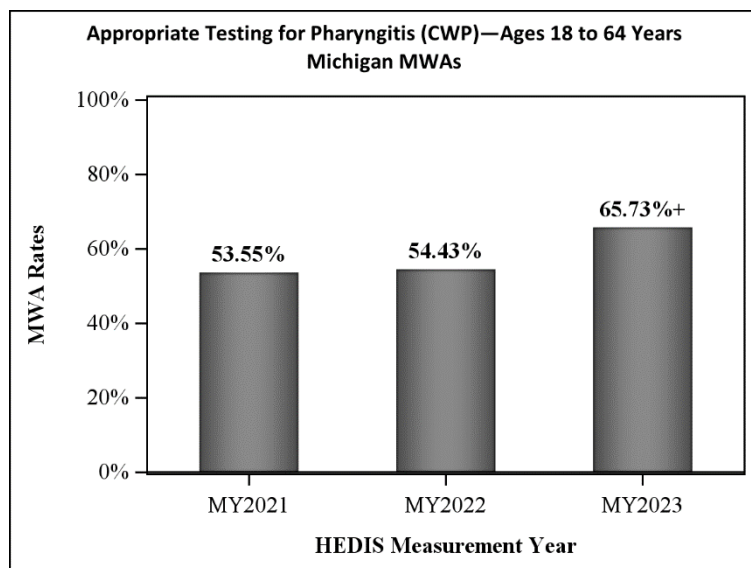
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



One MHP ranked above the HPL. Four MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Four MHPs ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 16 percentage points.

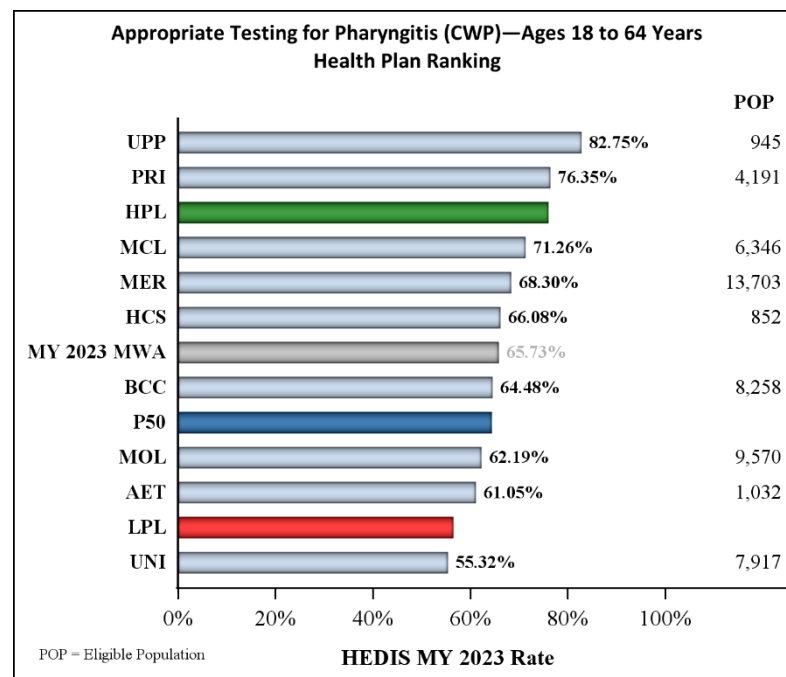
Appropriate Testing for Pharyngitis (CWP)—Ages 18 to 64 Years

Appropriate Testing for Pharyngitis (CWP)—Ages 18 to 64 Years assesses the percentage of episodes for members 18 to 64 years of age who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A strep test for the episode.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

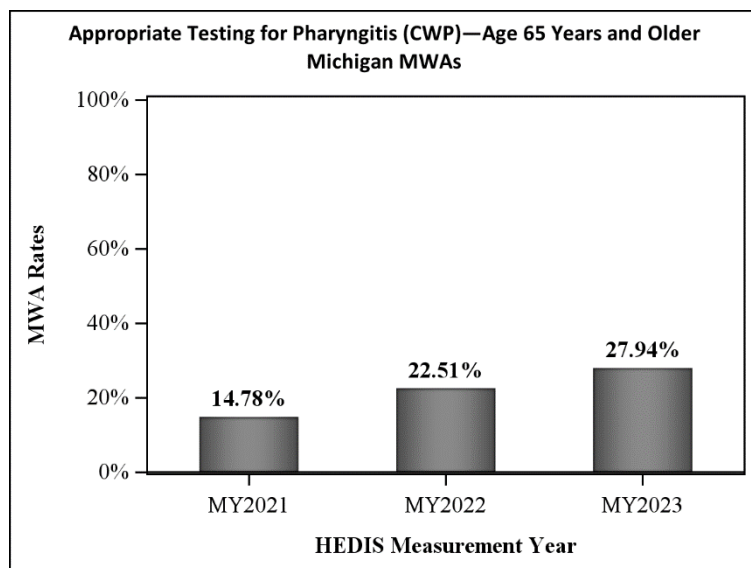
The HEDIS MY 2023 MWA significantly improved from HEDIS MY 2022.



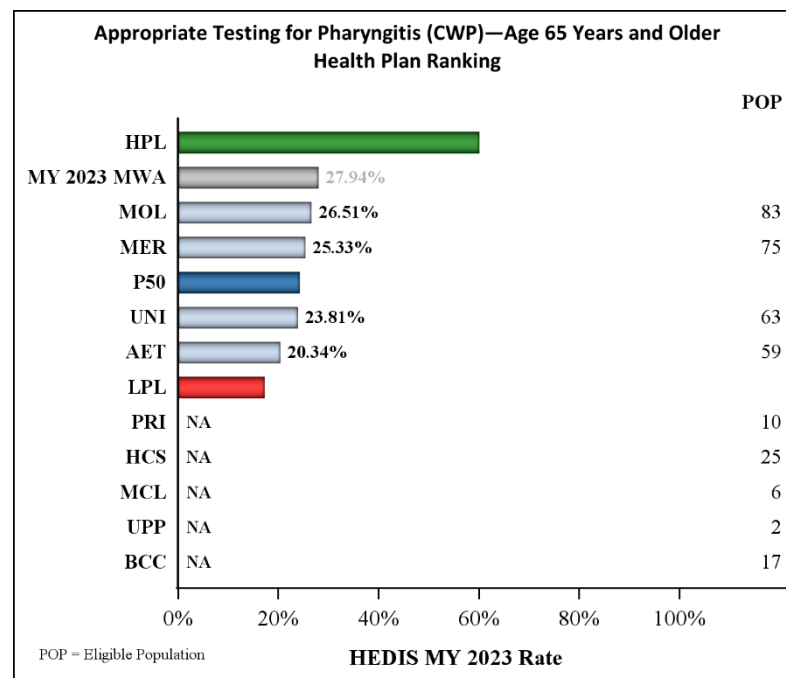
Two MHPs ranked above the HPL. Four MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Two MHPs ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 27 percentage points.

Appropriate Testing for Pharyngitis (CWP)—Ages 65 Years and Older

Appropriate Testing for Pharyngitis (CWP)—Ages 65 Years and Older assesses the percentage of episodes for members 65 years of age and older who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A strep test for the episode.



The HEDIS MY 2023 MWA rate did not demonstrate a significant change from HEDIS MY 2022.

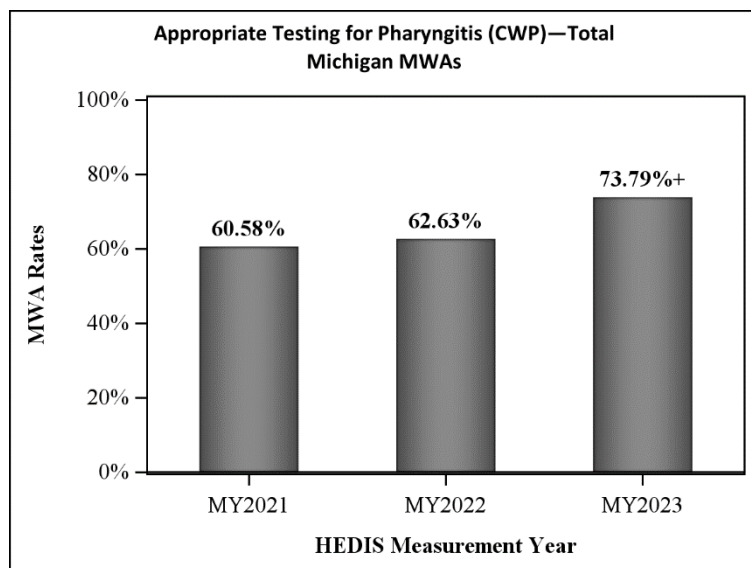


NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Two MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Two MHPs ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 6 percentage points.

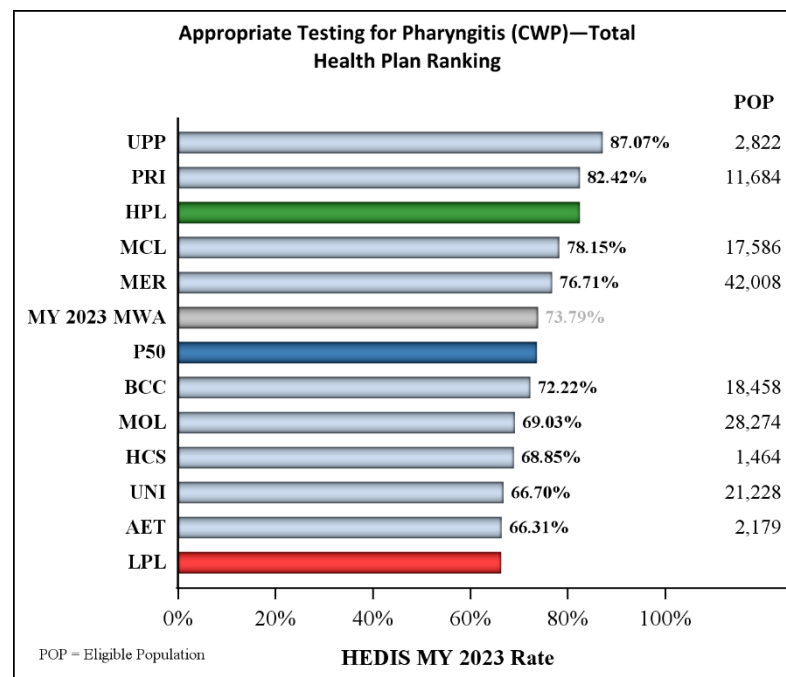
Appropriate Testing for Pharyngitis (CWP)—Total

Appropriate Testing for Pharyngitis (CWP)—Total assesses the percentage of episodes for members 3 years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A strep test for the episode.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

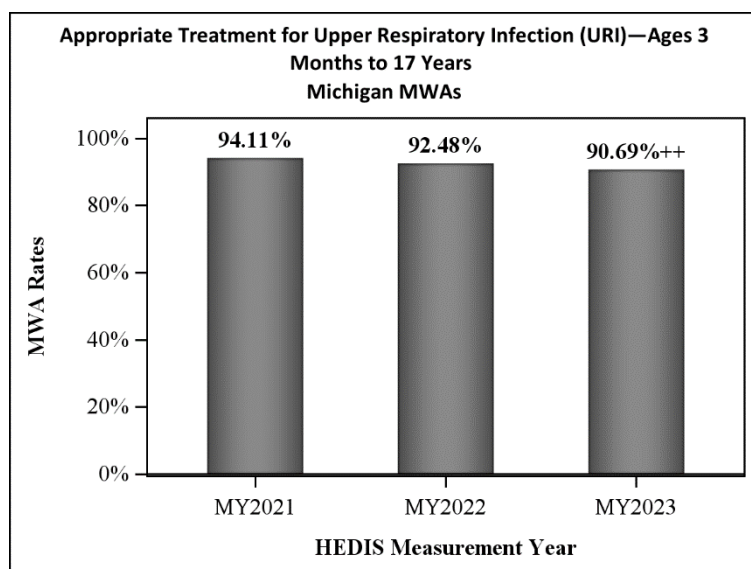
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



Two MHPs ranked above the HPL. Two MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Five MHPs ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 20 percentage points.

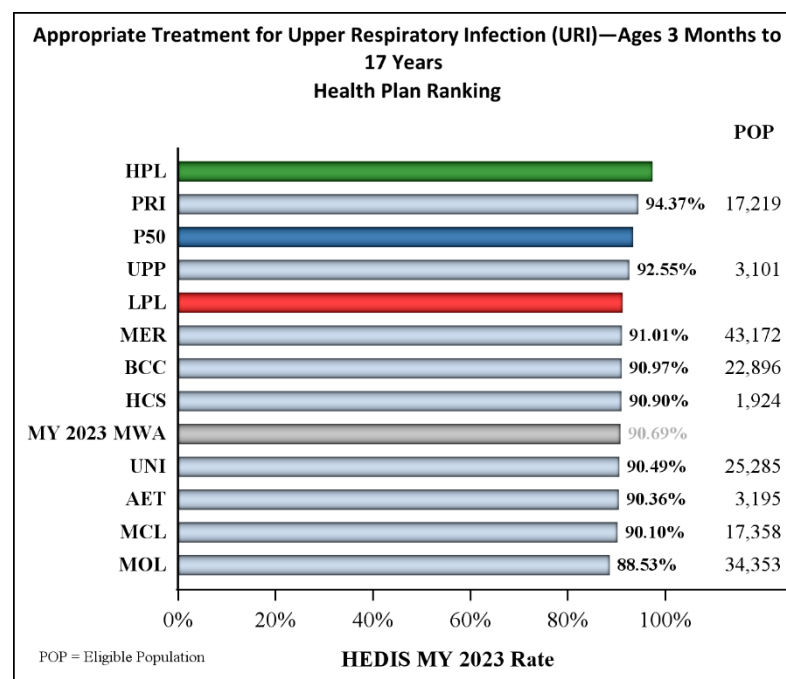
Appropriate Treatment for Upper Respiratory Infection (URI)—Ages 3 Months to 17 Years

Appropriate Treatment for Upper Respiratory Infection (URI)—Ages 3 Months to 17 Years assesses the percentage of members 3 months to 17 years of age with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

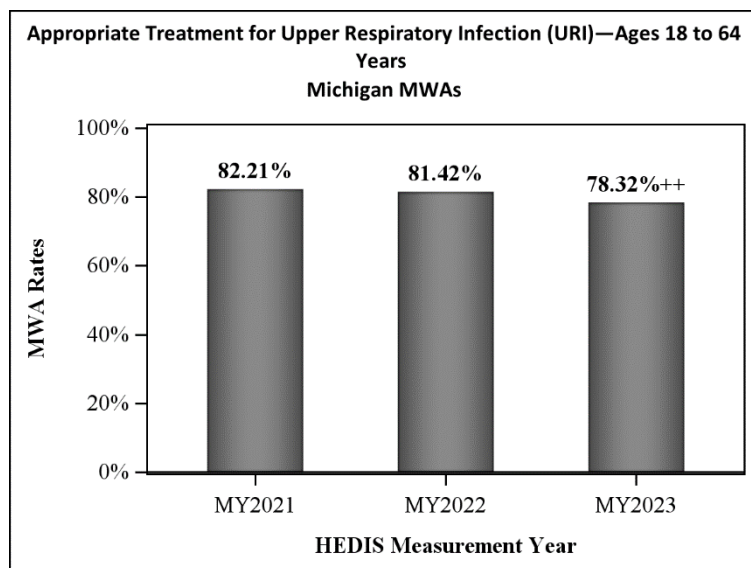
The HEDIS MY 2023 MWA rate significantly declined from HEDIS MY 2022.



One MHP ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. Seven MHPs and the MWA fell below the LPL. MHP performance varied by over 5 percentage points.

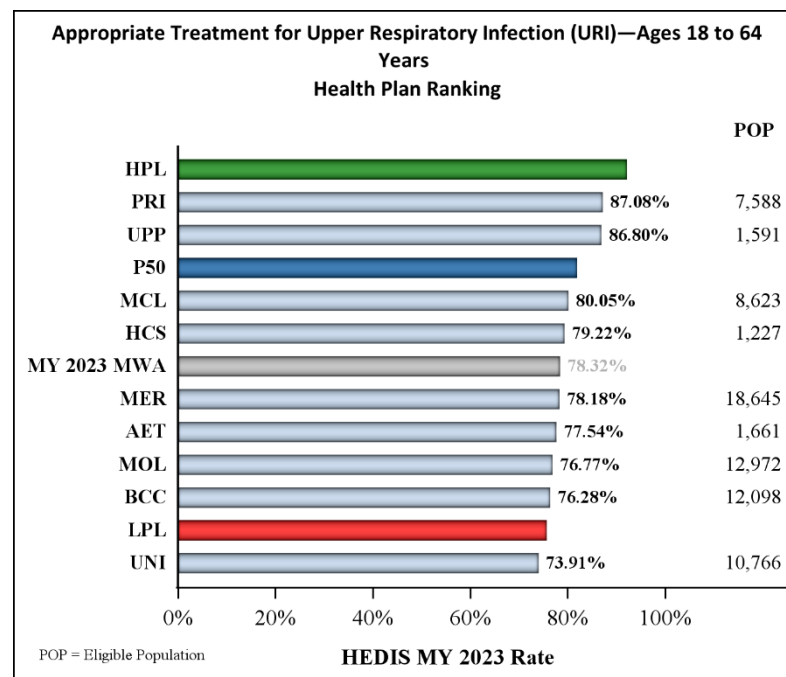
Appropriate Treatment for Upper Respiratory Infection (URI)—Ages 18 to 64 Years

Appropriate Treatment for Upper Respiratory Infection (URI)—Ages 18 to 64 Years assesses the percentage of members 18 to 64 years of age with a diagnosis of URI that did not result in an antibiotic dispensing event.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

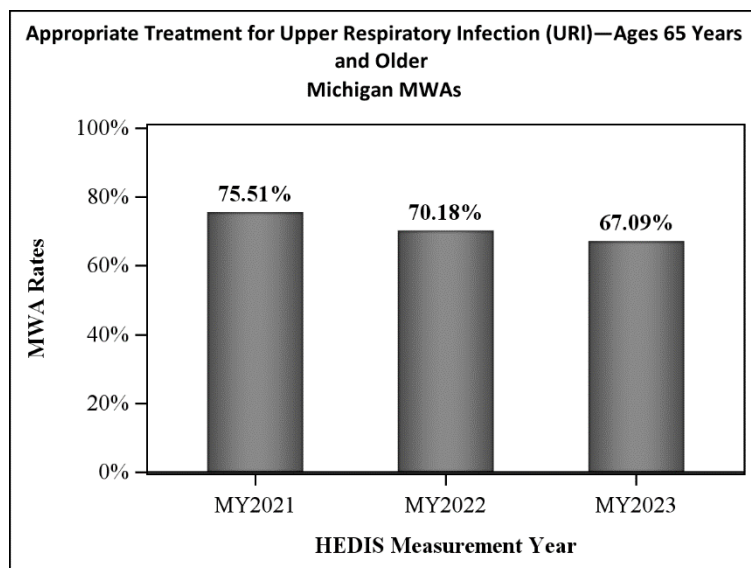
The HEDIS MY 2023 MWA rate significantly declined from HEDIS MY 2022.



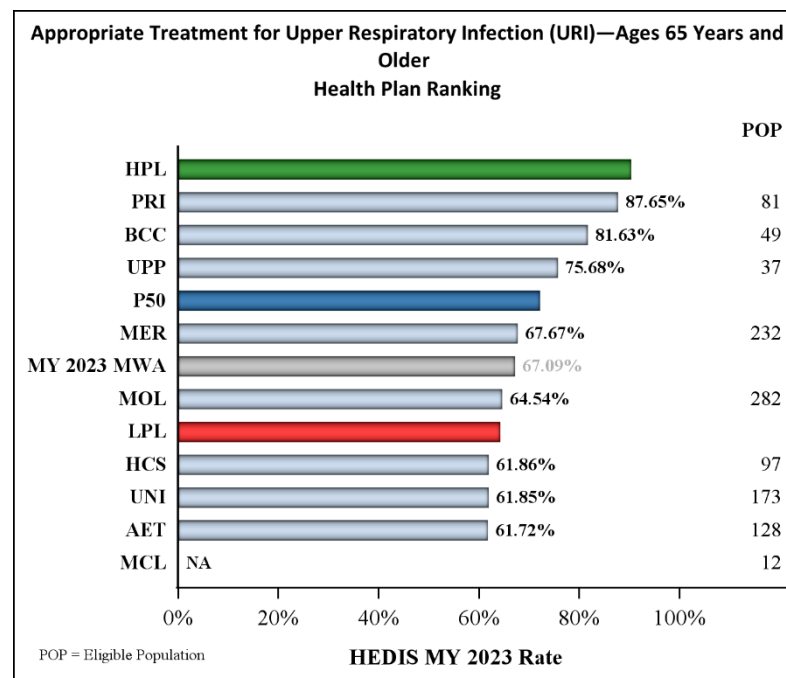
Two MHPs ranked above the 50th percentile but fell below the HPL. Six MHPs and the MWA ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 13 percentage points.

Appropriate Treatment for Upper Respiratory Infection (URI)—Ages 65 Years and Older

Appropriate Treatment for Upper Respiratory Infection (URI)—Ages 65 Years and Older assesses the percentage of members 65 years of age and older with a diagnosis of URI that did not result in an antibiotic dispensing event.



The HEDIS MY 2023 MWA rate did not demonstrate a significant change from HEDIS MY 2022.

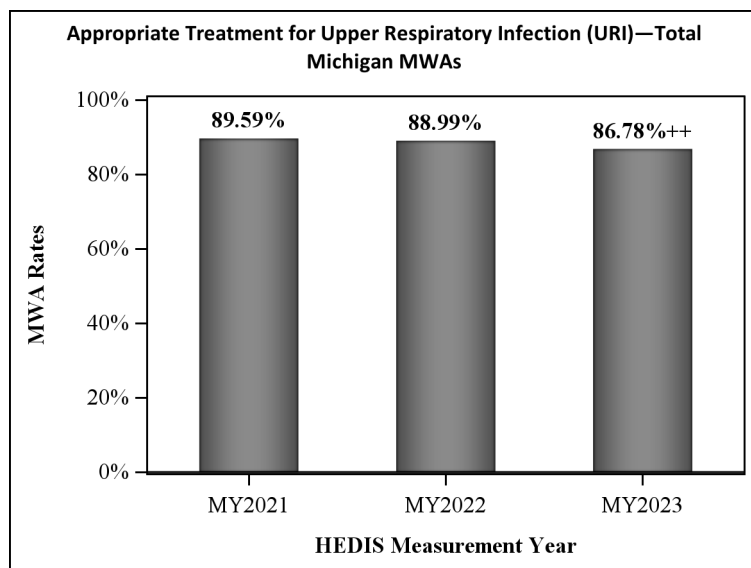


NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Three MHPs ranked above the 50th percentile but fell below the HPL. Two MHPs and the MWA ranked above the LPL but fell below the 50th percentile. Three MHPs fell below the LPL. MHP performance varied by over 25 percentage points.

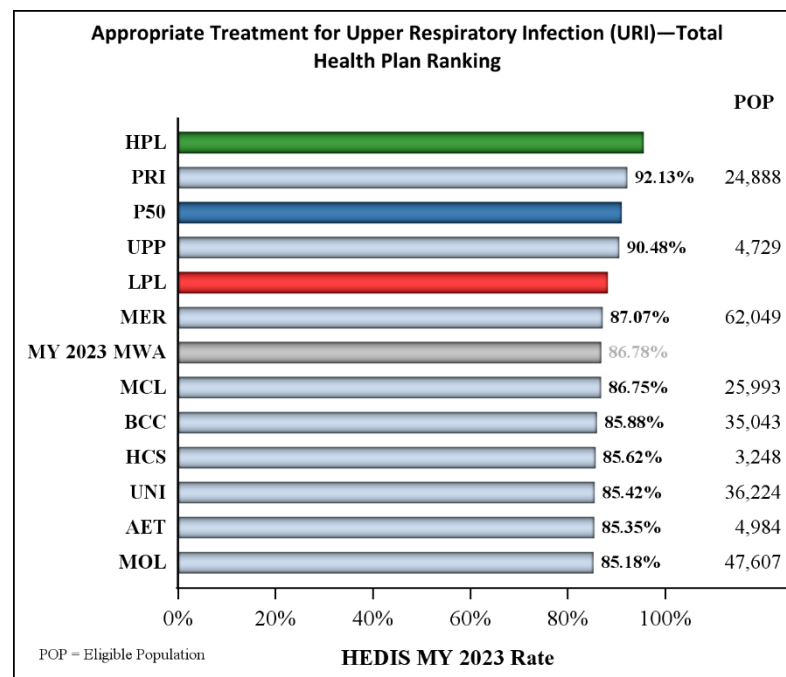
Appropriate Treatment for Upper Respiratory Infection (URI)—Total

Appropriate Treatment for Upper Respiratory Infection (URI)—Total assesses the percentage of episodes for members 3 months of age and older with a diagnosis of URI that did not result in an antibiotic dispensing event.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The HEDIS MY 2023 MWA rate significantly declined from HEDIS MY 2022.



One MHP ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. Seven MHPs and the MWA fell below the LPL. MHP performance varied by over 6 percentage points.

6. Obesity

Introduction

The Obesity domain encompasses the following HEDIS measures:

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile—Total, Counseling for Nutrition—Total, and Counseling for Physical Activity—Total*

Please see the “How to Get the Most From This Report” section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendices A, B, and C.

Summary of Findings

Table 6-1 presents the Michigan MWA performance for the measure indicators under the Obesity domain. The table lists the HEDIS MY 2023 MWA rates and performance levels, a comparison of the HEDIS MY 2022 MWA to the HEDIS MY 2023 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating significant changes from HEDIS MY 2022 MWA to HEDIS MY 2023 MWA.

Table 6-1—HEDIS MY 2023 MWA Performance Levels and Trend Results for Obesity

	HEDIS MY 2023 MWA and Performance Level ¹	HEDIS MY 2022 MWA— HEDIS MY 2023 MWA Comparison ²	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2023	Number of MHPs With Statistically Significant Decline in HEDIS MY 2023
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)</i>				
<i>Body Mass Index (BMI) Percentile—Total</i>	84.96%	+4.42 ⁺	2	0
<i>Counseling for Nutrition—Total</i>	74.37%	+3.49 ⁺	1	0
<i>Counseling for Physical Activity—Total</i>	72.90%	+3.49 ⁺	2	0

¹ HEDIS MY 2023 performance levels were based on comparisons of the HEDIS MY 2023 MWA rates to national Medicaid Quality Compass HEDIS MY 2022 MWA benchmarks. HEDIS MY 2023 performance levels represent the following percentile comparisons:

<25 th	≥25 th and ≤49 th	≥50 th and ≤74 th	≥75 th and ≤89 th	≥90 th
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² HEDIS MY 2022 MWA to HEDIS MY 2023 MWA comparisons were based on a Chi-square test of statistical significance with a p-value <0.01 due to large denominators.

Green Shading⁺ Indicates that the HEDIS MY 2023 MWA demonstrated a significant improvement from the HEDIS MY 2022 MWA.

Red Shading⁺⁺ Indicates that the HEDIS MY 2023 MWA demonstrated a significant decline from the HEDIS MY 2022 MWA.

Table 6-1 shows that for the Obesity domain, all *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators were an area of strength. All measure indicators ranked at or above the 50th percentile and demonstrated significant improvement from the HEDIS MY 2022 MWA. **PRI**, **UNI**, and **UPP** ranked above the HPL for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* measure indicator. **HCS** ranked above the HPL for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* measure indicator.

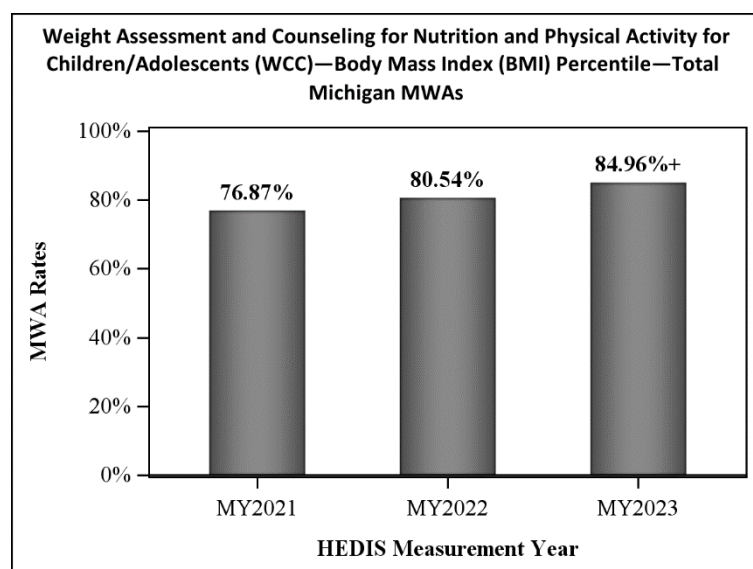
While none of the measure indicators in the Obesity domain demonstrated a significant decline in the MWA from HEDIS MY 2022 or ranked below the 50th percentile, MDHHS should continue to monitor the MHPs' performance for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators to ensure continued improvement. MHPs and providers should continue to strategize the best way to utilize every office visit or virtual visit to encourage a healthy lifestyle and provide education on healthy habits for children and adolescents. Additionally, MDHHS should continue to monitor **MCL**'s performance for this measure to ensure the MHP's performance does not continue to decline and encourage higher-performing MHPs to share and discuss best practices. Healthy lifestyle habits, including healthy eating and physical activity, can lower the risk of becoming obese and developing related diseases. Obesity can become a lifelong health issue; therefore, it is important to monitor weight problems in children and adolescents and provide guidance for maintaining a healthy weight and lifestyle.²²

²² National Committee for Quality Assurance. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents. Available at: <https://www.ncqa.org/hedis/measures/weight-assessment-and-counseling-for-nutrition-and-physical-activity-for-children-adolescents/>. Accessed on: Sept 17, 2024.

Measure-Specific Findings

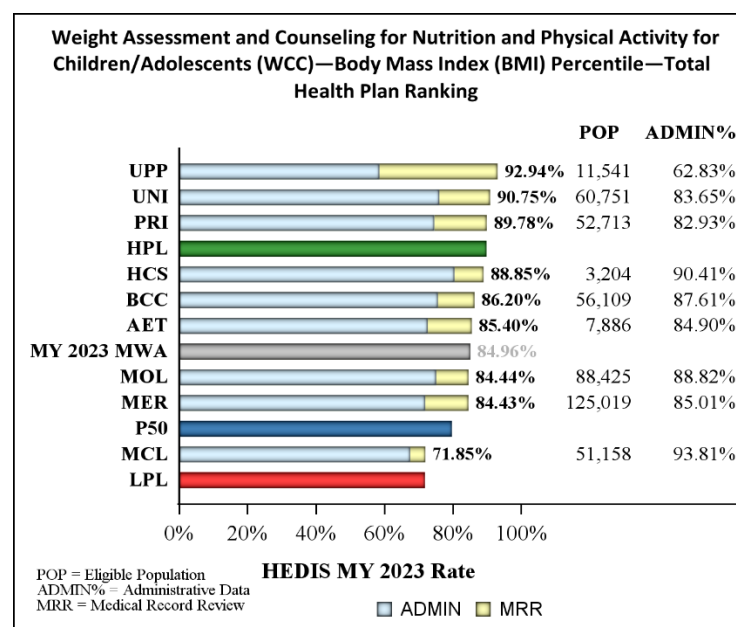
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile Documentation—Total

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile Documentation—Total assesses the percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and had evidence of BMI percentile documentation during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

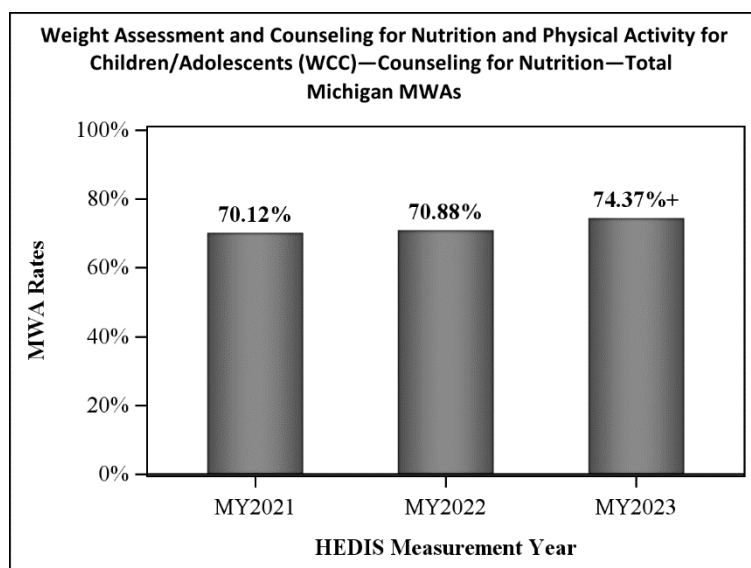
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



Three MHPs ranked above the HPL. Five MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 21 percentage points.

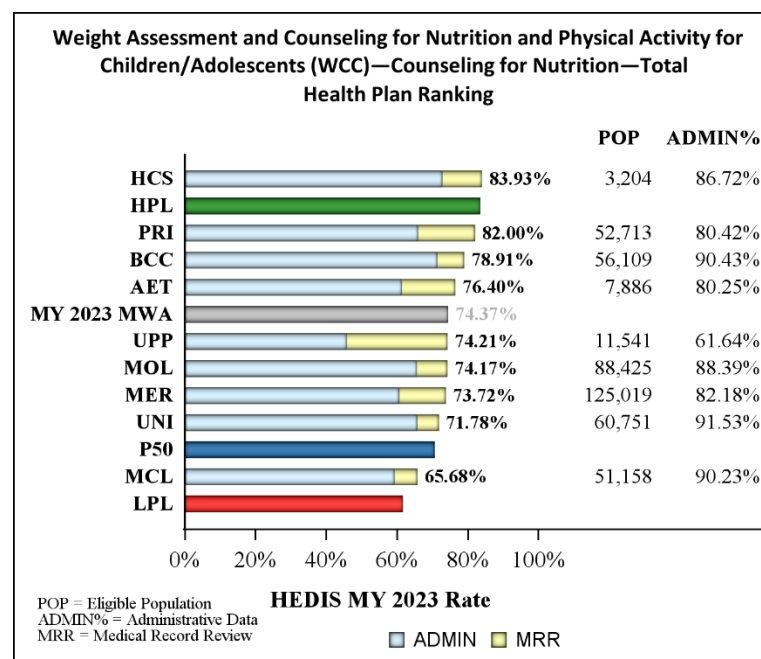
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)— Counseling for Nutrition—Total

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Nutrition—Total assesses the percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and had evidence of counseling for nutrition during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

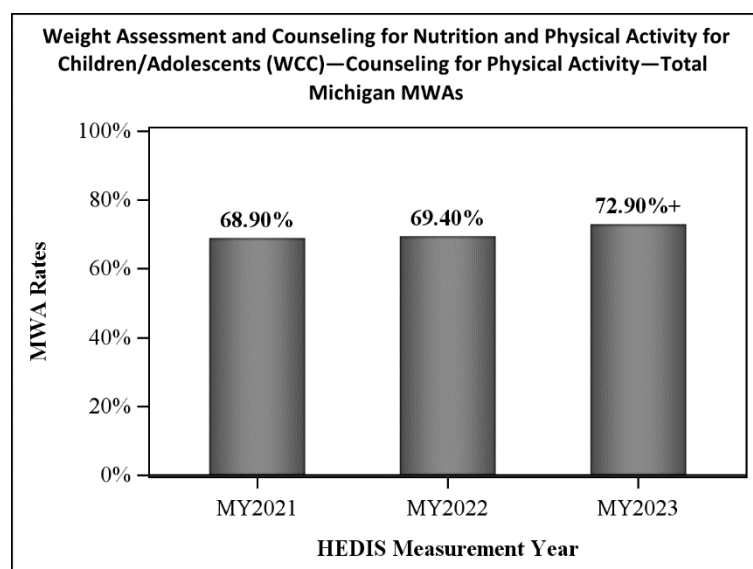
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



One MHP ranked above the HPL. Seven MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 18 percentage points.

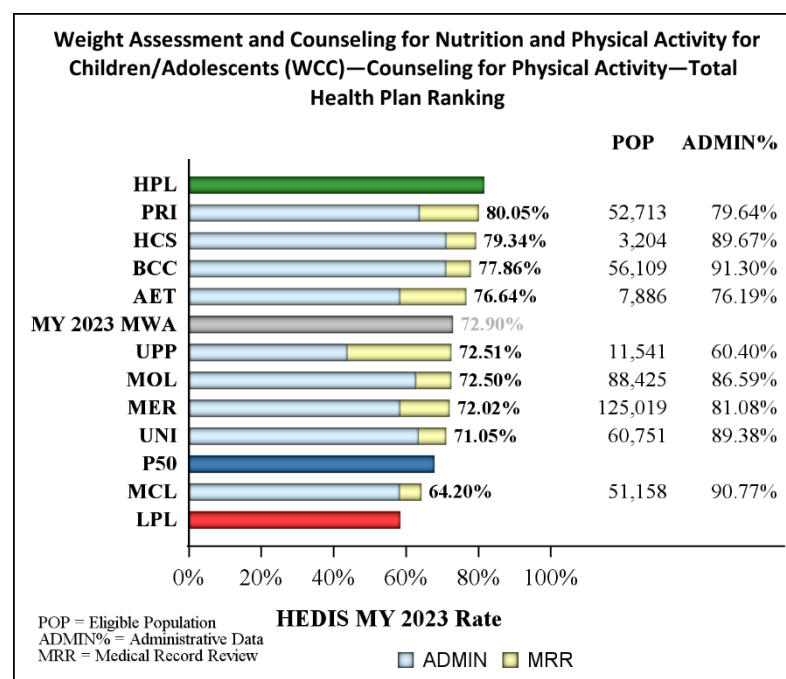
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)— Counseling for Physical Activity—Total

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Physical Activity—Total assesses the percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and had evidence of counseling for physical activity during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



Eight MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 15 percentage points.

7. Pregnancy Care

Introduction

The Pregnancy Care domain encompasses the following HEDIS measure:

- Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care and Postpartum Care*

Please see the “How to Get the Most From This Report” section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendices A, B, and C.

Summary of Findings

Table 7-1 presents the Michigan MWA performance for the measure indicators under the Pregnancy Care domain.

Table 7-1—HEDIS MY 2023 MWA Performance Levels and Trend Results for Pregnancy Care

	HEDIS MY 2023 MWA and Performance Level ¹	HEDIS MY 2022 MWA— HEDIS MY 2023 MWA Comparison ²	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2023	Number of MHPs With Statistically Significant Decline in HEDIS MY 2023
<i>Prenatal and Postpartum Care (PPC)</i>³				
<i>Timeliness of Prenatal Care</i>	83.81%	+5.36 ⁺	4	0
<i>Postpartum Care</i>	76.15%	+0.82 ⁺	0	0

¹ HEDIS MY 2023 performance levels were based on comparisons of the HEDIS MY 2023 MWA rates to national Medicaid Quality Compass HEDIS MY 2022 MWA benchmarks. HEDIS MY 2023 performance levels represent the following percentile comparisons:

<25th	≥25th and ≤49th	≥50th and ≤74th	≥75th and ≤89th	≥90th
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² HEDIS MY 2022 MWA to HEDIS MY 2023 MWA comparisons were based on a Chi-square test of statistical significance with a p-value <0.01 due to large denominators.

Green Shading⁺ Indicates that the HEDIS MY 2023 MWA demonstrated a significant improvement from the HEDIS MY 2022 MWA.

Red Shading⁺⁺ Indicates that the HEDIS MY 2023 MWA demonstrated a significant decline from the HEDIS MY 2022 MWA.

³ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

Table 7-1 shows that for the Pregnancy Care domain, *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* were an area of strength, as the measure indicators demonstrated significant improvement from the HEDIS MY 2022 MWA. Additionally, **BCC** and **UPP** ranked above the 50th percentile for both of the measure indicators within the Pregnancy Care domain, with **UPP** ranking above the HPL for both *Timeliness of Prenatal Care* and *Postpartum Care* measure indicators.

AET, **HCS**, and **MCL** all fell below the LPL for *Prenatal and Postpartum Care—Timeliness of Prenatal Care*; and **AET**, **HCS**, **MOL**, and **UNI** all fell below the LPL for *Prenatal and Postpartum Care—Postpartum Care*.

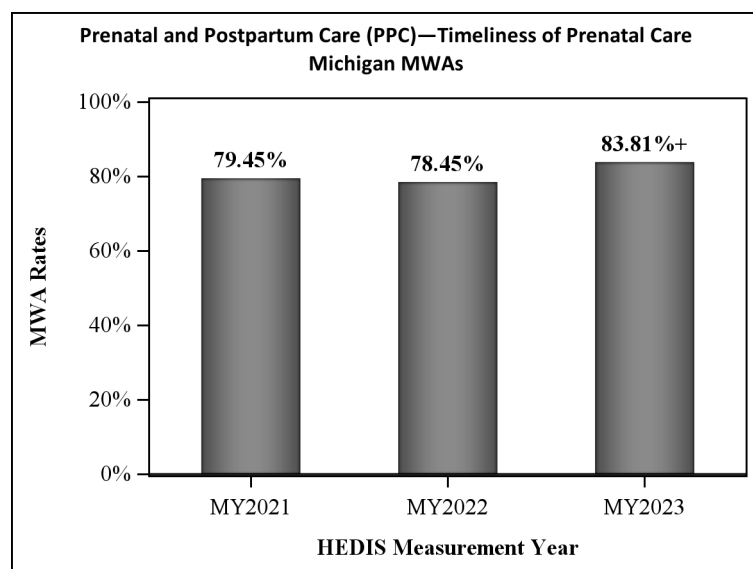
Timely and adequate prenatal and postpartum care can set the stage for long-term health and well-being of new mothers and their infants.²³ MDHHS should continue monitoring the MHPs' performance in the Pregnancy Care domain and assess the need for or evaluation of current prenatal and postpartum care coordination programs for lower-performing MHPs. Effective care coordination efforts or programs could potentially assist with scheduling prenatal and postpartum appointments, arranging transportation, and educating members on the importance of keeping appointments. MDHHS is also encouraged to work with the higher-performing MHPs to identify best practices for ensuring women's access to prenatal and postpartum care which can then be shared with the lower-performing MHPs to improve overall access.

²³ National Committee for Quality Assurance. Prenatal and Postpartum Care. Available at: <https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/>. Accessed on: Sept 17, 2024.

Measure-Specific Findings

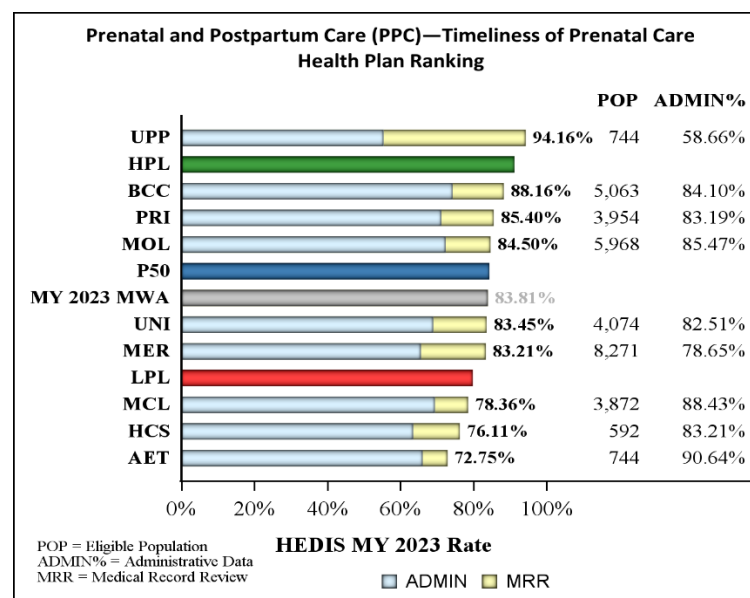
Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care

Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care assesses the percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the MHP. *Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.*



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

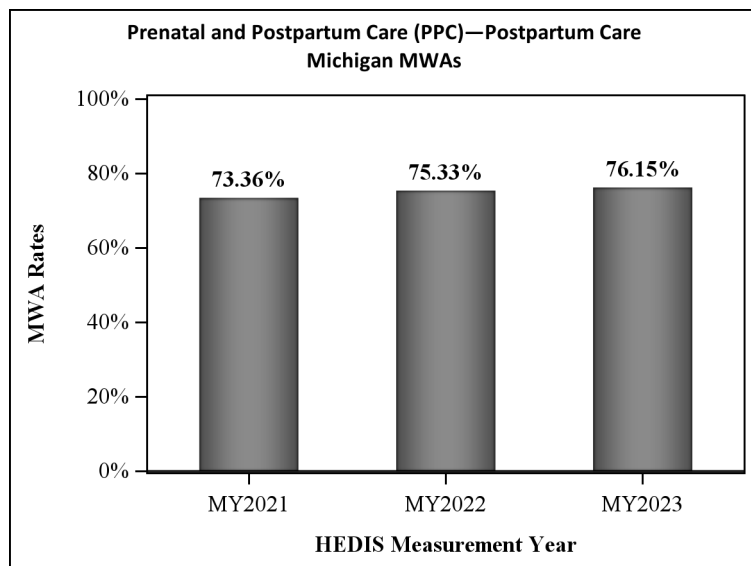
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



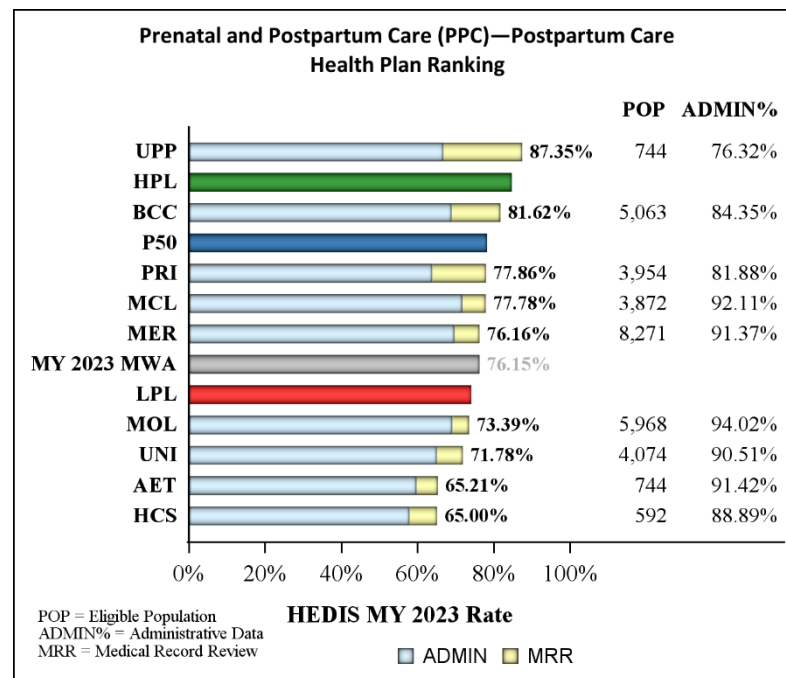
One MHP ranked above the HPL. Three MHPs ranked above the 50th percentile but fell below the HPL. Two MHPs and the MWA ranked above the LPL but fell below the 50th percentile. Three MHPs fell below the LPL. MHP performance varied by over 21 percentage points.

Prenatal and Postpartum Care (PPC)—Postpartum Care

Prenatal and Postpartum Care (PPC)—Postpartum Care assesses the percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery. Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.



The HEDIS MY 2023 MWA rate did not demonstrate a significant change from HEDIS MY 2022.



One MHP ranked above the HPL. One MHP ranked above the 50th percentile but fell below the HPL. Three MHPs and the MWA ranked above the LPL but fell below the 50th percentile. Four MHPs fell below the LPL. MHP performance varied by over 22 percentage points.

8. Living With Illness

Introduction

The Living With Illness domain encompasses the following HEDIS measures:

- *Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Control (<8.0%) and HbA1c Poor Control (>9.0%)*
- *Blood Pressure Control for Patients With Diabetes (BPD)*
- *Eye Exam for Patients with Diabetes (EED)*
- *Kidney Health Evaluation for Patients With Diabetes (KED)—Ages 18 to 64 Years, Ages 65 to 74 Years, Ages 75 to 85 Years, and Total*
- *Asthma Medication Ratio (AMR)—Total*
- *Controlling High Blood Pressure (CBP)*
- *Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)—Persistence of Beta-Blocker Treatment After a Heart Attack*
- *Cardiac Rehabilitation (CRE)—Initiation—Ages 18 to 64 Years, Initiation—Ages 65 Years and Older, Initiation—Total, Engagement 1—Ages 18 to 64 Years, Engagement 1—Ages 65 Years and Older, Engagement 1—Total, Engagement 2—Ages 18 to 64 Years, Engagement 2—Ages 65 Years and Older, Engagement 2—Total, Achievement—Ages 18 to 64 Years, Achievement—Ages 65 Years and Older, and Achievement—Total*
- *Antidepressant Medication Management (AMM)—Effective Acute Phase Treatment and Effective Continuation Phase Treatment*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*
- *Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)*
- *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)*
- *Diagnosed Mental Health Disorders (DMH)—Ages 1 to 17 Years, Ages 18 to 64 Years, Ages 65 Years and Older, and Total*

Please see the “How to Get the Most From This Report” section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendices A, B, and C.

Summary of Findings

Table 8-1 presents the Michigan MWA performance for the measure indicators under the Living With Illness domain. The table lists the HEDIS MY 2023 MWA rates and performance levels, a comparison of the HEDIS MY 2022 MWA to the HEDIS MY 2023 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating significant changes from HEDIS MY 2022 MWA to HEDIS MY 2023 MWA.

Table 8-1—HEDIS MY 2023 MWA Performance Levels and Trend Results for Living With Illness

	HEDIS MY 2023 MWA and Performance Level ¹	HEDIS MY 2022 MWA— HEDIS MY 2023 MWA Comparison ²	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2023	Number of MHPs With Statistically Significant Decline in HEDIS MY 2023
Hemoglobin A1c Control for Patients With Diabetes (HBD)				
<i>HbA1c Control (<8.0%)</i>	59.05%	+5.52 ⁺	2	0
<i>HbA1c Poor Control (>9.0%)*</i>	33.05%	-5.96 ⁺	3	0
Blood Pressure Control for Patients With Diabetes (BPD)				
<i>Blood Pressure Control for Patients With Diabetes</i>	70.49%	+3.57 ⁺	2	0
Eye Exam for Patients With Diabetes (EED)³				
<i>Eye Exam for Patients With Diabetes</i>	57.29%	+2.48 ⁺	1	0
Kidney Health Evaluation for Patients With Diabetes (KED)				
<i>Ages 18 to 64 Years</i>	38.15%	+3.06 ⁺	6	0
<i>Ages 65 to 74 Years</i>	39.64%	+3.11 ⁺	4	0
<i>Ages 75 to 85 Years</i>	38.57%	+4.13 ⁺	1	0
<i>Total</i>	38.24%	+3.08 ⁺	6	0
Asthma Medication Ratio (AMR)				
<i>Total</i>	57.78%	+0.05	2	1
Controlling High Blood Pressure (CBP)				
<i>Controlling High Blood Pressure</i>	63.71%	+1.63 ⁺	0	0
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)				
<i>Persistence of Beta-Blocker Treatment After a Heart Attack</i>	64.65%	-22.29 ⁺⁺	0	6
Cardiac Rehabilitation (CRE)				
<i>Initiation—Ages 18 to 64 Years</i>	4.52%	-0.95 ⁺⁺	1	1

	HEDIS MY 2023 MWA and Performance Level ¹	HEDIS MY 2022 MWA– HEDIS MY 2023 MWA Comparison ²	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2023	Number of MHPs With Statistically Significant Decline in HEDIS MY 2023
<i>Initiation—Ages 65 Years and Older</i>	6.55%	+3.25	0	0
<i>Initiation—Total</i>	4.62%	-0.76	1	1
<i>Engagement 1—Ages 18 to 64 Years</i>	5.73%	-1.81 ⁺⁺	0	1
<i>Engagement 1—Ages 65 Years and Older</i>	10.92%	-2.82	0	1
<i>Engagement 1—Total</i>	5.99%	-1.81 ⁺⁺	0	2
<i>Engagement 2—Ages 18 to 64 Years</i>	4.23%	-2.09 ⁺⁺	0	2
<i>Engagement 2—Ages 65 Years and Older</i>	10.48%	-3.26	0	1
<i>Engagement 2—Total</i>	4.54%	-2.09 ⁺⁺	1	2
<i>Achievement—Ages 18 to 64 Years</i>	1.77%	-1.75 ⁺⁺	0	2
<i>Achievement—Ages 65 Years and Older</i>	5.68%	-4.21	0	1
<i>Achievement—Total</i>	1.96%	-1.82 ⁺⁺	1	3
Antidepressant Medication Management (AMM)³				
<i>Effective Acute Phase Treatment</i>	72.46%	+2.43 ⁺	4	1
<i>Effective Continuation Phase Treatment</i>	56.84%	+0.28	2	2
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)				
<i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</i>	82.82%	+1.37 ⁺	3	0
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)				
<i>Diabetes Monitoring for People With Diabetes and Schizophrenia</i>	70.50%	+3.66 ⁺	2	1
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)				
<i>Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia</i>	74.72%	+4.41	0	0
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)				
<i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia</i>	65.81%	+1.47 ⁺	1	0
Diagnosed Mental Health Disorders (DMH)				
<i>Ages 1 to 17 Years</i>	23.87%	+2.70 ⁺	7	0
<i>Ages 18 to 64 Years</i>	35.37%	+2.53 ⁺	7	0

	HEDIS MY 2023 MWA and Performance Level ¹	HEDIS MY 2022 MWA– HEDIS MY 2023 MWA Comparison ²	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2023	Number of MHPs With Statistically Significant Decline in HEDIS MY 2023
<i>Ages 65 Years and Older</i>	36.93%	-0.40	0	0
<i>Total</i>	30.95%	+2.39 ⁺	7	0

¹ HEDIS MY 2023 performance levels were based on comparisons of the HEDIS MY 2022 MWA rates to national Medicaid Quality Compass HEDIS MY 2022 MWA benchmarks. HEDIS MY 2023 performance levels represent the following percentile comparisons:

<25th	≥25th and ≤49th	≥50th and ≤74th	≥75th and ≤89th	≥90th
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² HEDIS MY 2022 MWA to HEDIS MY 2023 MWA comparisons were based on a Chi-square test of statistical significance with a p-value <0.01 due to large denominators.

Green Shading⁺ Indicates that the HEDIS MY 2023 MWA demonstrated a significant improvement from the HEDIS MY 2022 MWA.

Red Shading⁺ Indicates that the HEDIS MY 2023 MWA demonstrated a significant decline from the HEDIS MY 2022 MWA.

³ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

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

Table 8-1 shows that for the Living With Illness domain, the following measure indicators were areas of significant strength:

- *Hemoglobin A1c Control for Patients With Diabetes—Poor HbA1c Control (>9.0%) and HbA1c Control (<8.0%)*
- *Blood Pressure Control for Patients With Diabetes*
- *Eye Exam for Patients With Diabetes*
- *Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years, Ages 65 to 74 Years, Ages 75 to 85 Years, and Total*
- *Controlling High Blood Pressure*
- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Diabetes Monitoring for People With Diabetes and Schizophrenia*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
- *Diagnosed Mental Health Disorders—Ages 1 to 17 Years, Ages 18 to 64 Years, Ages 65 Years and Older, and Total.*

All of these measure indicators ranked at or above the 50th percentile, with both of the *Hemoglobin A1c Control for Patients With Diabetes* measure indicators; *Blood Pressure Control for Patients With Diabetes*, *Antidepressant Medication Management—Effective Acute Phase Treatment*; and *Diabetes*

Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications ranking at or above the 75th percentile. All of these measure indicators also demonstrated significant improvement from the HEDIS MY 2022 MWA. **BCC**, **MER**, **PRI**, **UNI**, and **UPP** ranked above the 50th percentile for the most measure indicators within the Living With Illness domain. **UPP** ranked above the HPL for the most measure indicators within the Living With Illness domain.

While the HEDIS MY 2023 MWA demonstrated considerable improvement from HEDIS MY 2022 across the Living With Illness domain, the *Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator rate had a significant decrease of over 22 percentage points in comparison to the MWA for HEDIS MY 2022 and ranked below the 25th percentile, demonstrating an area for improvement. Multiple MHPs ranked below the LPL for this measure.

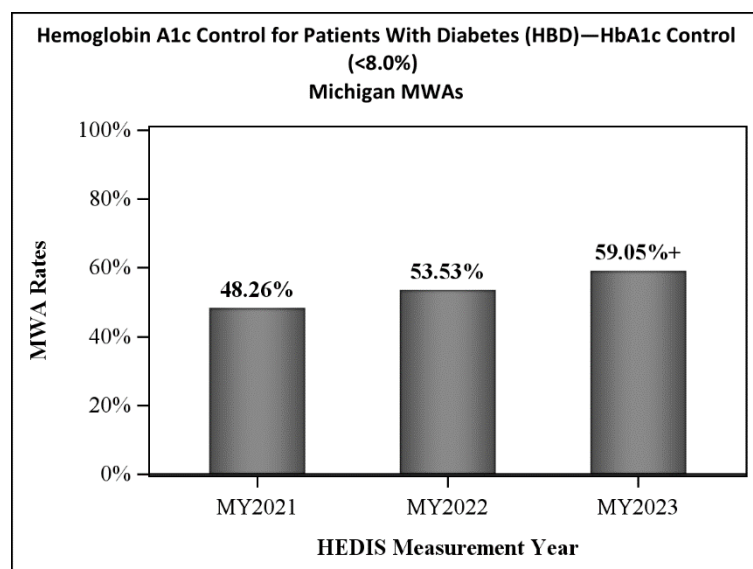
MDHHS is encouraged to conduct a root cause analysis to identify the causal factors that resulted in a rapid and significant decline of the *Persistence of Beta-Blocker Treatment After a Heart Attack* measure performance across multiple MHPs. The prevalent MHP underperformance may indicate a need for further education and awareness of measure requirements, measure specifications for meeting criteria, and knowledge of intervention types most impactful and efficacious in meeting measure standards. Medical guidelines support taking a beta-blocker after a heart attack to prevent another heart attack from occurring.²⁴ Additionally, MDHHS should continue to work with the MHPs to readily identify interventions and operational process changes that led to improved rates ranking at or above the 50th percentile within the Living With Illness domain, while supporting and strengthening methods that resulted in improved year-over-year performance.

²⁴ National Committee for Quality Assurance. Persistence of Beta-Blocker Treatment After a Heart Attack. Available at: <https://www.ncqa.org/hedis/measures/persistence-of-beta-blocker-treatment-after-a-heart-attack/>. Accessed on: Sept 17, 2024.

Measure-Specific Findings

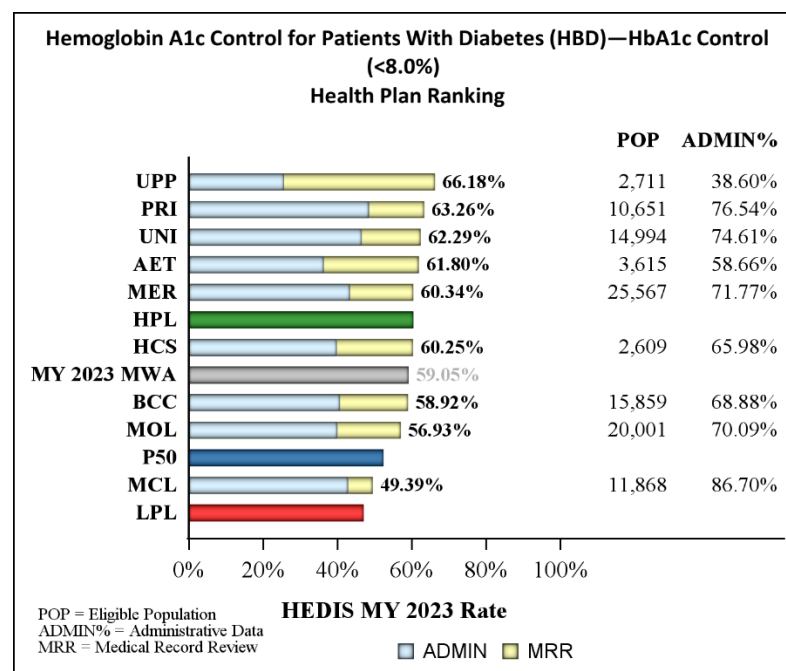
Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Control (<8.0%)

Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Control (<8.0%) assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) whose most recently documented HbA1c level was less than 8.0 percent.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

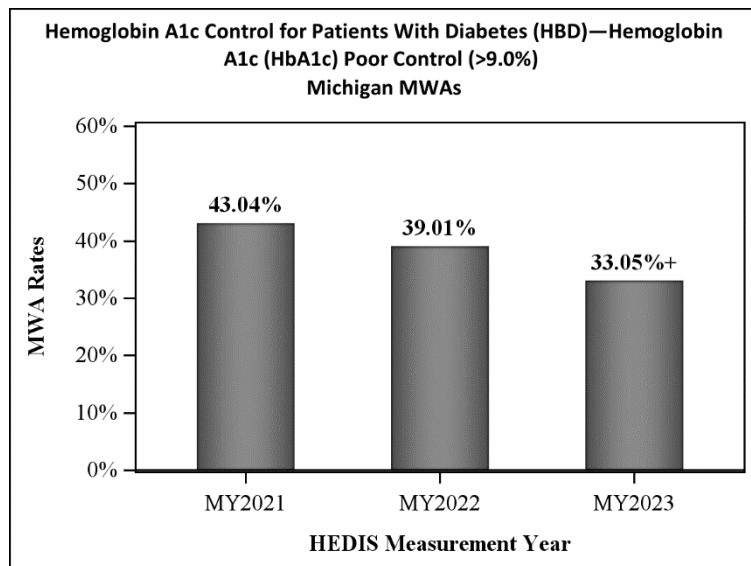
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



Five MHPs ranked above the HPL. Three MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 16 percentage points.

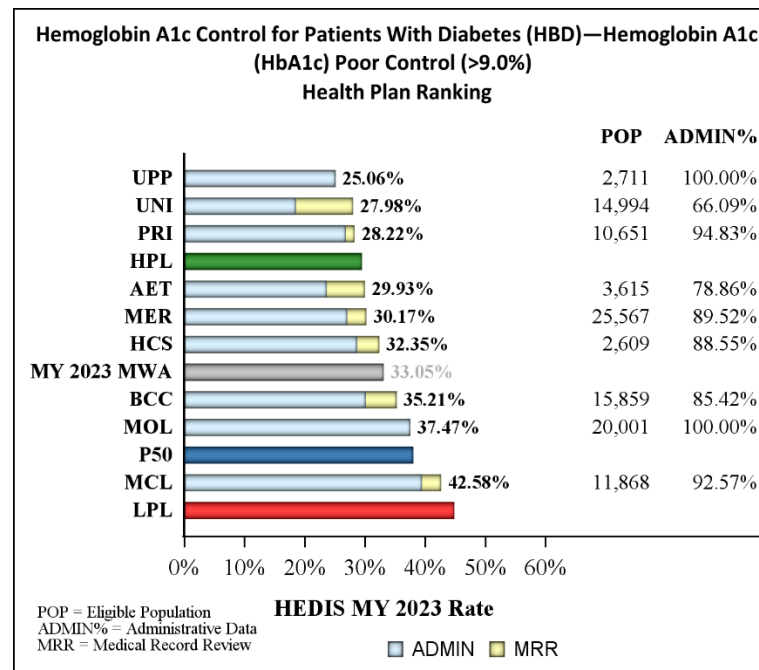
Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Poor Control (>9.0%)

Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Poor Control (>9.0%) assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) whose most recently documented HbA1c level was greater than 9.0 percent. For this measure, a lower rate indicates better performance.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

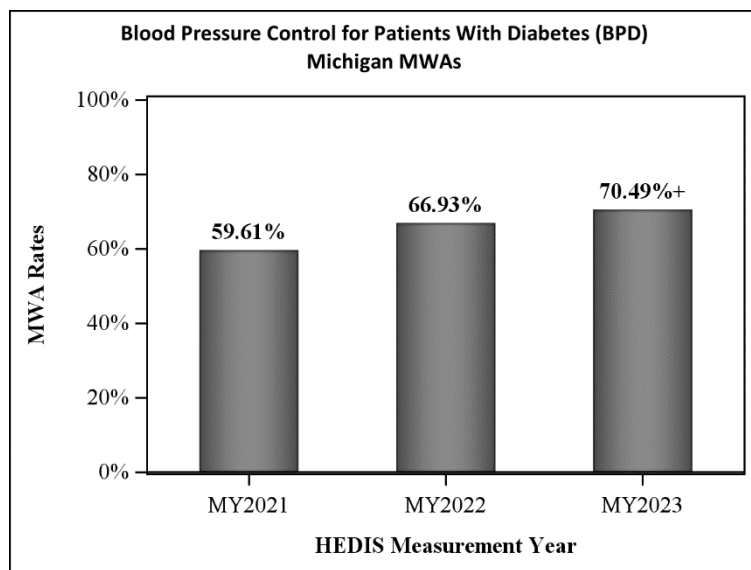
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



Three MHPs ranked above the HPL. Five MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 17 percentage points.

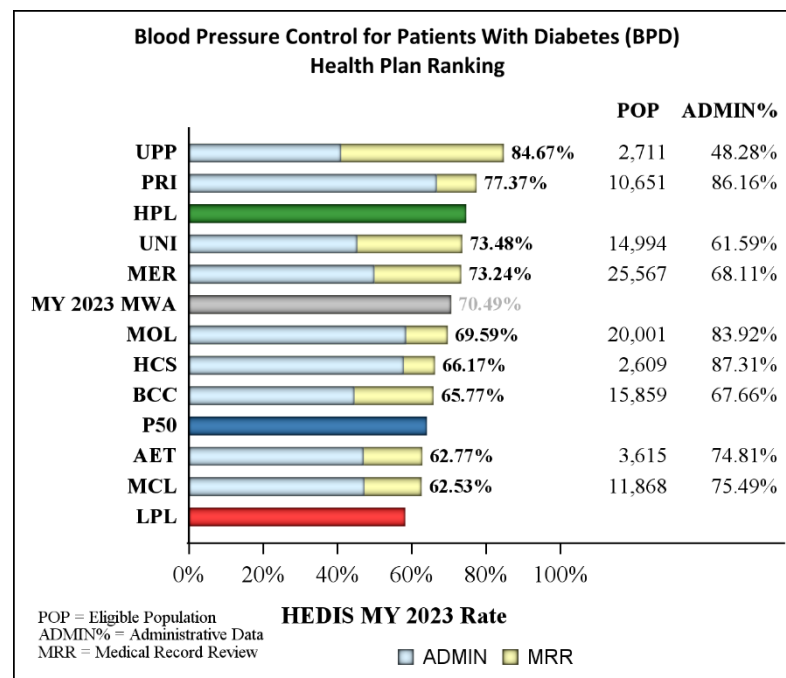
Blood Pressure Control for Patients With Diabetes (BPD)

Blood Pressure Control for Patients With Diabetes (BPD) assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and 2) whose blood pressure (BP) was adequately controlled (140/90 mm Hg) during the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

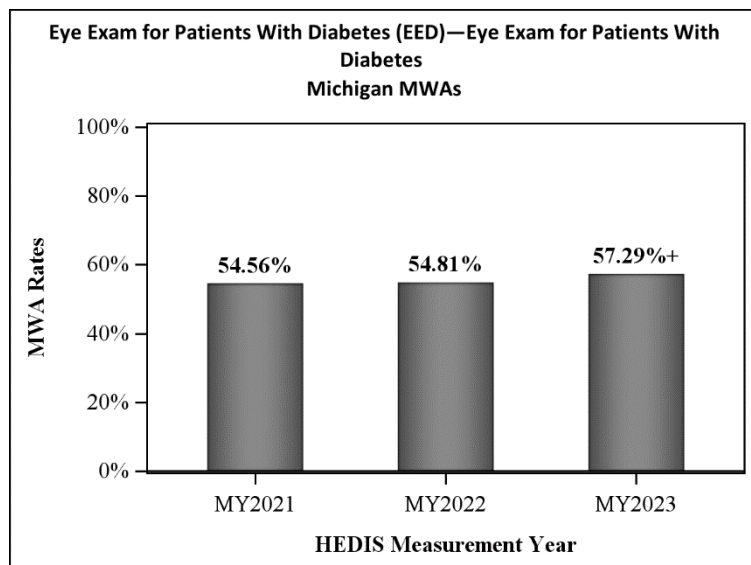
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



Two MHPs ranked above the HPL. Five MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Two MHPs ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 22 percentage points.

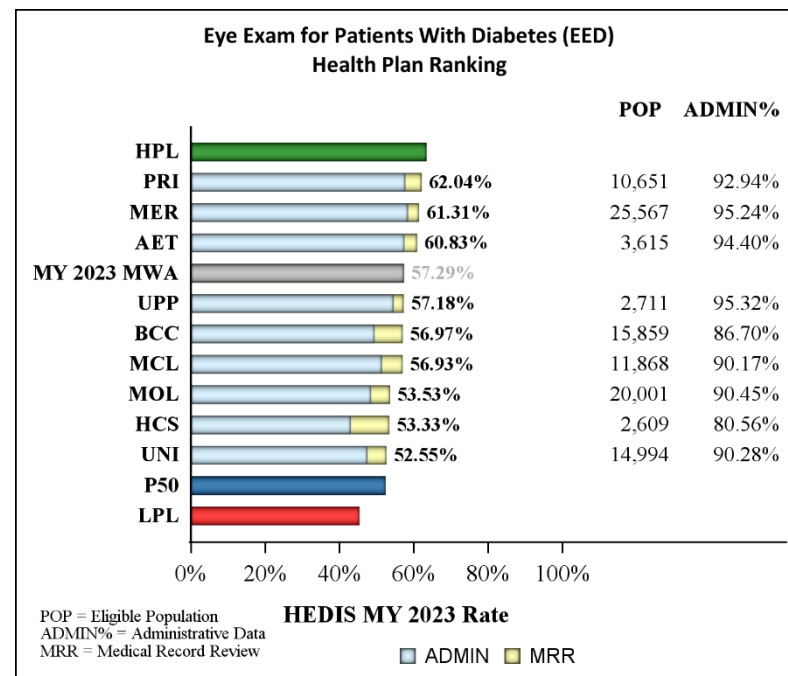
Eye Exam for Patients With Diabetes (EED)

Eye Exam for Patients With Diabetes (EED) assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had a retinal eye exam. Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

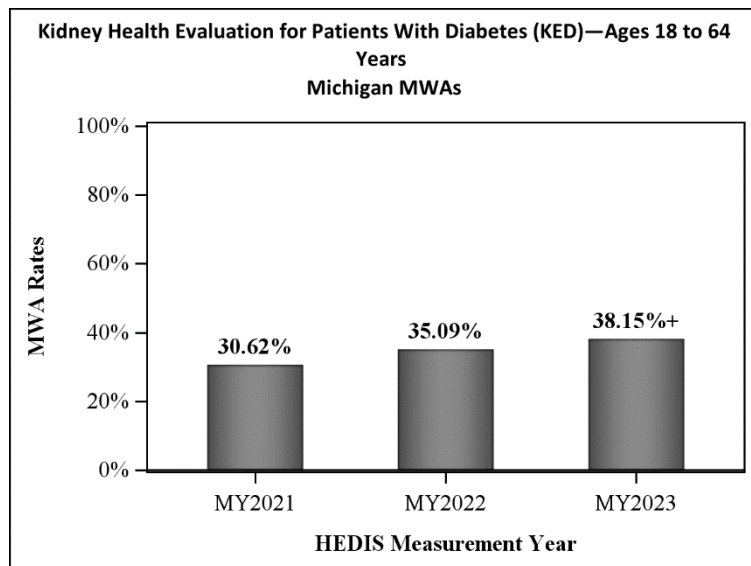
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



All nine MHPs and the MWA ranked above the 50th percentile but fell below the HPL. MHP performance varied by over 9 percentage points.

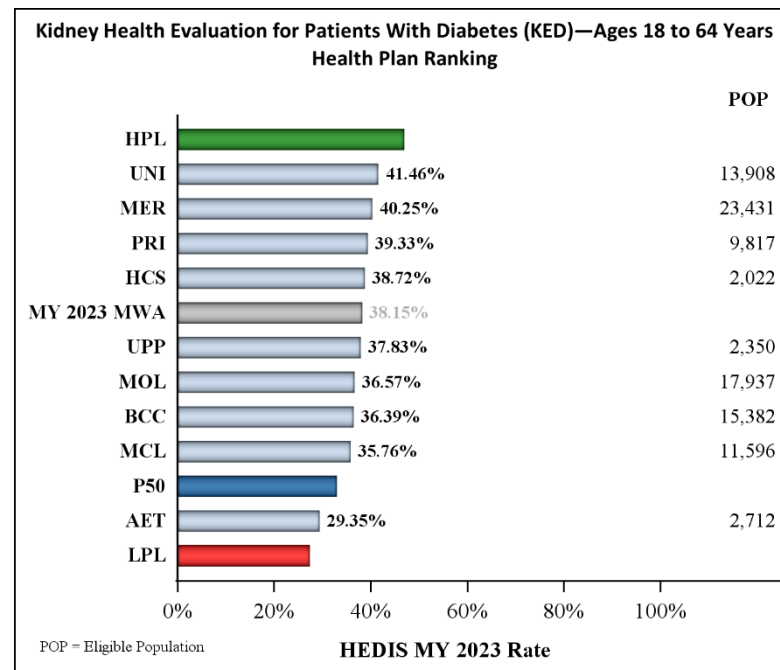
Kidney Health Evaluation for People With Diabetes (KED)—Ages 18 to 64 Years

Kidney Health Evaluation for Patients With Diabetes (KED)—Ages 18 to 64 Years assesses the percentage of members 18 to 64 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

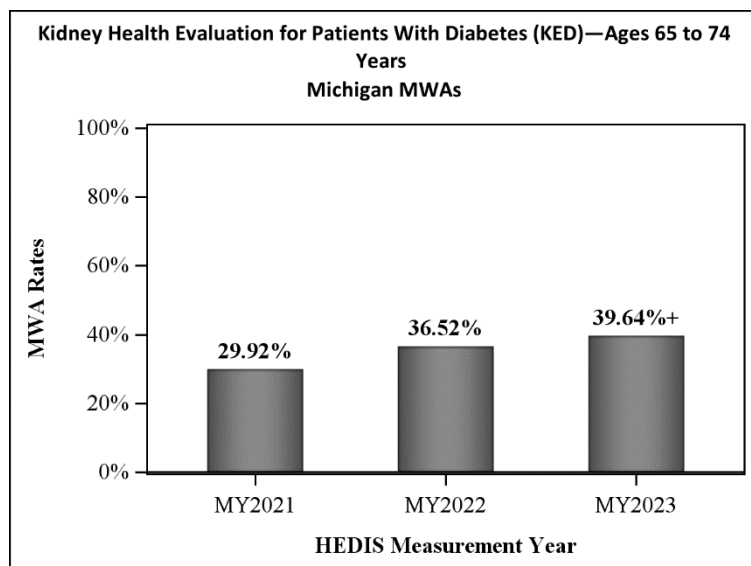
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



Eight MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 12 percentage points.

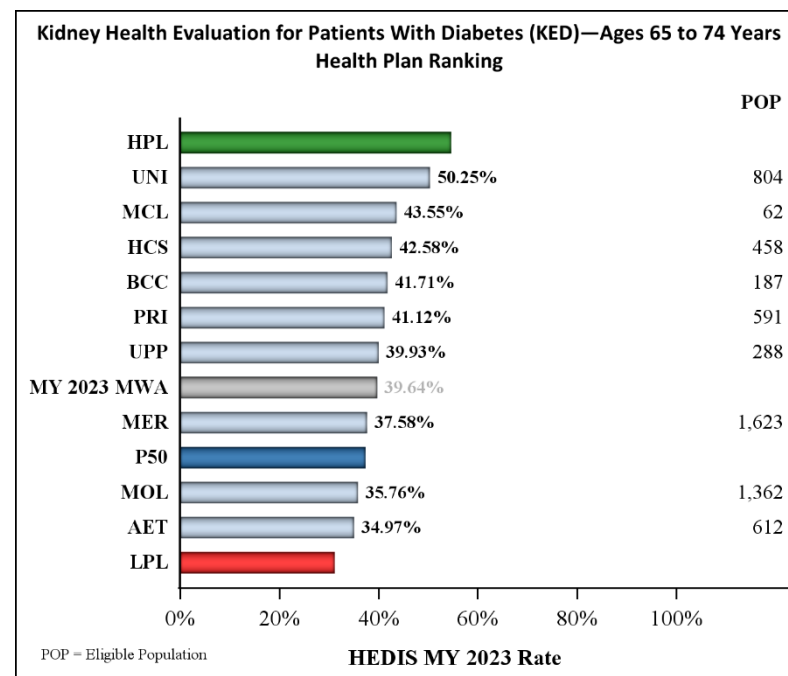
Kidney Health Evaluation for People With Diabetes (KED)—Ages 65 to 74 Years

Kidney Health Evaluation for Patients With Diabetes (KED)—Ages 65 to 74 Years assesses the percentage of members 65 to 74 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an eGFR and an uACR, during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

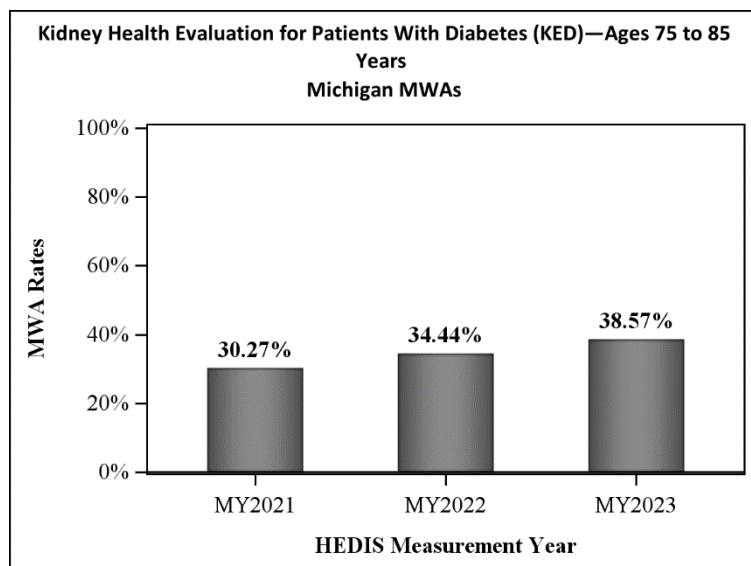
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



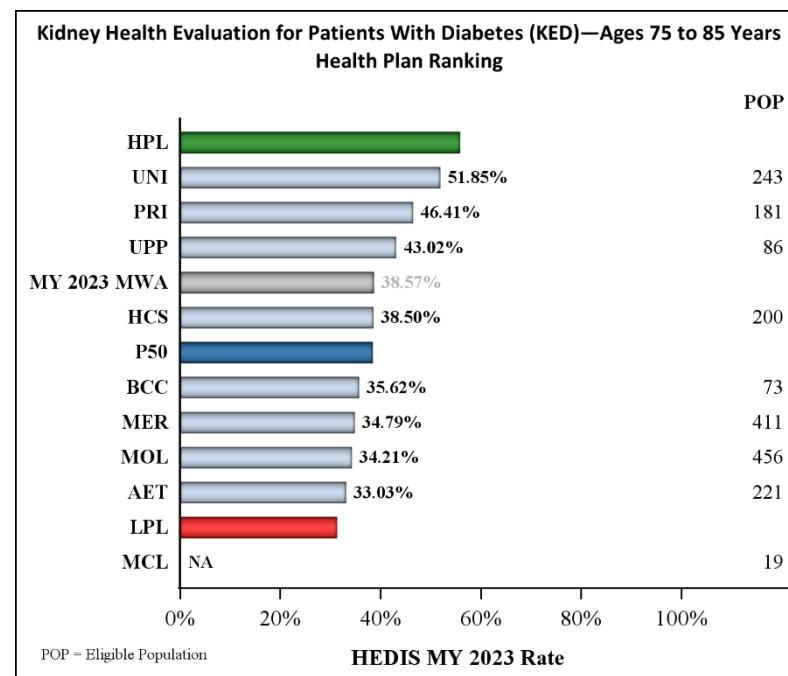
Seven MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Two MHPs ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 15 percentage points.

Kidney Health Evaluation for People With Diabetes (KED)—Ages 75 to 85 Years

Kidney Health Evaluation for Patients With Diabetes (KED)—Ages 75 to 85 Years assesses the percentage of members 75 to 85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an eGFR and an uACR, during the MY.



The HEDIS MY 2023 MWA rate did not demonstrate a significant change from HEDIS MY 2022.

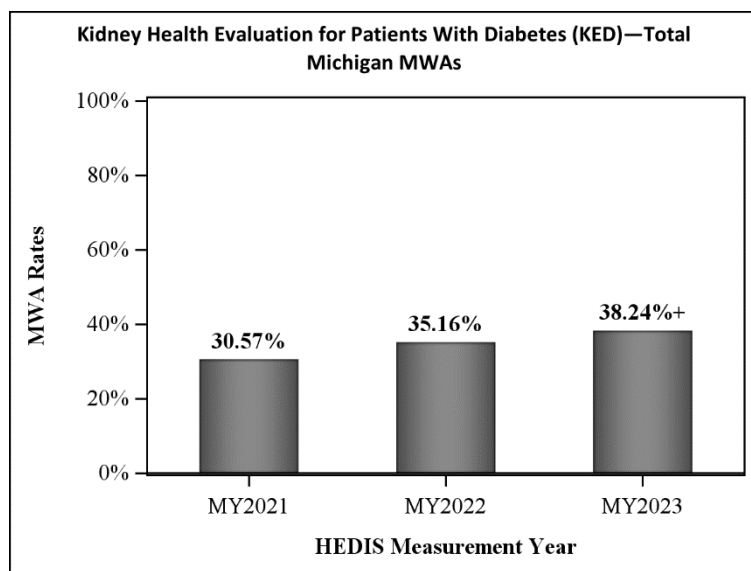


NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Four MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Four MHPs ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 18 percentage points.

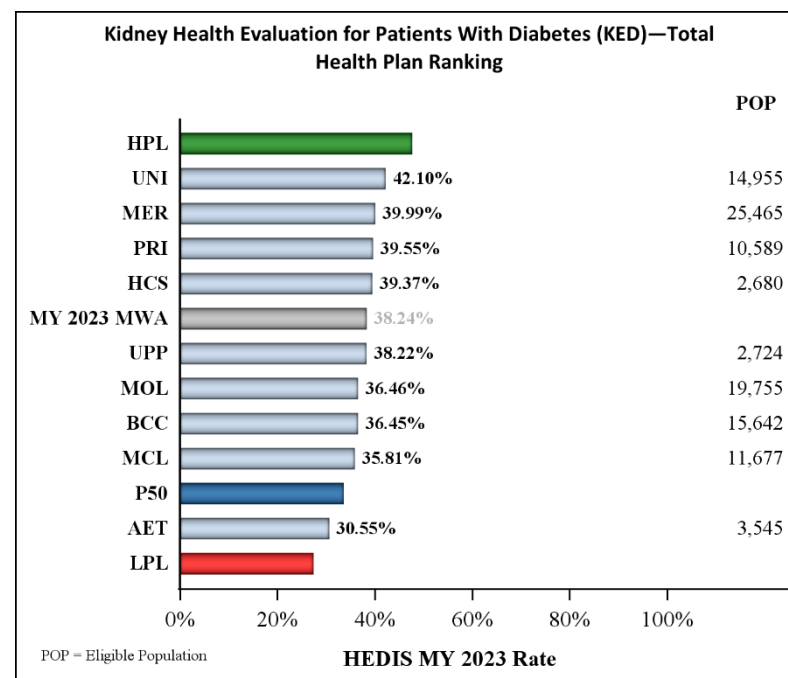
Kidney Health Evaluation for People With Diabetes (KED)—Total

Kidney Health Evaluation for Patients With Diabetes (KED)—Total assesses the percentage of members 18 to 85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an eGFR and an uACR, during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

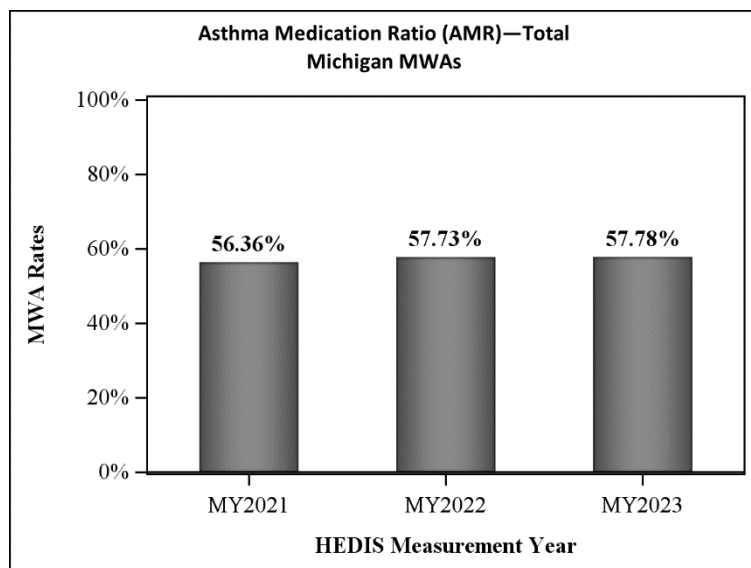
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



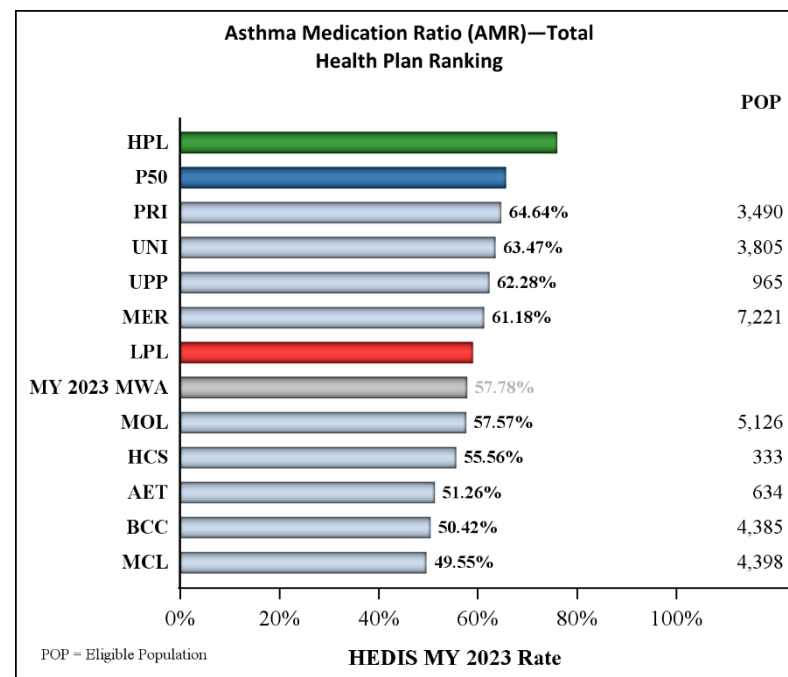
Eight MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 11 percentage points.

Asthma Medication Ratio (AMR)—Total

Asthma Medication Ratio (AMR)—Total assesses the percentage of members 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the MY.



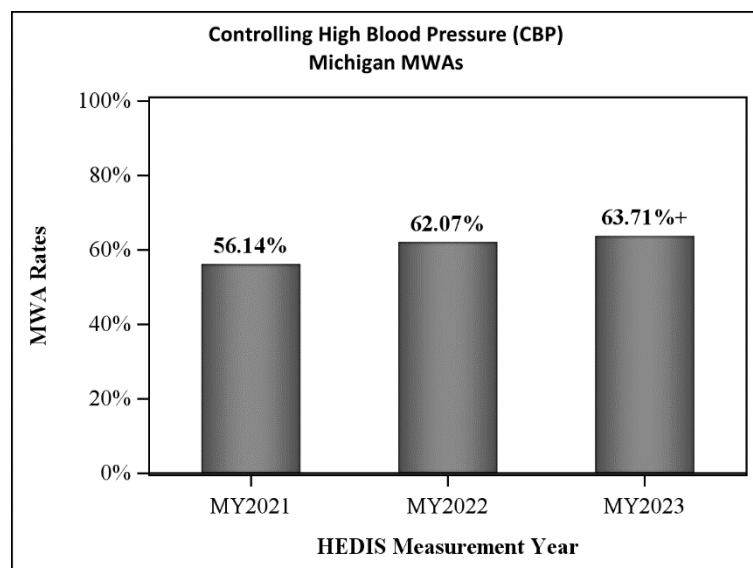
The HEDIS MY 2023 MWA rate did not demonstrate a significant change from HEDIS MY 2022.



Four MHPs ranked above the LPL but fell below the 50th percentile. Five MHPs and the MWA fell below the LPL. MHP performance varied by over 15 percentage points.

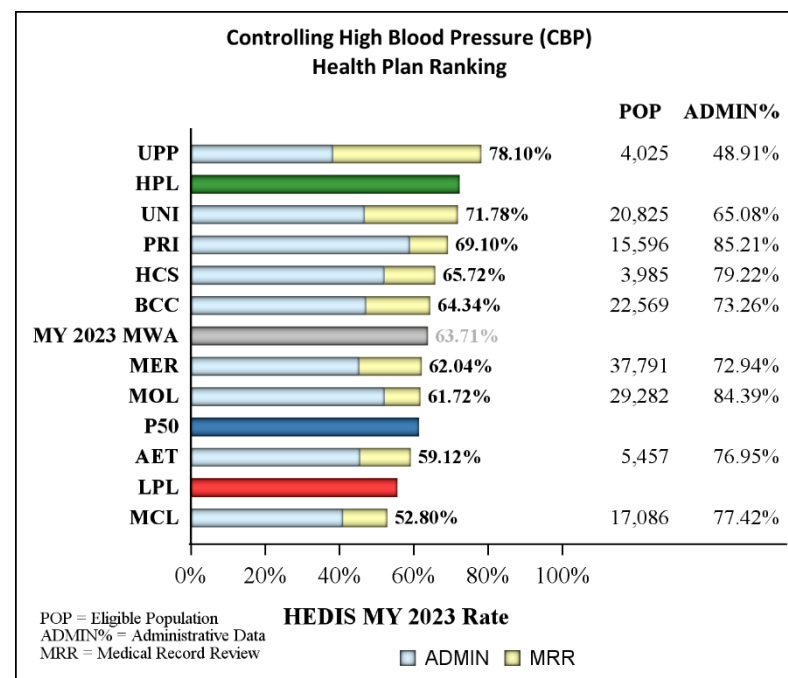
Controlling High Blood Pressure (CBP)

Controlling High Blood Pressure (CBP) assesses the percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

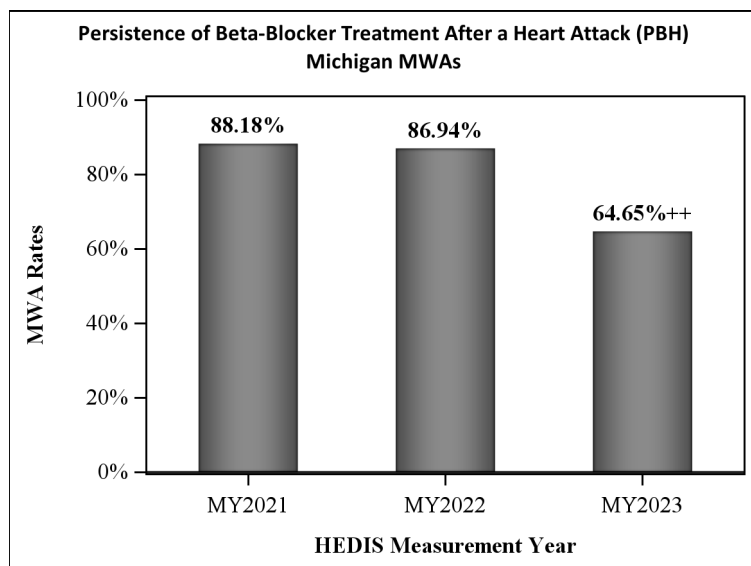
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



One MHP ranked above the HPL. Six MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 25 percentage points.

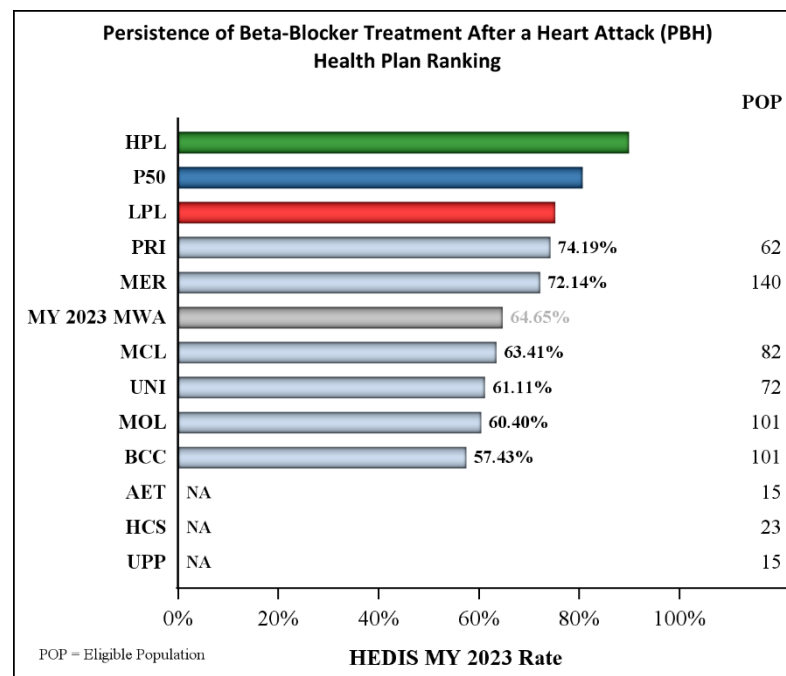
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) assesses the percentage of members 18 years of age and older who were hospitalized and discharged during the measurement period with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The HEDIS MY 2023 MWA rate significantly declined from HEDIS MY 2022.

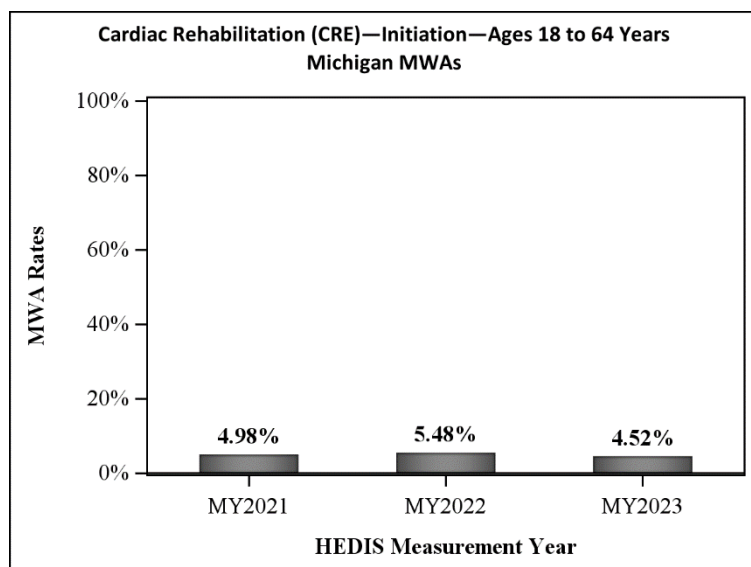


NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

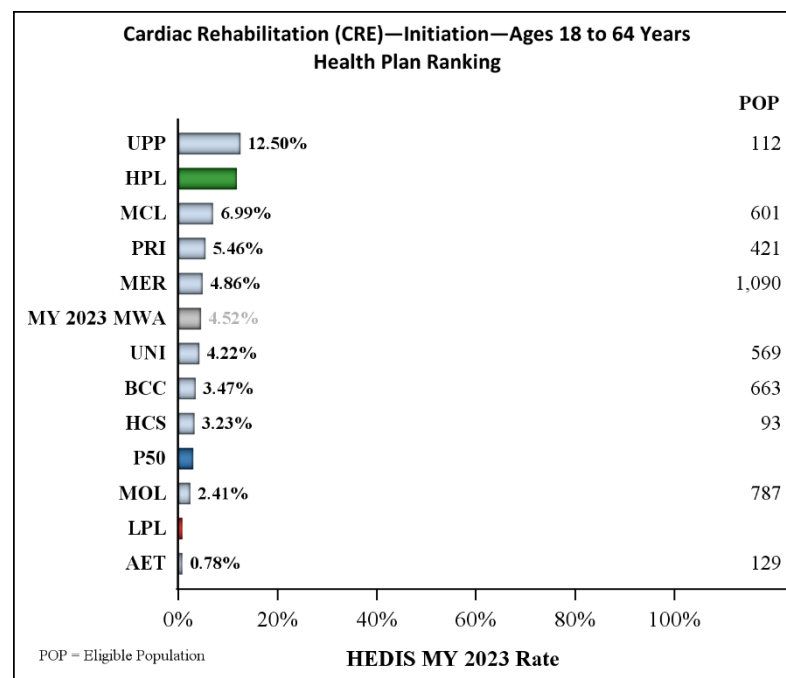
Six MHPs and the MWA fell below the LPL. MHP performance varied by over 16 percentage points.

Cardiac Rehabilitation (CRE)—Initiation—Ages 18 to 64 Years

Cardiac Rehabilitation (CRE)—Initiation—Ages 18 to 64 Years assesses the percentage of members 18 to 64 years of age who attended two or more sessions of cardiac rehabilitation within 30 days after a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation, or heart valve repair/replacement.



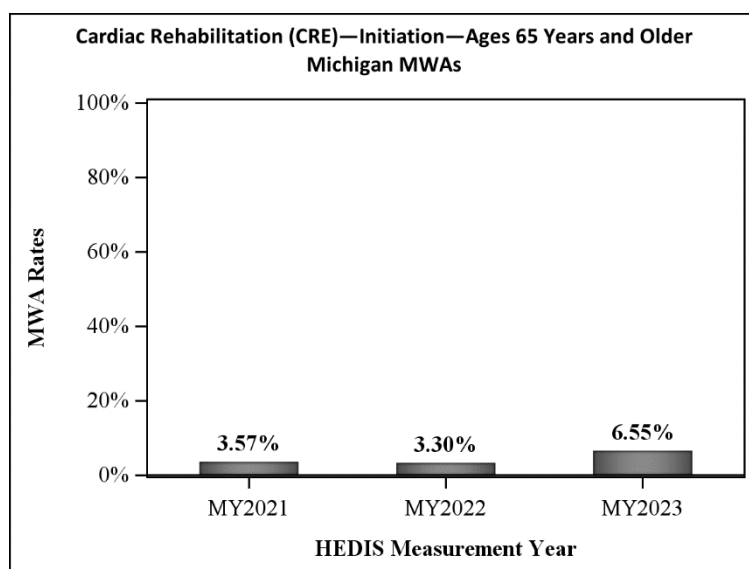
The HEDIS MY 2023 MWA rate did not demonstrate a significant change from HEDIS MY 2022.



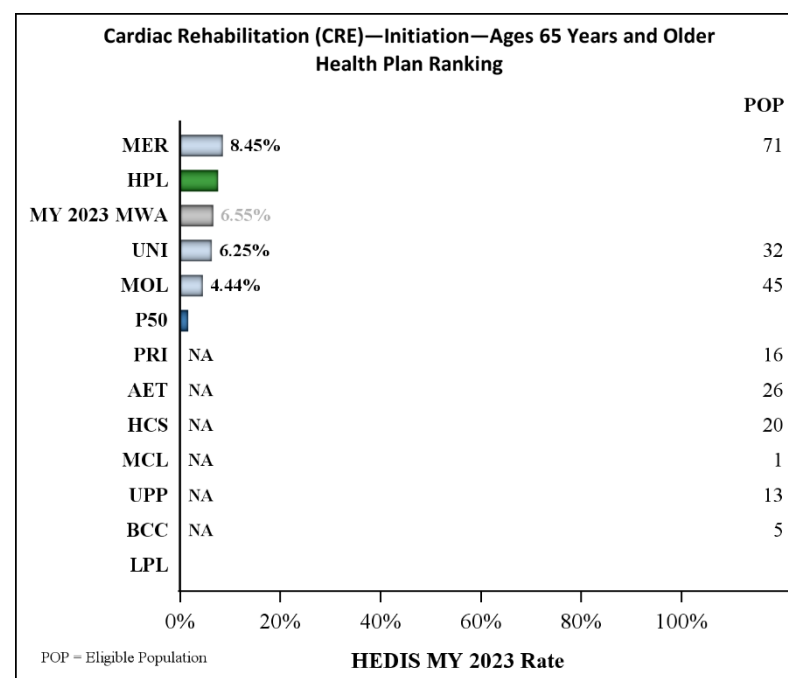
One MHP ranked above the HPL. Six MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 11 percentage points.

Cardiac Rehabilitation (CRE)—Initiation—Ages 65 Years and Older

Cardiac Rehabilitation (CRE)—Initiation—Ages 65 Years and Older assesses the percentage of members 65 years of age and older who attended two or more sessions of cardiac rehabilitation within 30 days after a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation, or heart valve repair/replacement.



The HEDIS MY 2023 MWA did not demonstrate a significant change from HEDIS MY 2022.

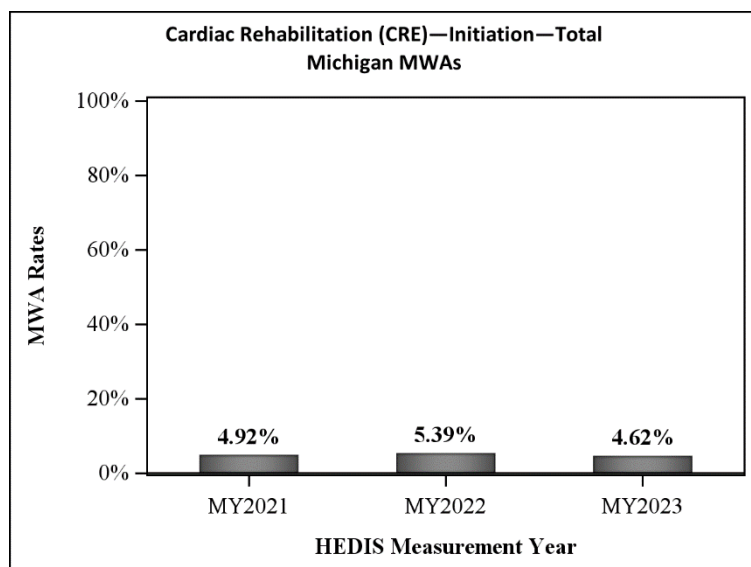


NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

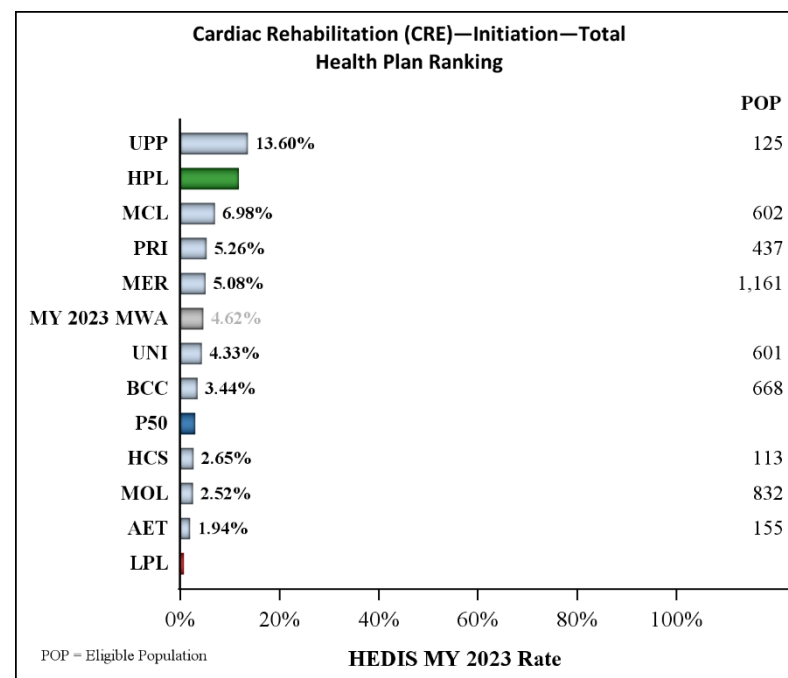
One MHP ranked above the HPL. Two MHPs and the MWA ranked above the 50th percentile but fell below the HPL. MHP performance varied by over 4 percentage points.

Cardiac Rehabilitation (CRE)—Initiation—Total

Cardiac Rehabilitation (CRE)—Initiation—Total assesses the total percentage of members 18 years of age and older who attended two or more sessions of cardiac rehabilitation within 30 days after a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation, or heart valve repair/replacement.



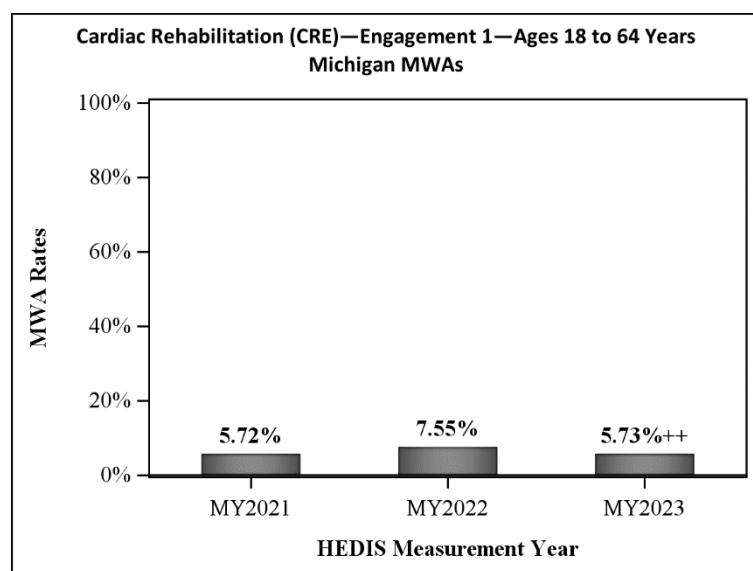
The HEDIS MY 2023 MWA rate did not demonstrate a significant change from HEDIS MY 2022.



One MHP ranked above the HPL. Five MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Three MHPs ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 11 percentage points.

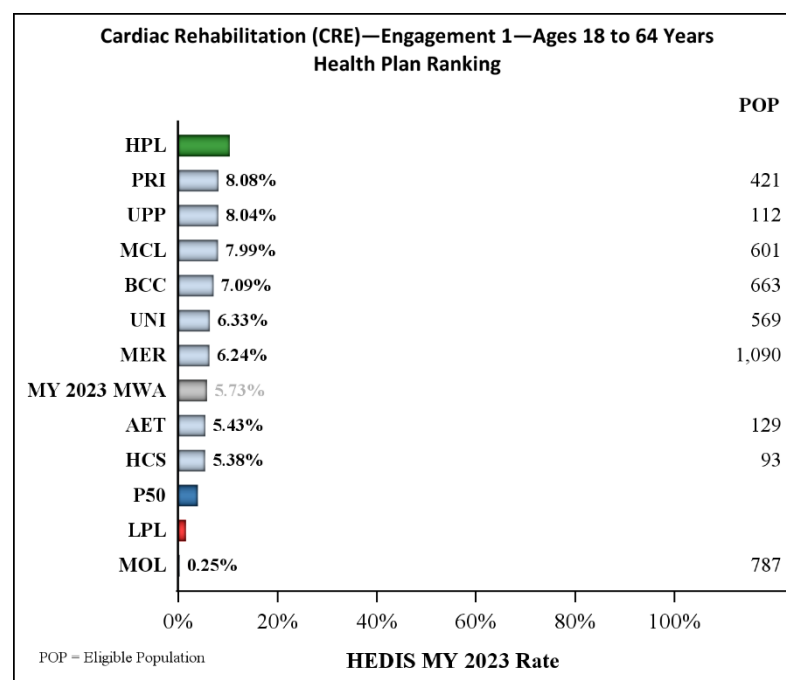
Cardiac Rehabilitation (CRE)—Engagement 1—Ages 18 to 64 Years

Cardiac Rehabilitation (CRE)—Engagement 1—Ages 18 to 64 Years assesses the percentage of members 18 to 64 years of age who attended 12 or more sessions of cardiac rehabilitation within 90 days after a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation, or heart valve repair/replacement.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

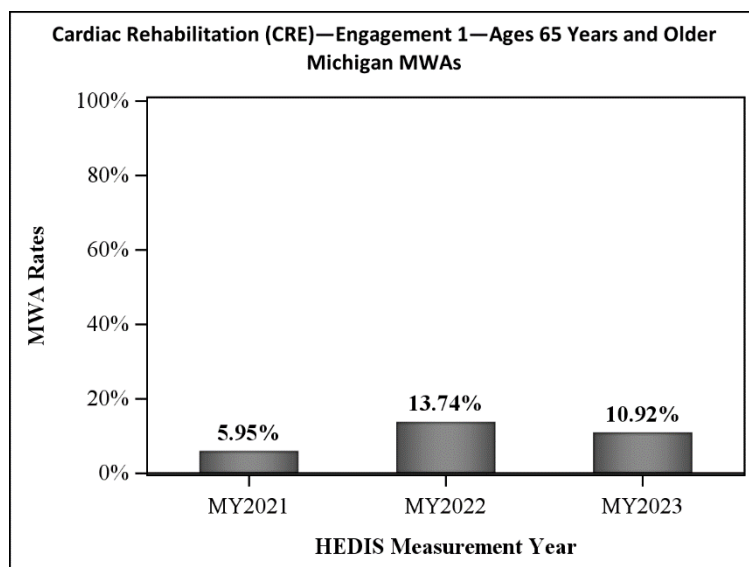
The HEDIS MY 2023 MWA rate significantly declined from HEDIS MY 2022.



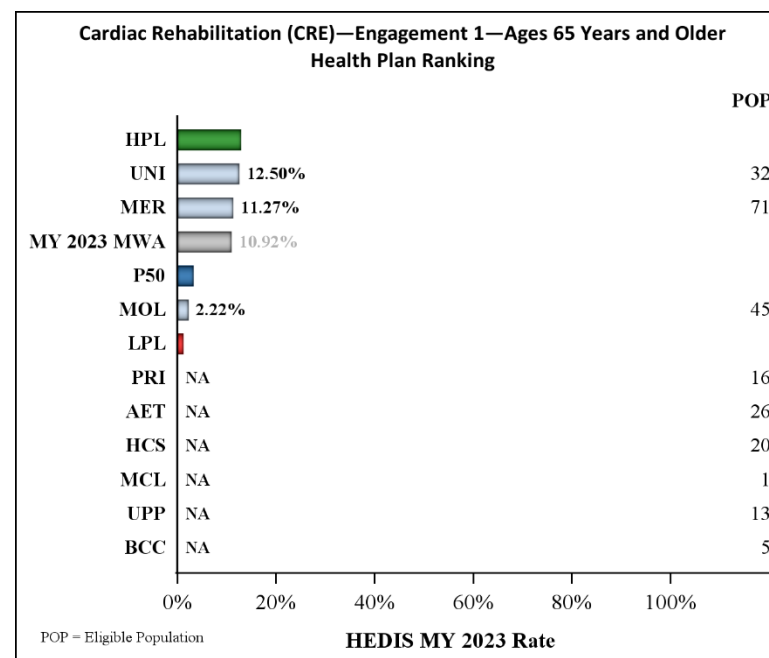
Eight MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP fell below the LPL. MHP performance varied by over 7 percentage points.

Cardiac Rehabilitation (CRE)—Engagement 1—Ages 65 Years and Older

Cardiac Rehabilitation (CRE)—Engagement 1—Ages 65 Years and Older assesses the percentage of members 65 years of age and older who attended 12 or more sessions of cardiac rehabilitation within 90 days after a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation, or heart valve repair/replacement.



The HEDIS MY 2023 MWA did not demonstrate a significant change from HEDIS MY 2022.

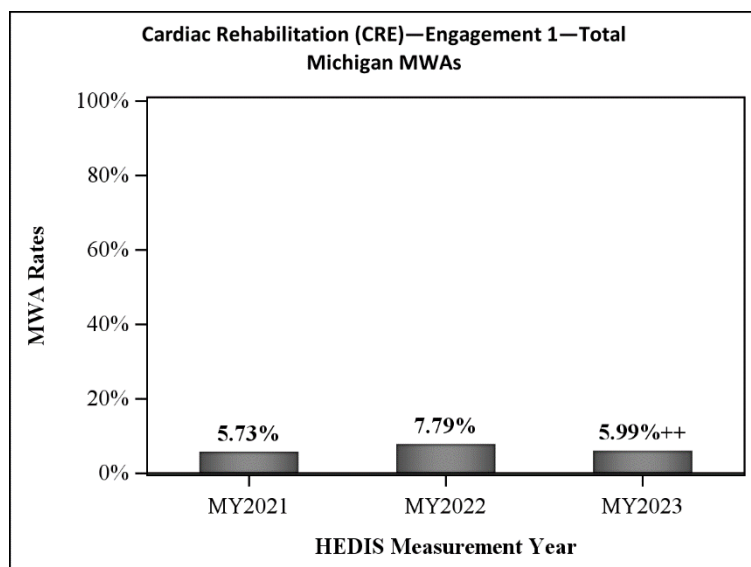


NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Two MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 10 percentage points.

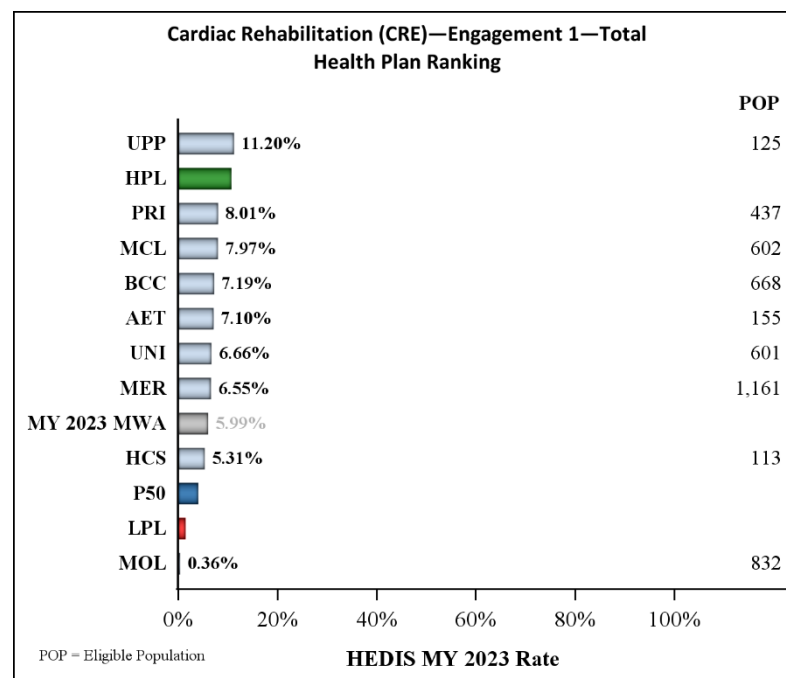
Cardiac Rehabilitation (CRE)—Engagement 1—Total

Cardiac Rehabilitation (CRE)—Engagement 1—Total assesses the total percentage of members 18 years of age and older who attended 12 or more sessions of cardiac rehabilitation within 90 days after a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation, or heart valve repair/replacement.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

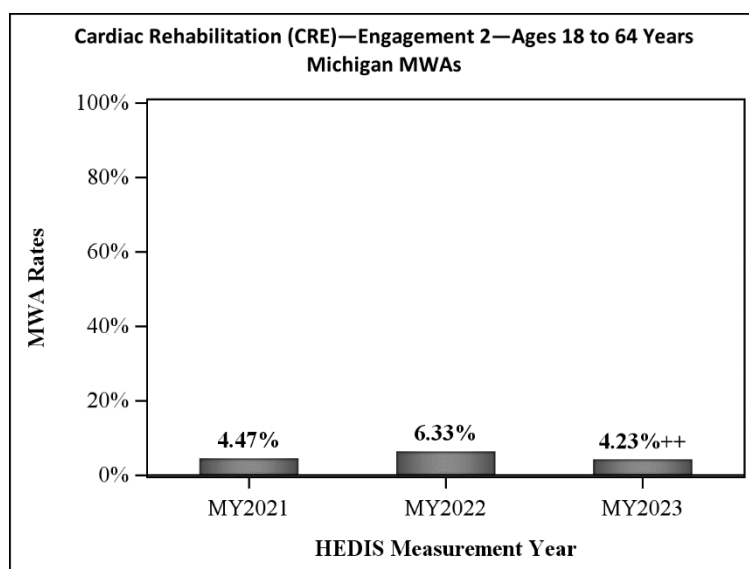
The HEDIS MY 2023 MWA rate significantly declined from HEDIS MY 2022.



One MHP ranked above the HPL. Seven MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP fell below the LPL. MHP performance varied by over 10 percentage points.

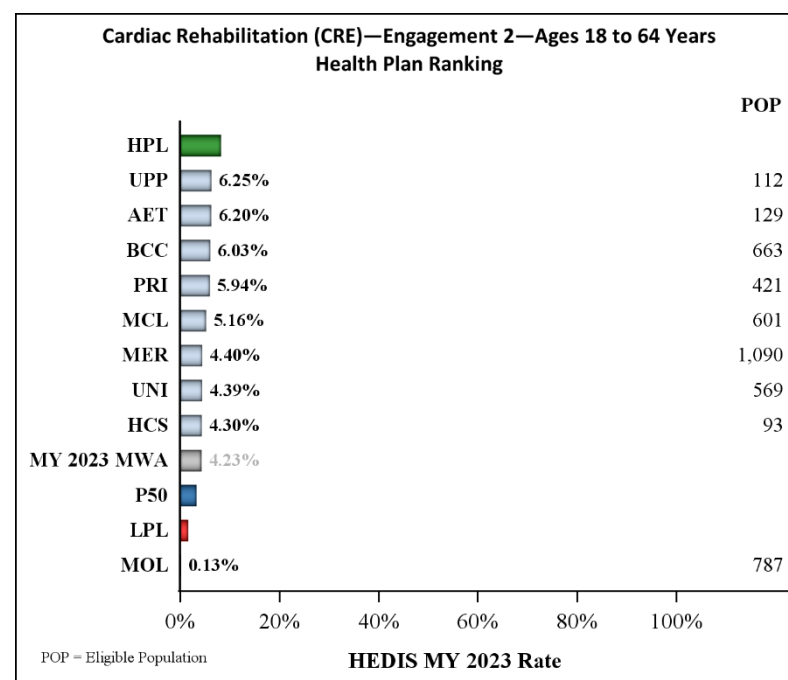
Cardiac Rehabilitation (CRE)—Engagement 2—Ages 18 to 64 Years

Cardiac Rehabilitation (CRE)—Engagement 2—Ages 18 to 64 Years assesses the percentage of members 18 to 64 years who attended 24 or more sessions of cardiac rehabilitation within 90 days after a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation, or heart valve repair/replacement.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

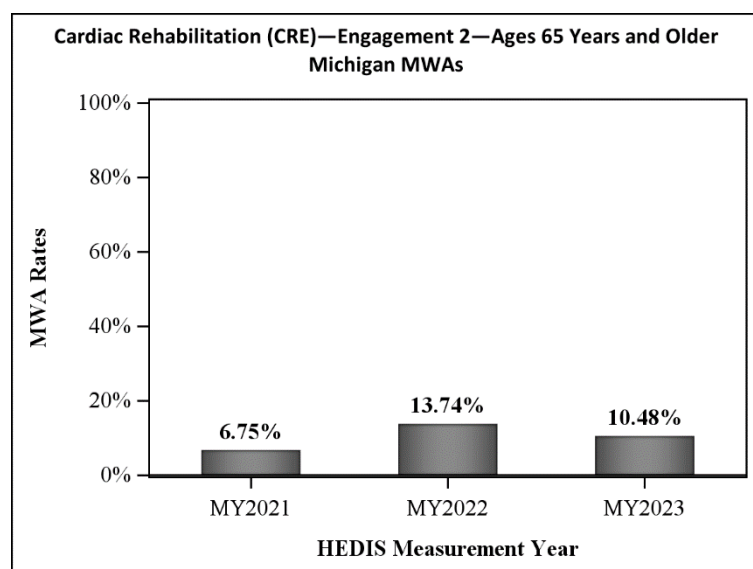
The HEDIS MY 2023 MWA rate significantly declined from HEDIS MY 2022.



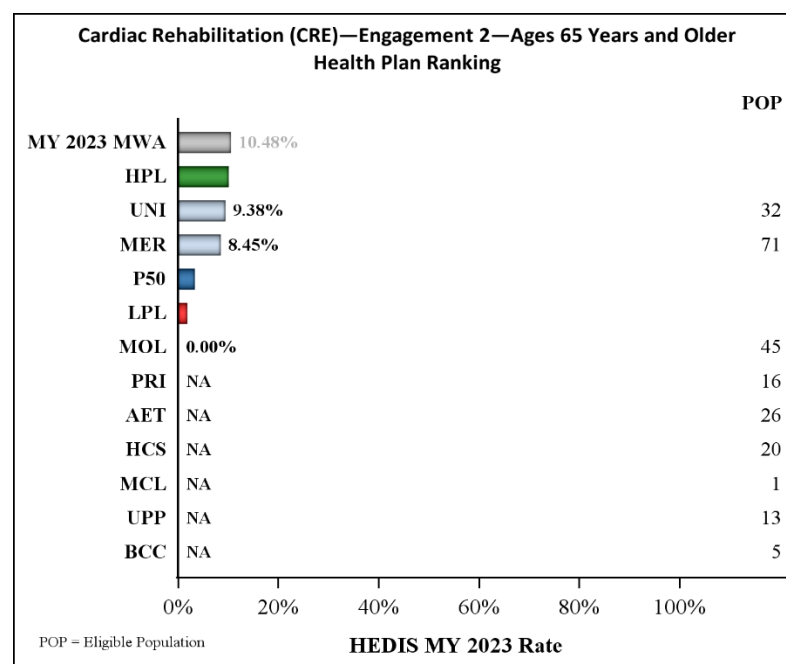
Eight MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP fell below the LPL. MHP performance varied by over 6 percentage points.

Cardiac Rehabilitation (CRE)—Engagement 2—Ages 65 Years and Older

Cardiac Rehabilitation (CRE)—Engagement 2—Ages 65 Years and Older assesses the percentage of members 65 years of age and older who attended 24 or more sessions of cardiac rehabilitation within 90 days after a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation, or heart valve repair/replacement.



The HEDIS MY 2023 MWA rate did not demonstrate a significant change from HEDIS MY 2022.

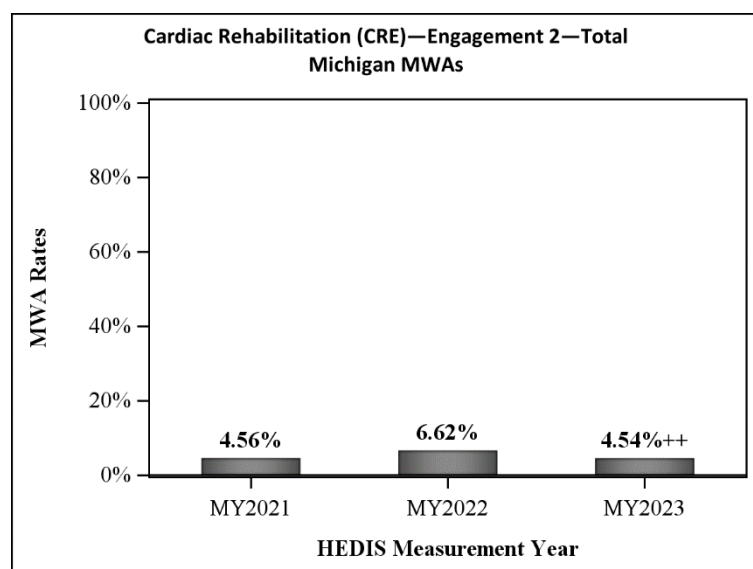


NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

The MWA ranked above the HPL. Two MHPs ranked above the 50th percentile but fell below the HPL. One MHP fell below the LPL. MHP performance varied by over 9 percentage points.

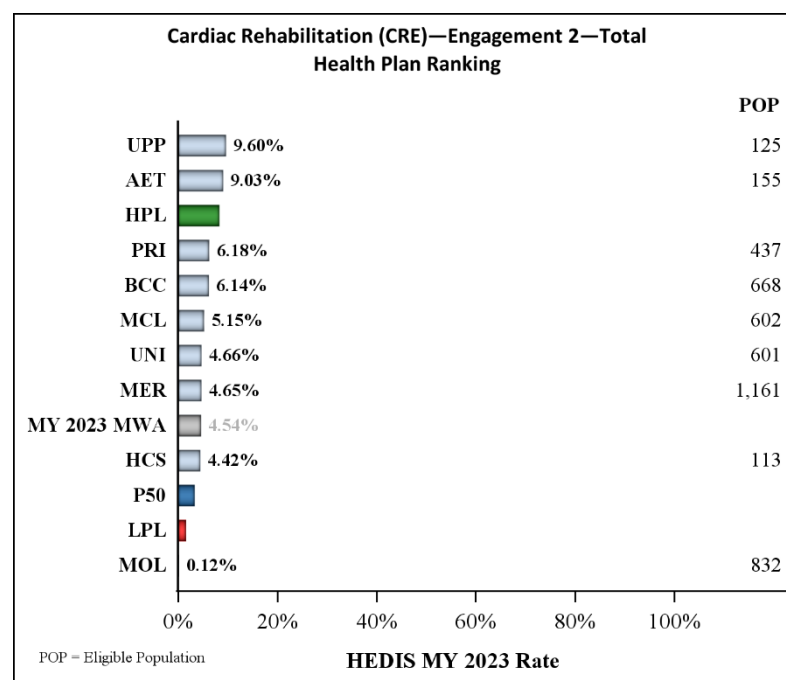
Cardiac Rehabilitation (CRE)—Engagement 2—Total

Cardiac Rehabilitation (CRE)—Engagement 2—Total assesses the total percentage of members 18 years of age and older who attended 24 or more sessions of cardiac rehabilitation within 90 days after a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation, or heart valve repair/replacement.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

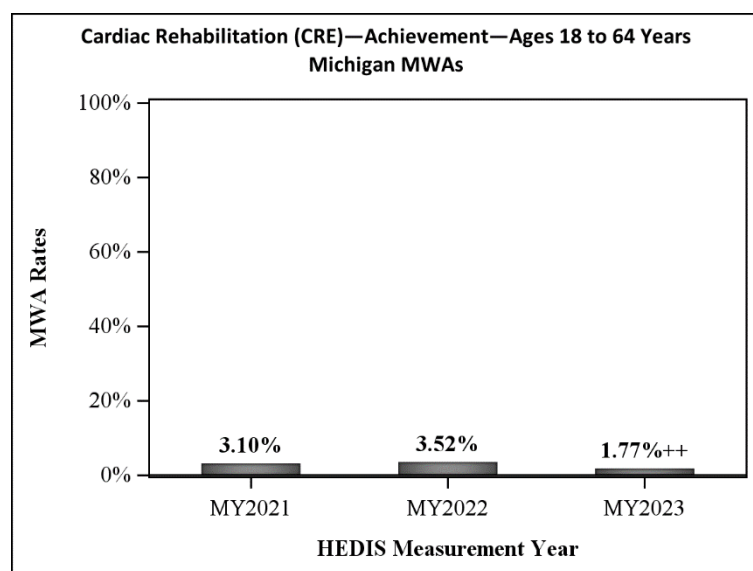
The HEDIS MY 2023 MWA rate significantly declined from HEDIS MY 2022.



Two MHPs ranked above the HPL. Six MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP fell below the LPL. MHP performance varied by over 9 percentage points.

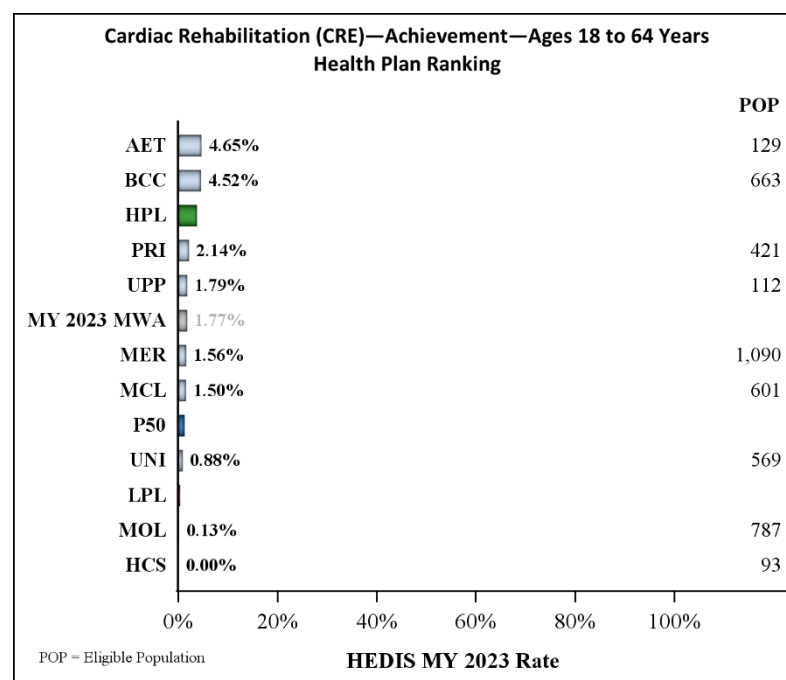
Cardiac Rehabilitation (CRE)—Achievement—Ages 18 to 64 Years

Cardiac Rehabilitation (CRE)—Achievement—Ages 18 to 64 Years assesses the percentage of members 18 to 64 years of age who attended 36 or more sessions of cardiac rehabilitation within 180 days after a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation, or heart valve repair/replacement.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

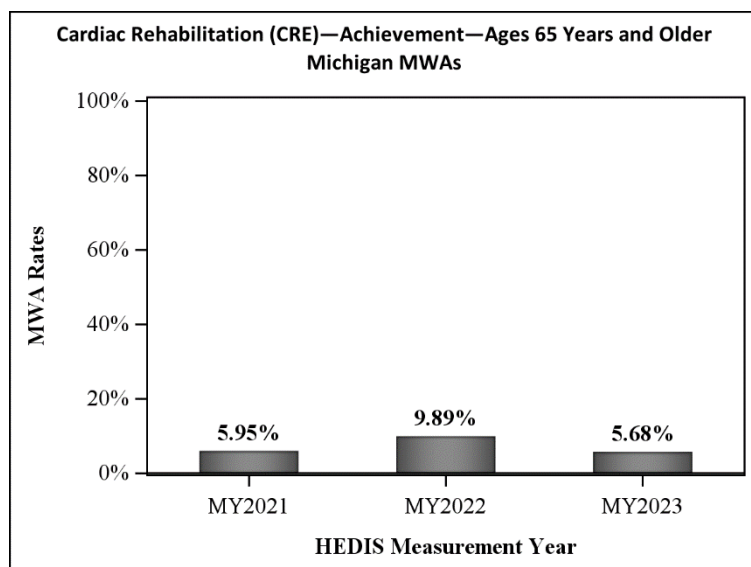
The HEDIS MY 2023 MWA rate significantly declined from HEDIS MY 2022.



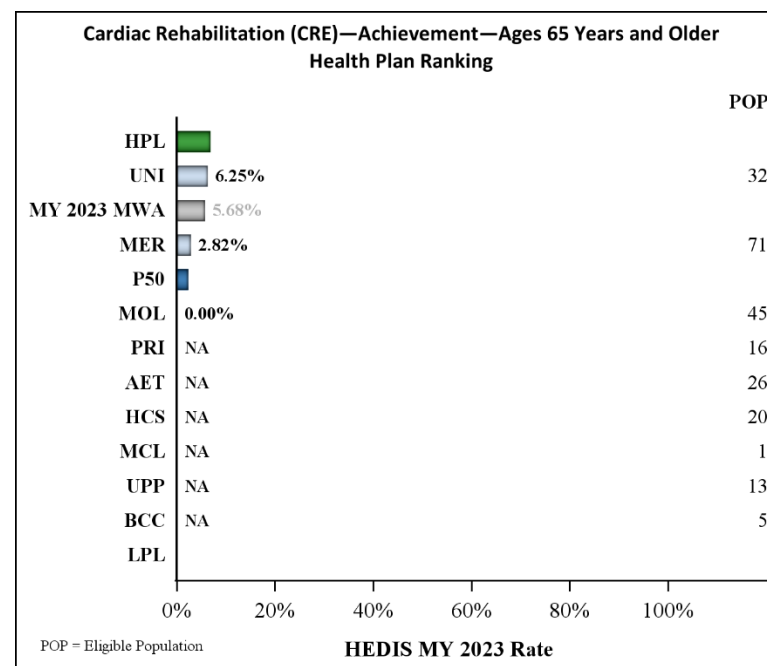
Two MHPs ranked above the HPL. Four MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. Two MHPs fell below the LPL. MHP performance varied by over 4 percentage points.

Cardiac Rehabilitation (CRE)—Achievement—Ages 65 Years and Older

Cardiac Rehabilitation (CRE)—Achievement—Ages 65 Years and Older assesses the percentage of members 65 years of age and older who attended 36 or more sessions of cardiac rehabilitation within 180 days after a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation, or heart valve repair/replacement.



The HEDIS MY 2023 MWA rate did not demonstrate a significant change from HEDIS MY 2022.

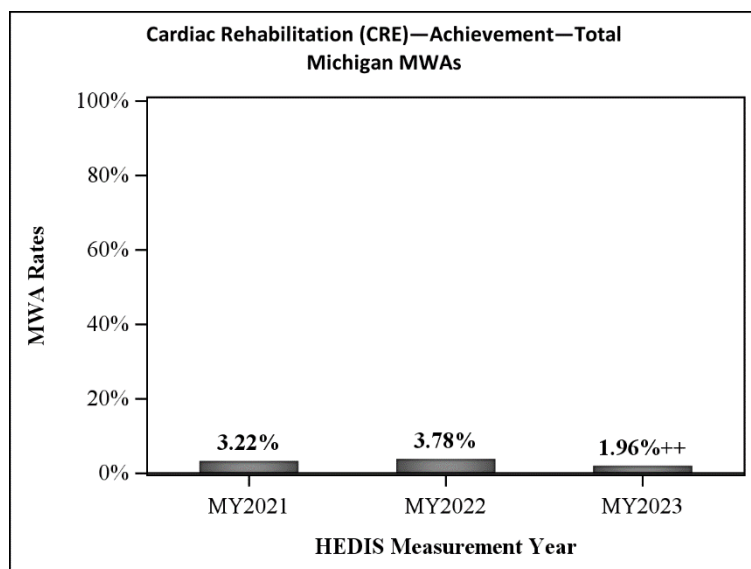


NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Two MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 6 percentage points.

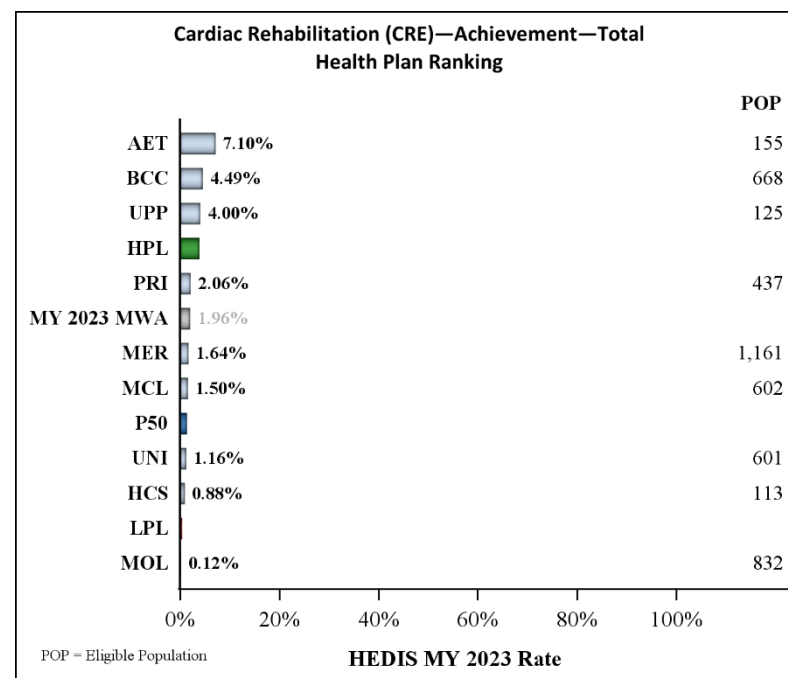
Cardiac Rehabilitation (CRE)—Achievement—Total

Cardiac Rehabilitation (CRE)—Achievement—Total assesses the total percentage of members 18 years of age and older who attended 36 or more sessions of cardiac rehabilitation within 180 days after a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation, or heart valve repair/replacement.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

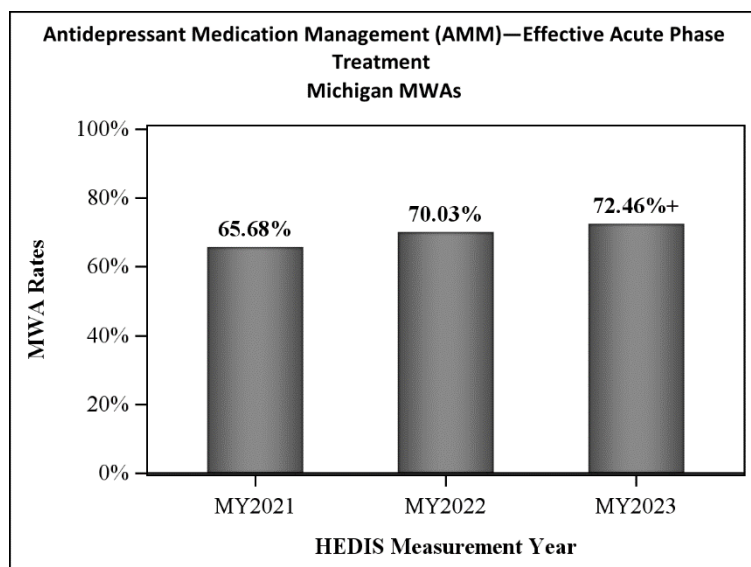
The HEDIS MY 2023 MWA rate significantly declined from HEDIS MY 2022.



Three MHPs ranked above the HPL. Three MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Two MHPs ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 6 percentage points.

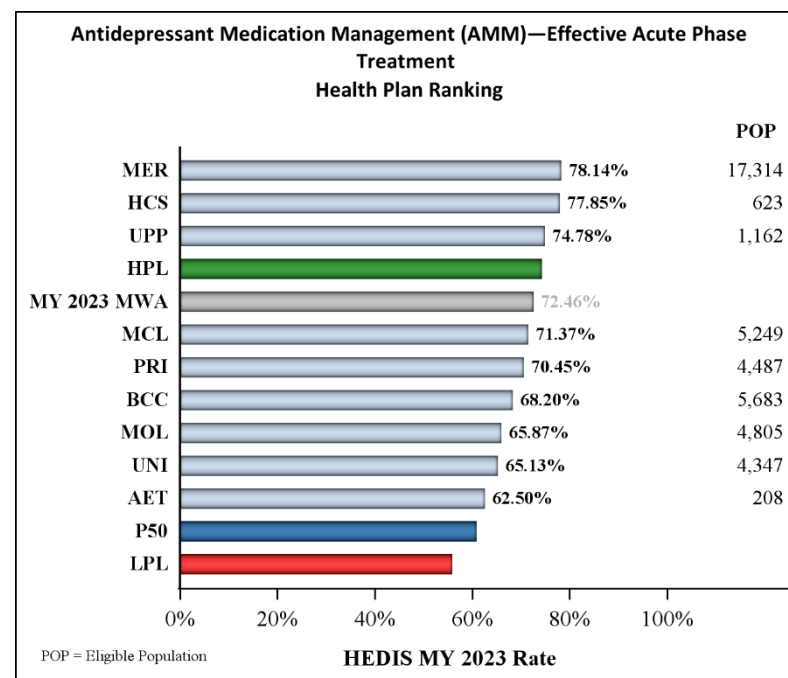
Antidepressant Medication Management (AMM)—Effective Acute Phase Treatment

Antidepressant Medication Management (AMM)—Effective Acute Phase Treatment assesses the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and remained on an antidepressant medication treatment for at least 84 days (12 weeks). *Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.*



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

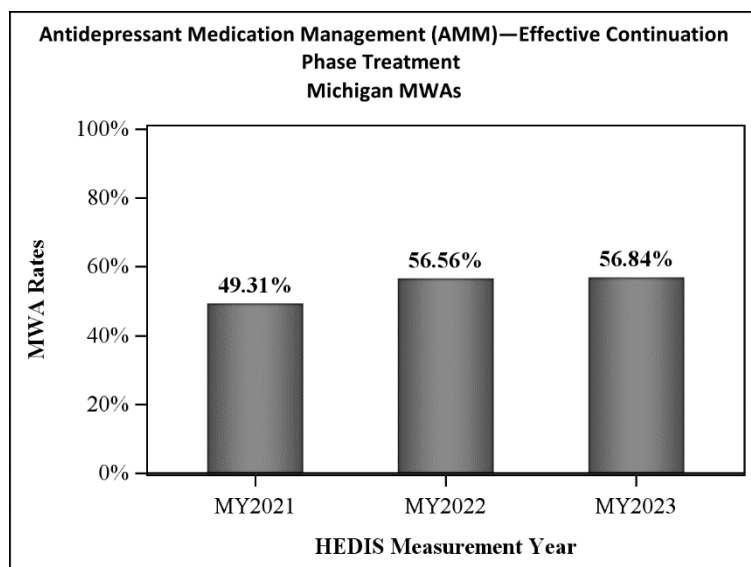
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



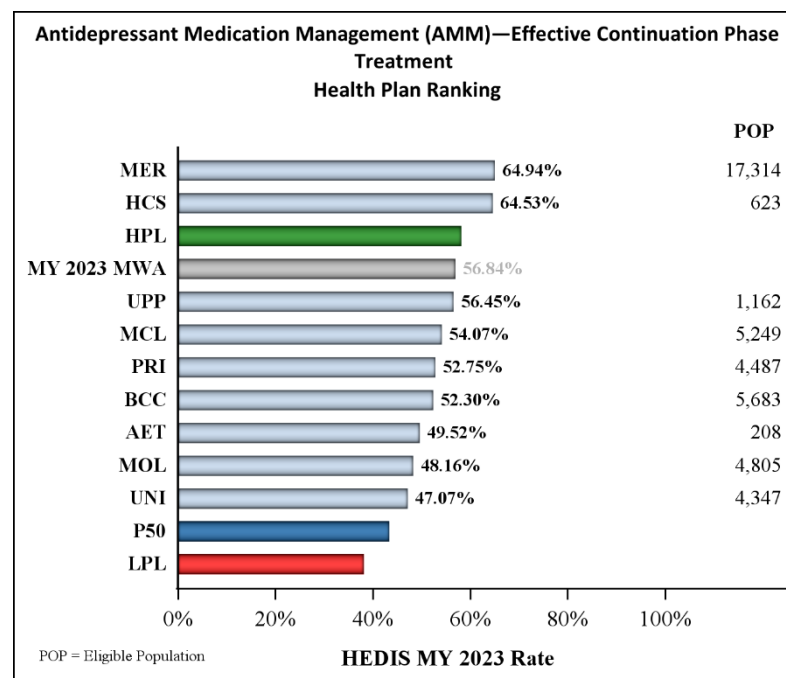
Three MHPs ranked above the HPL. Six MHPs and the MWA ranked above the 50th percentile but fell below the HPL. MHP performance varied by over 15 percentage points.

Antidepressant Medication Management (AMM)—Effective Continuation Phase Treatment

Antidepressant Medication Management (AMM)—Effective Continuation Phase Treatment assesses the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and remained on an antidepressant medication treatment for at least 180 days (6 months). *Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.*



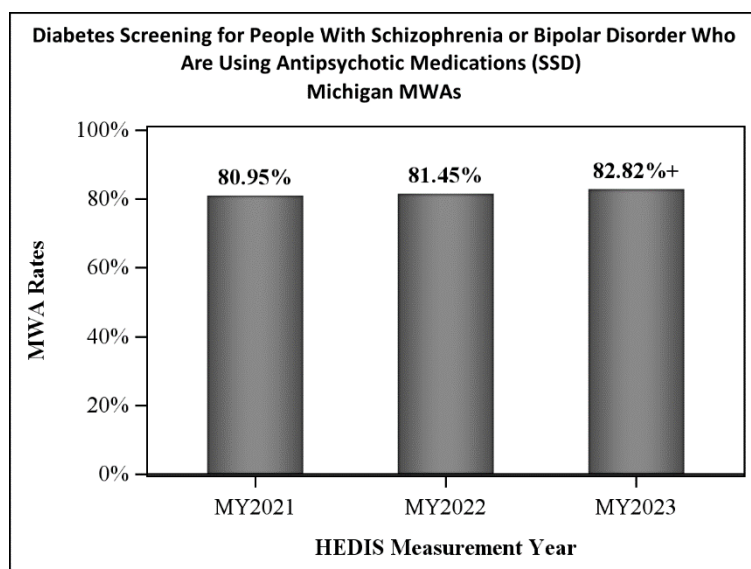
The HEDIS MY 2023 MWA did not demonstrate a significant change from HEDIS MY 2022.



Two MHPs ranked above the HPL. Seven MHPs and the MWA ranked above the 50th percentile but fell below the HPL. MHP performance varied by over 17 percentage points.

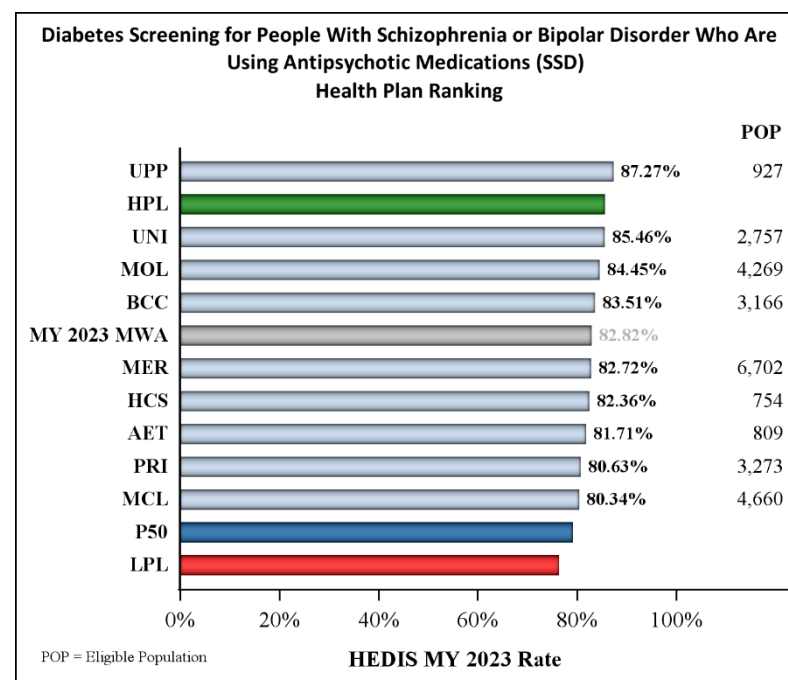
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) assesses the percentage of members 18 to 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

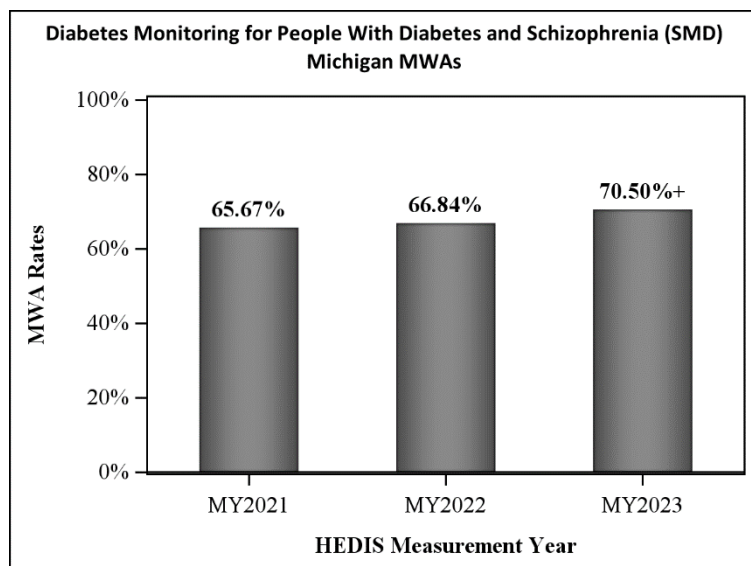
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



One MHP ranked above the HPL. Eight MHPs and the MWA ranked above the 50th percentile but fell below the HPL. MHP performance varied by over 6 percentage points.

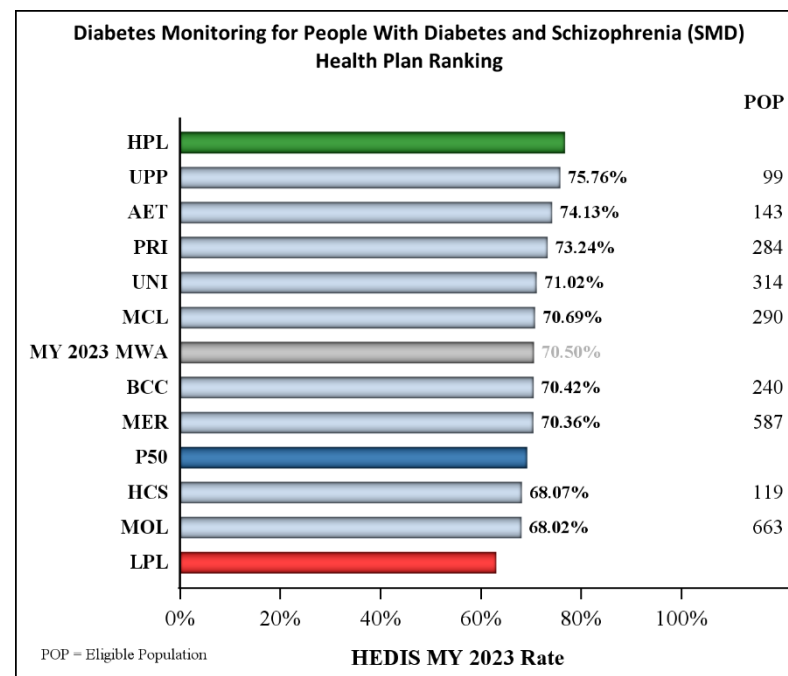
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) assesses the percentage of members 18 to 64 years of age with schizophrenia or schizoaffective disorder and diabetes, who had both a low-density lipoprotein cholesterol (LDL-C) test and an HbA1c test during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

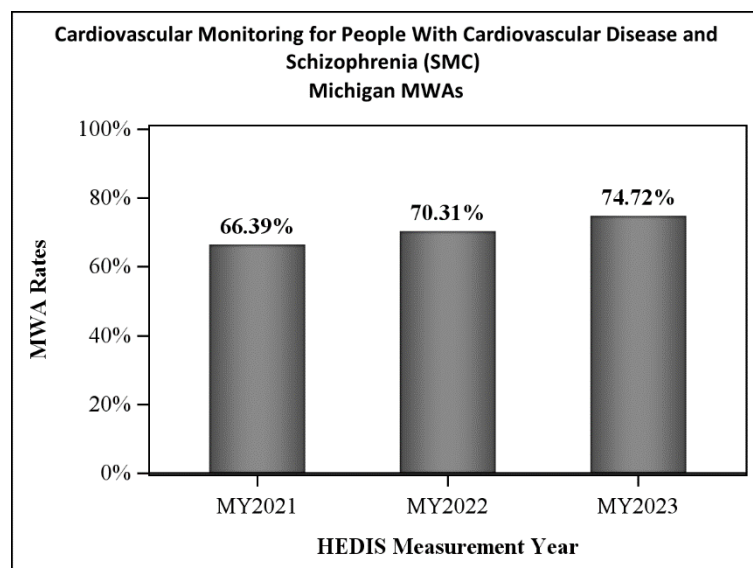
The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



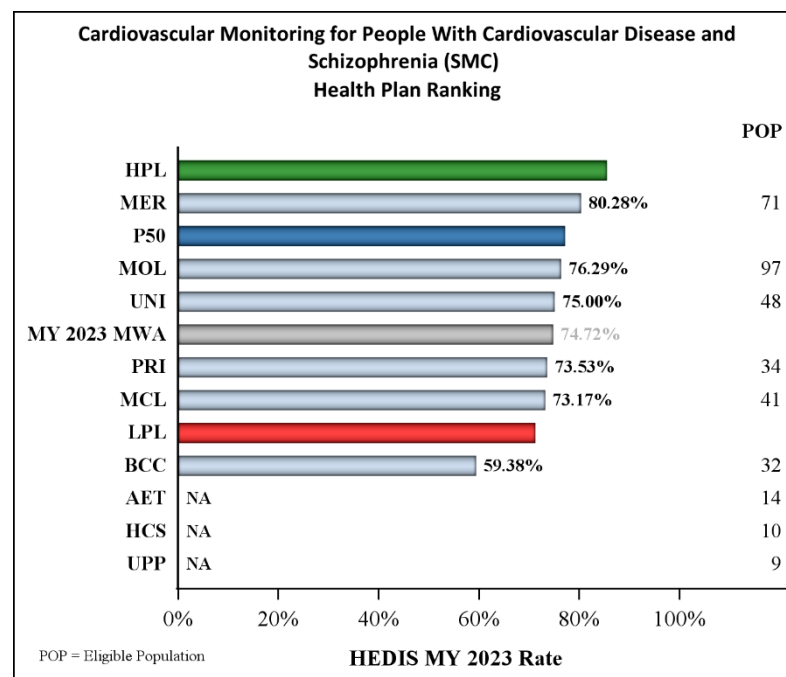
Seven MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Two MHPs ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 7 percentage points.

Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC) assesses the percentage of members 18 to 64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease who had an LDL-C test during the MY.



The HEDIS MY 2023 MWA rate did not demonstrate a significant change from HEDIS MY 2022.

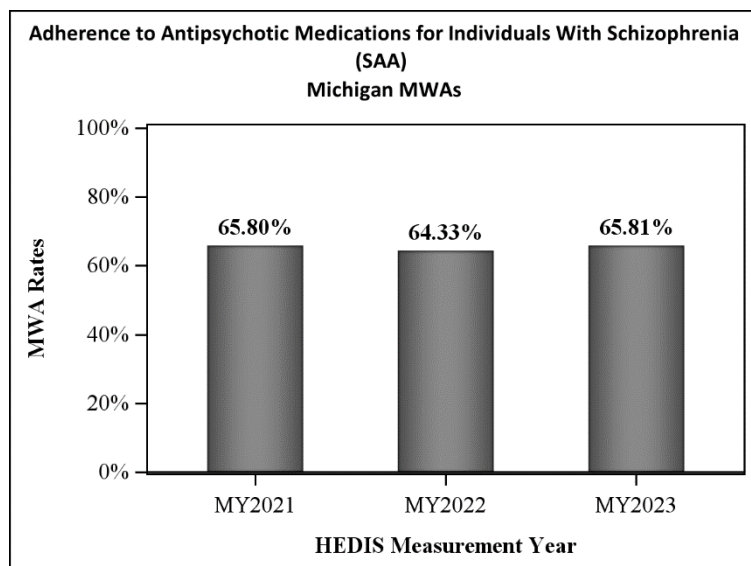


NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

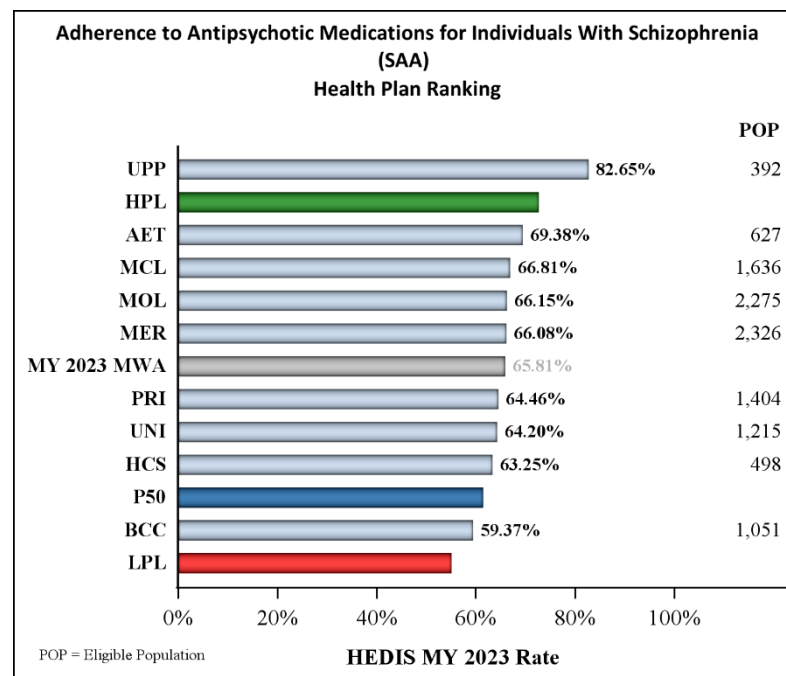
One MHP ranked above the 50th percentile but fell below the HPL. Four MHPs and the MWA ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 20 percentage points.

Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)

Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA) assesses the percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.



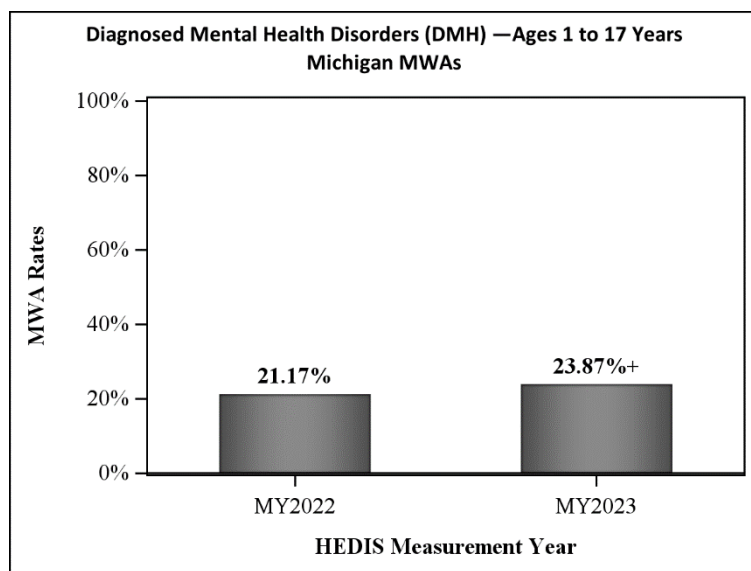
The HEDIS MY 2023 MWA rate did not demonstrate a significant change from HEDIS MY 2022.



One MHP ranked above the HPL. Seven MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 23 percentage points.

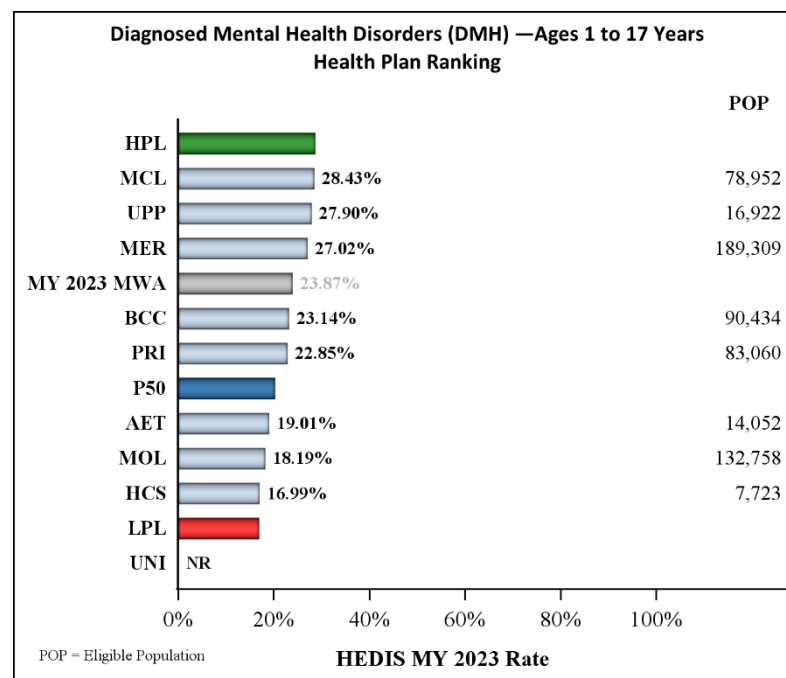
Diagnosed Mental Health Disorders (DMH)—Ages 1 to 17 Years

Diagnosed Mental Health Disorders (DMH)—Ages 1 to 17 Years assesses the percentage of members ages 1 to 17 years who were diagnosed with a mental health disorder during the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.

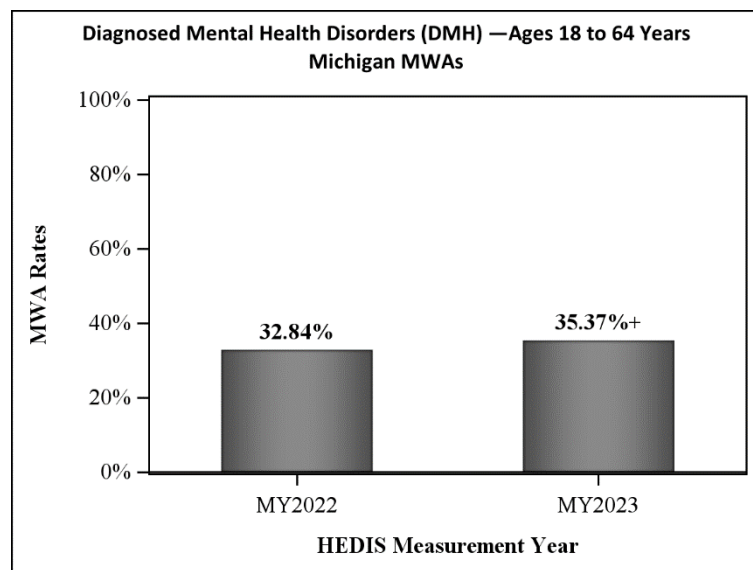


NR indicates one of the following designations: The MHP chose not to report the required measure indicator rate, or the MHP's reported rate was invalid.

Five MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Three MHPs ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 11 percentage points.

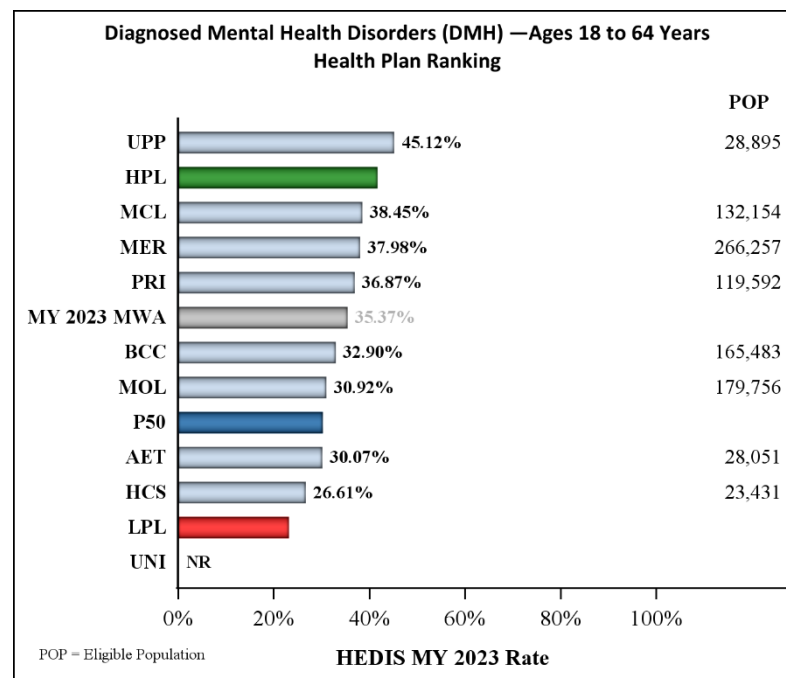
Diagnosed Mental Health Disorders (DMH)—Ages 18 to 64 Years

Diagnosed Mental Health Disorders (DMH)—Ages 18 to 64 Years assesses the percentage of members 18 to 64 years of age who were diagnosed with a mental health disorder during the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.

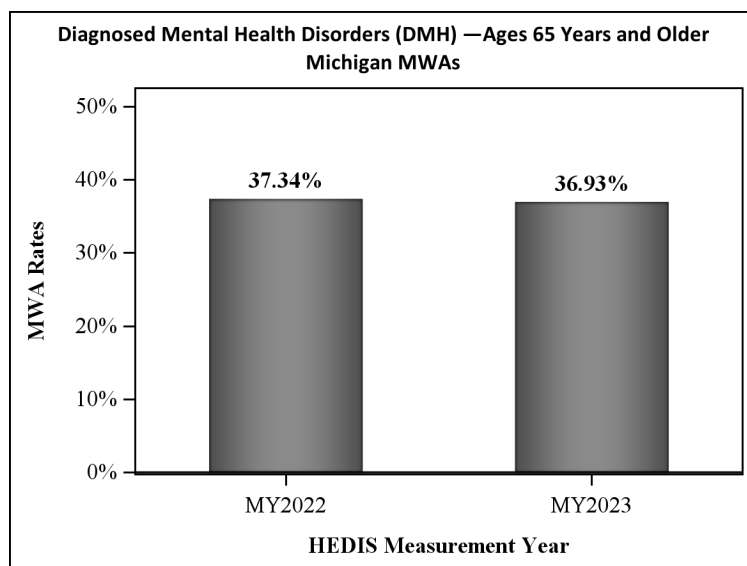


NR indicates one of the following designations: The MHP chose not to report the required measure indicator rate, or the MHP's reported rate was invalid.

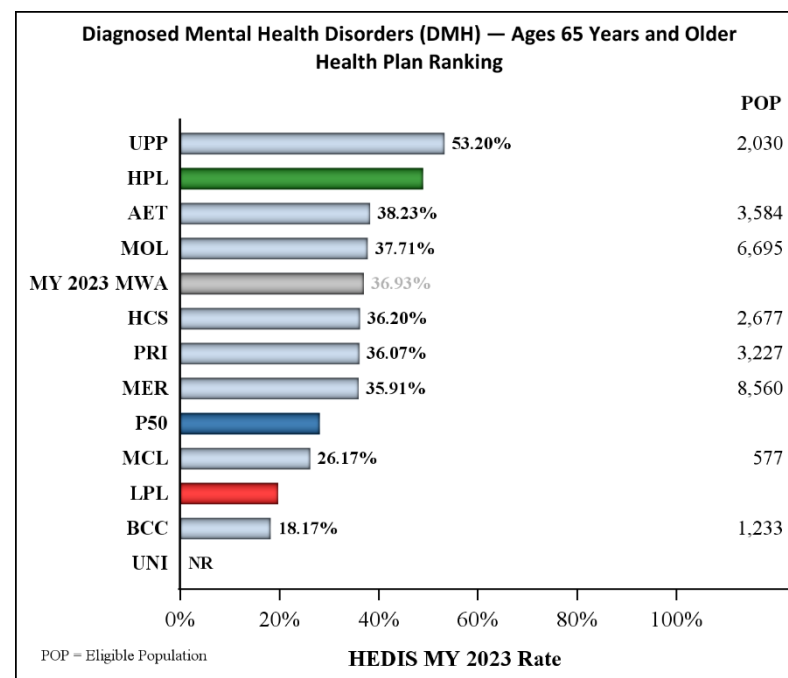
One MHP ranked above the HPL. Five MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Two MHPs ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 18 percentage points.

Diagnosed Mental Health Disorders (DMH)—Ages 65 Years and Older

Diagnosed Mental Health Disorders (DMH)—Ages 65 Years and Older assesses the percentage of members 65 years of age and older who were diagnosed with a mental health disorder during the measurement year.



The HEDIS MY 2023 MWA did not demonstrate a significant change from HEDIS MY 2022.

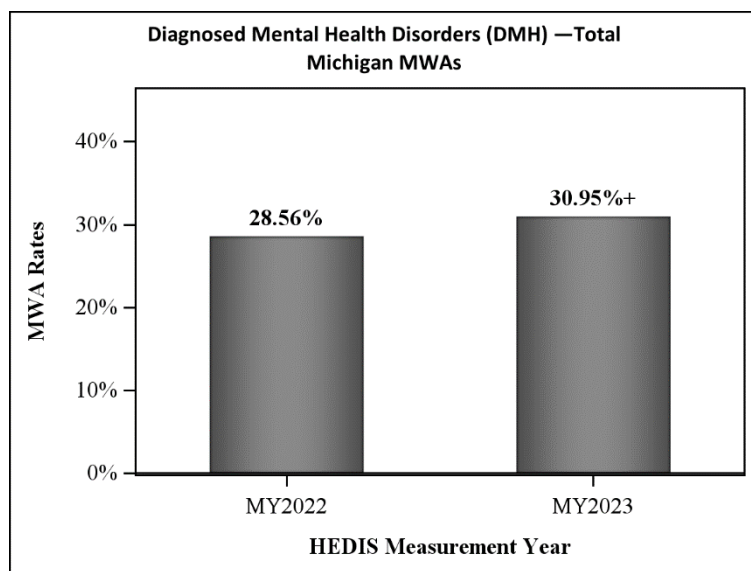


NR indicates one of the following designations: The MHP chose not to report the required measure indicator rate, or the MHP's reported rate was invalid.

One MHP ranked above the HPL. Five MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 35 percentage points.

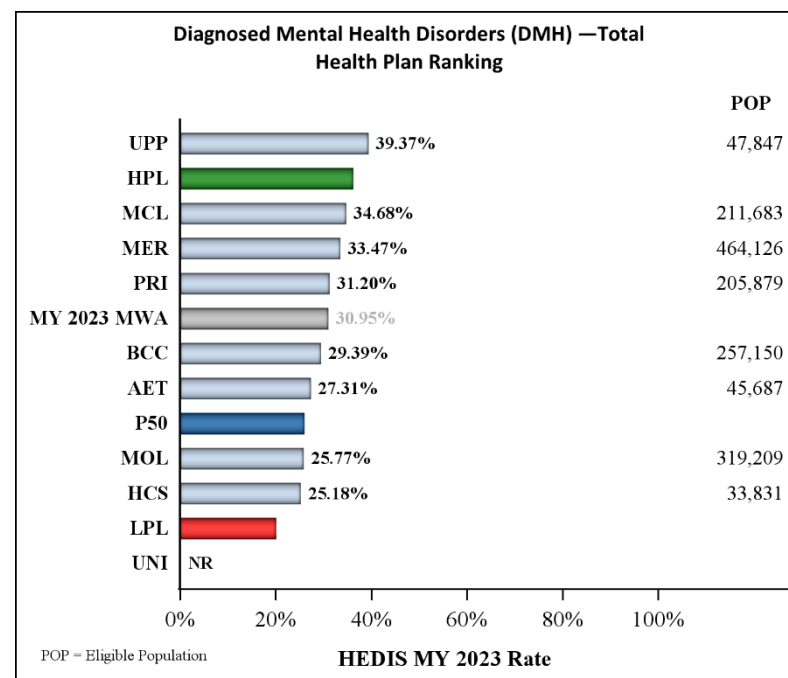
Diagnosed Mental Health Disorders (DMH)—Total

Diagnosed Mental Health Disorders (DMH)—Total assesses the total percentage of members 1 year of age and older who were diagnosed with a mental health disorder during the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2023 MWA rate significantly improved from HEDIS MY 2022.



NR indicates one of the following designations: The MHP chose not to report the required measure indicator rate, or the MHP's reported rate was invalid.

One MHP ranked above the HPL. Five MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Two MHPs ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 14 percentage points.

9. Health Plan Diversity

Introduction

The Health Plan Diversity domain encompasses the following HEDIS measures:

- *Race/Ethnicity Diversity of Membership (RDM)*
- *Language Diversity of Membership (LDM)—Spoken Language Preferred for Health Care, Language Preferred for Written Materials, and Other Language Needs*

Summary of Findings

Although measures under this domain are not performance measures and are not compared to percentiles, changes observed in the results may provide insight into how select member characteristics affect the MHPs' provision of services and care. The *Race/Ethnicity Diversity of Membership* measure shows that the HEDIS MY 2023 MWA rates for different racial/ethnic groups were fairly stable across years, with less than 3 percentage points difference between MY 2022 and MY 2023 for all racial/ethnic groups.

For the *Language Diversity of Membership* measure, MY 2023 rates remained similar to prior years, with Michigan members reporting English as the preferred spoken language for healthcare and preferred language for written materials, with less than 1 percentage point difference between MY 2022 and MY 2023.

Race/Ethnicity Diversity of Membership

Measure Definition

Race/Ethnicity Diversity of Membership is an unduplicated count and percentage of members enrolled at any time during the MY, by race and ethnicity.

Results

Table 9-1a and Table 9-1b show that the statewide rates for reported racial/ethnic groups remained similar to prior years.

Table 9-1a—MHP and MWA Results for Race/Ethnicity Diversity of Membership (RDM)

Plan	Eligible Population	White—Rate	Black or African American—Rate	American Indian and Alaska Native—Rate	Asian—Rate	Native Hawaiian and Other Pacific Islander—Rate
AET	68,498	33.38%	51.51%	0.38%	1.40%	0.08%
BCC	384,330	52.36%	34.39%	1.23%	2.43%	2.30%
HCS	52,156	41.05%	45.48%	0.48%	2.03%	0.12%
MCL	300,748	69.06%	21.14%	1.11%	1.08%	0.12%
MER	616,854	64.51%	23.64%	0.93%	1.20%	0.11%
MOL	435,074	25.29%	0.52%	10.94%	1.00%	0.01%
PRI	312,320	62.32%	26.24%	0.85%	1.95%	0.12%
UNI	349,279	57.09%	30.60%	0.64%	2.47%	0.13%
UPP	67,477	89.97%	1.98%	4.04%	0.52%	0.16%
HEDIS MY 2023 MWA		54.74%	22.92%	2.69%	1.60%	0.43%
HEDIS MY 2022 MWA		55.14%	25.81%	0.86%	1.10%	0.44%
HEDIS MY 2021 MWA		57.88%	28.72%	0.88%	0.98%	0.49%

Table 9-1b—MHP and MWA Results for Race/Ethnicity Diversity of Membership (RDM)

Plan	Some Other Race—Rate	Two or More Races—Rate	Ethnicity Reporting Category: Hispanic or Latino—Rate	Unknown—Rate	Declined—Rate
AET	7.07%	0.00%	3.74%	6.19%	0.00%
BCC	0.00%	0.03%	7.60%	<0.01%	7.25%
HCS	2.85%	0.00%	3.31%	7.95%	0.03%
MCL	0.00%	0.00%	6.75%	7.49%	0.00%
MER	6.90%	<0.01%	0.10%	2.71%	0.00%
MOL	<0.01%	0.00%	7.06%	62.23%	<0.01%
PRI	<0.01%	0.00%	8.96%	8.51%	0.00%
UNI	8.83%	0.00%	6.79%	0.24%	0.00%
UPP	0.08%	0.00%	2.50%	0.00%	3.24%
HEDIS MY 2023 MWA	3.09%	<0.01%	5.35%	13.37%	1.16%
HEDIS MY 2022 MWA	3.28%	<0.01%	3.63%	13.21%	0.15%
HEDIS MY 2021 MWA	0.08%	<0.01%	1.76%	10.57%	0.40%

* Starting from HEDIS 2011, the rates associated with members of Hispanic origin were not based on the total number of members in the health plan. Therefore, HSAG calculated the rates presented here using the total number of members reported from the Hispanic or Latino column divided by the total number of members in the health plan reported in the MHP IDSS files.

Language Diversity of Membership

Measure Definition

Language Diversity of Membership is an unduplicated count and percentage of members enrolled at any time during the MY by spoken language preferred for healthcare, the preferred language for written materials, and the preferred language for other language needs.

Results

Table 9-2 shows that the percentage of Michigan members using English as the preferred spoken language for healthcare decreased slightly (less than 1 percentage point) when compared to MY 2022 but remains the preferred spoken language for healthcare at the statewide level.

**Table 9-2—MHP and MWA Results for Language Diversity of Membership (LDM)—
Spoken Language Preferred for Healthcare**

Plan	Eligible Population	Spoken Language Preferred for Health Care—English—Rate	Spoken Language Preferred for Health Care—Non-English—Rate	Spoken Language Preferred for Health Care—Unknown—Rate	Spoken Language Preferred for Health Care—Declined—Rate
AET	68,498	0.00%	0.00%	100.00%	0.00%
BCC	384,330	96.05%	3.86%	0.10%	0.00%
HCS	52,156	97.75%	0.92%	1.33%	0.00%
MCL	300,748	98.73%	1.10%	0.18%	0.00%
MER	616,854	97.79%	1.65%	0.57%	0.00%
MOL	435,074	98.10%	1.88%	0.02%	0.00%
PRI	312,320	0.00%	0.00%	100.00%	0.00%
UNI	349,279	95.99%	4.00%	<0.01%	0.00%
UPP	67,477	99.85%	0.13%	0.01%	0.00%
HEDIS MY 2023 MWA		83.10%	1.97%	14.92%	0.00%
HEDIS MY 2022 MWA		83.58%	1.80%	14.62%	0.00%
HEDIS MY 2021 MWA		78.95%	1.23%	19.82%	0.00%

Table 9-3 shows that for each MHP, Michigan members who reported a language reported English as the language preferred for written materials. At the statewide level, English remained the preferred language for written materials for over 70 percent of Michigan members from MY 2021 to MY 2023.

**Table 9-3—MHP and MWA Results for Language Diversity of Membership (LDM)—
Language Preferred for Written Materials**

Plan	Eligible Population	Language Preferred for Written Materials—English—Rate	Language Preferred for Written Materials—Non-English—Rate	Language Preferred for Written Materials—Unknown—Rate	Language Preferred for Written Materials—Declined—Rate
AET	68,498	0.00%	0.00%	100.00%	0.00%
BCC	384,330	96.24%	3.69%	0.07%	0.00%
HCS	52,156	97.75%	0.92%	1.33%	0.00%
MCL	300,748	98.73%	1.10%	0.18%	0.00%
MER	616,854	97.79%	1.65%	0.57%	0.00%
MOL	435,074	98.10%	1.88%	0.02%	0.00%
PRI	312,320	0.00%	0.00%	100.00%	0.00%
UNI	349,279	0.00%	0.00%	100.00%	0.00%
UPP	67,477	99.85%	0.13%	0.01%	0.00%
HEDIS MY 2023 MWA		70.17%	1.41%	28.42%	0.00%
HEDIS MY 2022 MWA		83.59%	1.77%	14.63%	0.00%
HEDIS MY 2021 MWA		73.60%	1.19%	25.21%	0.00%

Table 9-4 shows that at the statewide level, Michigan members reported English as their preferred language for other language needs, and the Michigan members who listed Unknown as their preferred language for other language needs significantly increased from the prior year. Please note that *Language Diversity of Membership—Other Language Needs* captures data collected from questions that cannot be mapped to any other category (e.g., What is the primary language spoken at home?).

Table 9-4—MHP and MWA Results for Language Diversity of Membership (LDM)—Other Language Needs

Plan	Eligible Population	Other Language Needs—English—Rate	Other Language Needs—Non-English—Rate	Other Language Needs—Unknown—Rate	Other Language Needs—Declined—Rate
AET	68,498	96.48%	1.32%	2.20%	0.00%
BCC	384,330	98.23%	1.76%	<0.01%	0.00%
HCS	52,156	97.75%	0.92%	1.33%	0.00%
MCL	300,748	0.00%	0.00%	100.00%	0.00%
MER	616,854	97.79%	1.65%	0.57%	0.00%
MOL	435,074	98.10%	1.88%	0.02%	0.00%
PRI	312,320	0.00%	0.00%	100.00%	0.00%
UNI	349,279	0.00%	0.00%	100.00%	0.00%
UPP	67,477	0.00%	0.00%	100.00%	0.00%
HEDIS MY 2023 MWA		58.94%	1.02%	40.04%	0.00%
HEDIS MY 2022 MWA		72.54%	1.45%	26.01%	0.00%
HEDIS MY 2021 MWA		73.38%	1.16%	25.46%	0.00%

Introduction

The Utilization domain encompasses the following HEDIS measures:

- *Ambulatory Care (AMB)—ED Visits—Total and Outpatient Visits—Total*
- *Inpatient Utilization (IPU)—General Hospital/Acute Care—Discharges—Total Inpatient—Total All Ages, Average Length of Stay—Total Inpatient—Total All Ages, Discharges—Maternity—Total All Ages, Average Length of Stay—Maternity—Total All Ages, Discharges—Surgery—Total All Ages, Average Length of Stay—Surgery—Total All Ages, Discharges—Medicine—Total All Ages, and Average Length of Stay—Medicine—Total All Ages*
- *Use of Opioids From Multiple Providers (UOP)—Multiple Prescribers, Multiple Pharmacies, and Multiple Prescribers and Multiple Pharmacies*
- *Use of Opioids at High Dosage (HDO)*
- *Risk of Continued Opioid Use (COU)—At Least 15 Days Covered—Total and At Least 31 Days Covered—Total*
- *Plan All-Cause Readmissions (PCR)—Observed Readmissions—Total, Expected Readmissions—Total, and O/E Ratio—Total*

The following tables present the HEDIS MY 2023 MHP-specific rates as well as the MWA or MA for HEDIS MY 2023, HEDIS MY 2022, and HEDIS MY 2021, where applicable. To align with calculations from prior years, HSAG calculated traditional averages for the *Ambulatory Care—Total* and *Inpatient Utilization—General Hospital/Acute Care—Total* measure indicators in the Utilization domain; therefore, the MA is presented for those two measures rather than the MWA, which was calculated and presented for all other measures. The *Ambulatory Care* and *Inpatient Utilization* measures are designed to describe the frequency of specific services provided by the MHPs and are not risk adjusted. Therefore, it is important to assess utilization supplemented by information on the characteristics of each MHP's population.

Summary of Findings

Reported rates for the MHPs and MWA rates for the *Ambulatory Care* and *Inpatient Utilization* measures do not take into account the characteristics of the population; therefore, HSAG could not draw conclusions on performance based on these measures. For the *Plan All-Cause Readmissions* measure, six MHPs had an O/E ratio less than 1.0, indicating that these MHPs had fewer observed readmissions than were expected based on patient mix. The remaining three MHPs had an O/E ratio greater than 1.0, indicating they had more readmissions.

Measure-Specific Findings

Ambulatory Care—Total

The *Ambulatory Care—Total* measure summarizes utilization of ambulatory care for *ED Visits—Total* and *Outpatient Visits—Total*. In this section, the results for the total age group are presented. Of note, while the MHPs’ reporting was based on member months during the measurement year, the *ED Visits—Total* and *Outpatient Visits—Total* measure indicator rates are based on per 1,000 member years, in alignment with NCQA’s changes to the technical specifications.

Results

Table 10-1 shows *ED Visits—Total* and *Outpatient Visits—Total* per 1,000 member years for ambulatory care for the total age group.

Table 10-1—Ambulatory Care—Total for Total Age Group (AMB)

Plan	Eligible Population	Emergency Department Visits±—Rate	Outpatient Visits—Rate
AET	674,804	731.27	4,366.73
BCC	3,840,341	552.88	4,328.00
HCS	508,767	577.42	4,669.76
MCL	3,066,786	617.88	4,865.68
MER	6,529,441	626.26	4,528.93
MOL	4,525,180	586.22	3,818.73
PRI	3,089,270	626.37	6,002.21
UNI	3,528,322	608.23	4,350.71
UPP	694,612	602.62	4,017.25
HEDIS MY 2023 MWA		606.52	4,550.73
HEDIS MY 2022 MWA		613.30	4,893.15
HEDIS MY 2021 MWA		596.47	4,974.16

± Awareness is advised when interpreting results for this indicator as a lower rate is a higher percentile.

For the *ED Visits—Total* measure indicator, the MA increased by 10.5 visits per 1,000 member years from HEDIS MY 2021 to HEDIS MY 2023. The MA for the *Outpatient Visits—Total* measure indicator decreased from HEDIS MY 2021 to HEDIS MY 2023 by 423.43 visits per 1,000 member years.

Inpatient Utilization—General Hospital/Acute Care—Total

The *Inpatient Utilization—General Hospital/Acute Care—Total* measure summarizes utilization of acute inpatient care and services in four categories: *Total Inpatient*, *Maternity*, *Surgery*, and *Medicine*. Of note, while the MHPs’ reporting was based on member months during the measurement year, the *Total Discharges* measure indicator rates are based on per 1,000 member years, in alignment with NCQA’s changes to the technical specifications.

Results

Table 10-2 shows the member months for all ages and the *Total Discharges* per 1,000 member years for the total age group. The values in the table below are presented for information only.

Table 10-2—Inpatient Utilization—General Hospital/Acute Care: Total Discharges for Total Age Group (IPU)

Plan	Eligible Population	Discharges— Total Inpatient— Total All Ages —Rate	Discharges— Maternity—Total All Ages —Rate*	Discharges— Surgery— Total All Ages —Rate	Discharges— Medicine—Total All Ages —Rate
AET	674,804	92.99	20.68	25.77	51.87
BCC	3,840,341	66.06	23.37	16.05	31.75
HCS	508,767	94.91	19.93	24.62	54.79
MCL	3,066,786	70.55	22.01	18.38	34.99
MER	6,529,441	69.86	22.27	17.44	35.72
MOL	4,525,180	63.80	23.61	14.79	31.31
PRI	3,089,270	56.94	22.43	14.14	25.92
UNI	3,528,322	59.57	20.28	14.56	29.43
UPP	694,612	68.08	18.02	20.25	34.22
HEDIS MY 2023 MWA		66.50	22.18	16.55	33.06
HEDIS MY 2022 MWA		68.34	23.75	15.56	34.79
HEDIS MY 2021 MWA		76.31	25.59	17.69	39.41

* The Maternity measure indicators were calculated using member months for members 10 to 64 years of age.

Table 10-3 displays the *Total Average Length of Stay* for all ages. The values in the table are presented for information only.

Table 10-3—Inpatient Utilization—General Hospital/Acute Care: Total Average Length of Stay for Total Age Group (IPU)

Plan	Eligible Population	Average Length of Stay— Total Inpatient— Total All Ages —Rate	Average Length of Stay— Maternity— Total All Ages —Rate	Average Length of Stay —Surgery —Total All Ages —Rate	Average Length of Stay —Medicine —Total All Ages —Rate
AET	674,804	6.23	2.61	9.95	5.45
BCC	3,840,341	4.80	2.79	7.69	4.50
HCS	508,767	5.25	2.63	8.29	4.63
MCL	3,066,786	4.45	2.44	6.68	4.26
MER	6,529,441	4.75	2.78	7.67	4.25
MOL	4,525,180	4.98	2.79	8.73	4.44
PRI	3,089,270	4.80	2.90	7.94	4.33
UNI	3,528,322	4.78	2.45	7.76	4.53
UPP	694,612	5.06	2.58	7.55	4.57
HEDIS MY 2023 MWA		4.84	2.71	7.85	4.43
HEDIS MY 2022 MWA		5.00	2.61	8.45	4.69
HEDIS MY 2021 MWA		4.83	2.61	8.16	4.41

Use of Opioids From Multiple Providers

The *Use of Opioids From Multiple Providers* summarizes the proportion of members 18 years of age and older, receiving prescription opioids for ≥ 15 days during the MY, who received opioids from multiple providers. Three rates are reported: *Multiple Prescribers*, *Multiple Pharmacies*, and *Multiple Prescribers and Multiple Pharmacies*.

Results

Table 10-4 shows the HEDIS MY 2023 rates for receiving prescription opioids. The values in the table below are presented for information only.

Table 10-4—Use of Opioids From Multiple Providers (UOP)*

Plan	Eligible Population	Multiple Prescribers —Rate	Multiple Pharmacies —Rate	Multiple Prescribers and Multiple Pharmacies —Rate
AET	2,084	16.17%	4.32%	3.02%
BCC	7,919	17.14%	3.33%	2.07%
HCS	1,395	15.41%	2.37%	1.65%
MCL	7,190	15.13%	3.02%	1.45%
MER	18,182	13.12%	1.90%	1.01%
MOL	11,633	15.40%	2.93%	1.85%
PRI	5,977	19.84%	2.09%	1.09%
UNI	7,823	15.85%	2.44%	1.25%
UPP	2,131	18.25%	7.04%	4.46%
HEDIS MY 2023 MWA		15.53%	2.73%	1.57%
HEDIS MY 2022 MWA		15.13%	2.54%	1.46%
HEDIS MY 2021 MWA		15.03%	2.32%	1.52%

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

Use of Opioids at High Dosage

The *Use of Opioids at High Dosage* summarizes the proportion of members 18 years of age and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥ 90) for ≥ 15 days during the MY.

Results

Table 10-5 shows the HEDIS MY 2023 rates for members receiving prescription opioids at a high dosage. The values in the table below are presented for information only.

Table 10-5—Use of Opioids at High Dosage (HDO)*

Plan	Use of Opioids at High Dosage—Eligible Population	Use of Opioids at High Dosage—Rate
AET	1,751	2.28%
BCC	6,989	0.84%
HCS	1,126	1.60%
MCL	6,386	1.22%
MER	16,316	1.04%
MOL	10,248	1.12%
PRI	5,272	1.59%
UNI	6,823	1.86%
UPP	1,866	2.41%
HEDIS MY 2023 MWA		1.30%
HEDIS MY 2022 MWA		1.53%
HEDIS MY 2021 MWA		3.98%

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

Risk of Continued Opioid Use

The *Risk of Continued Opioid Use* summarizes new episodes of opioid use that put members 18 years of age and older at risk for continued opioid use.

Results

Table 10-6 shows the HEDIS MY 2023 rates for members whose new episode lasted at least 15 days in a 30-day period and at least 31 days in a 62-day period. The values in the table below are presented for information only.

Table 10-6—Risk of Continued Opioid Use (COU)*

Plan	Eligible Population	At Least 15 Days Covered —Total—Rate	At Least 31 Days Covered —Total—Rate
AET	3,252	9.13%	6.58%
BCC	18,158	7.40%	5.09%
HCS	2,410	11.83%	6.56%
MCL	15,290	6.45%	4.55%
MER	30,266	14.83%	9.67%
MOL	20,260	10.85%	5.73%
PRI	12,310	10.37%	5.22%
UNI	15,119	8.74%	6.00%
UPP	3,782	7.75%	4.97%
HEDIS MY 2023 MWA		10.33%	6.47%
HEDIS MY 2022 MWA		11.17%	6.66%
HEDIS MY 2021 MWA		10.78%	7.10%

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

Plan All-Cause Readmissions

The *Plan All-Cause Readmissions* measure summarizes the percentage of inpatient hospital admissions for members 18 years of age and older that result in an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. This measure is risk-adjusted, so an O/E ratio is also calculated that indicates whether an MHP had more readmissions (O/E ratio greater than 1.0) or fewer readmissions (O/E ratio less than 1.0) than expected based on population mix.

Results

Table 10-7 shows the HEDIS MY 2023 observed rates, expected rates, and the O/E ratio for inpatient hospital admissions that were followed by an unplanned readmission for any diagnosis within 30 days.

Table 10-7—Plan All-Cause Readmissions (PCR)*

Plan	Eligible Population	Observed Readmissions —Total—Rate	Expected Readmissions —Total—Rate	OE Ratio— Total—Rate
AET	1,307	13.39%	10.73%	1.2484
BCC	7,864	11.55%	10.31%	1.1200
HCS	1,146	9.60%	10.19%	0.9415
MCL	12,099	8.52%	9.38%	0.9089
MER	14,454	11.29%	10.40%	1.0855
MOL	14,653	8.38%	9.67%	0.8666
PRI	7,853	7.59%	9.69%	0.7829
UNI	6,013	10.24%	10.65%	0.9619
UPP	1,503	7.12%	9.70%	0.7340
HEDIS MY 2023 MWA		9.57%	9.97%	0.9600
HEDIS MY 2022 MWA		9.83%	10.05%	0.9784
HEDIS MY 2021 MWA		9.21%	9.81%	0.9386

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

The rates of observed readmissions ranged from 7.12 percent for UPP to 13.39 percent for AET; however, three of the nine MHPs had an O/E ratio greater than 1.0, indicating that these MHPs had more readmissions. The remaining six MHPs had an O/E ratio less than 1.0, indicating that these MHPs had fewer observed readmissions than were expected based on patient mix.

11. HEDIS Reporting Capabilities—Information Systems Findings

HEDIS Reporting Capabilities—Information Systems Findings

NCQA's IS standards are the guidelines that certified HEDIS compliance auditors use to assess an MHP's ability to report HEDIS data accurately and reliably.²⁵ Compliance with the guidelines also helps an auditor to understand an MHP's HEDIS reporting capabilities. For HEDIS MY 2023, MHPs were assessed on four IS standards. To assess an MHP's adherence to the IS standards, HSAG reviewed several documents for the MHPs. These included the MHPs' final audit reports (FARs), IS compliance tools, and the IDSS files approved by their respective NCQA-licensed audit organization (LO).

All nine of the Michigan MHPs that underwent NCQA HEDIS Compliance Audits in Michigan in 2023 contracted with the same LOs in 2024. The MHPs were able to select their preferred LO. Overall, the Michigan MHPs have continued to consistently maintain the same LOs across reporting years.

For HEDIS MY 2023, all MHPs contracted with external software vendors for HEDIS measure production and rate calculation. HSAG reviewed the MHPs' FARs and ensured that these software vendors participated in and passed the NCQA Measure CertificationSM process.²⁶ MHPs could purchase the software containing HEDIS Certified MeasuresSM²⁷ and generate measure results internally or provide all data to the software vendor to generate HEDIS Certified Measures for them. Either way, using software containing HEDIS Certified Measures may reduce the MHPs' burden for reporting and help ensure rate validity. For the MHP that calculated its rate using internally developed source code, the auditor selected a core set of measures and manually reviewed the programming code to verify accuracy and compliance with HEDIS MY 2023 technical specifications.

HSAG found that, in general, all MHPs' IS and processes were compliant with the applicable IS standards and the HEDIS determination reporting requirements related to the measures for HEDIS MY 2023. The following sections present NCQA's IS standards and summarize the audit findings related to each IS standard for the MHPs.

IS R—Data Management and Reporting

This standard assesses whether:

- The organization's data management enables measurement.
- Data extraction and loads are complete and accurate.

²⁵ National Committee for Quality Assurance. *HEDIS® MY 2023, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures*. Washington D.C.

²⁶ NCQA Measure CertificationSM is a service mark of the NCQA.

²⁷ HEDIS Certified MeasuresSM is a service mark of the NCQA.

- Data transformation and integration is accurate and valid.
- Data quality and governance are components of the organization's data management.
- Oversight and controls ensure correct implementation of measure reporting software.

All MHPs were fully compliant with *IS R, Data Management and Reporting*.

IS C—Clinical and Care Delivery Data

This standard assesses whether:

- Data capture is complete.
- Data conform with industry standards.
- Transaction file data are accurate.
- The organization confirms ingested data meet expectations for data quality.

All MHPs were fully compliant with *IS C, Clinical and Care Delivery Data*.

IS M—Medical Record Review Processes

This standard assesses whether:

- Forms capture all fields relevant to measure reporting. Electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off, and sign-off).
- Retrieval and abstraction of data from medical records is reliably and accurately performed.
- Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in the files for measure reporting.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

All MHPs except **UPP** were fully compliant with *IS M, Medical Record Review Processes*. During the medical record review validation (MRRV), the audit team identified one exclusion error for a measure. This case was removed and returned to the sample. The audit team reviewed the remaining exclusions that were not selected in the original sample and approved them. **UPP** was partially compliant with this standard, and there was minimal impact on HEDIS reporting.

IS A—Administrative Data

This standard assesses whether:

- Data conform with industry standards and measure requirements.

- Data are complete and accurate.
- The membership information system enables measurement.

All MHPs were fully compliant with *IS A, Administrative Data*.

Glossary

Table 12-1 provides definitions of terms and acronyms used throughout this report.

Table 12-1—Definition of Terms

Term	Description
ADHD	Attention-deficit/hyperactivity disorder.
Audit Result	The HEDIS auditor’s final determination, based on audit findings, of the appropriateness of the MHP to publicly report its HEDIS measure rates. Each measure indicator rate included in the HEDIS audit receives an audit result of <i>Reportable (R)</i> , <i>Small Denominator (NA)</i> , <i>Biased Rate (BR)</i> , <i>No Benefit (NB)</i> , <i>Not Required (NQ)</i> , <i>Not Reported (NR)</i> , and <i>Un-Audited (UN)</i> .
ADMIN%	Percentage of the rate derived using administrative data (e.g., claims data and immunization registry).
BMI	Body mass index.
BR	Biased Rate; indicates that the MHP’s reported rate was invalid; therefore, the rate was not presented.
CDC	Centers for Disease Control and Prevention.
Data Completeness	The degree to which occurring services/diagnoses appear in the MHP’s administrative data systems.
Denominator	The number of members who meet all criteria specified in a measure for inclusion in the eligible population. When using the administrative method, the entire eligible population becomes the denominator. When using the hybrid method, a sample of the eligible population becomes the denominator.
DTaP	Diphtheria, tetanus, and acellular pertussis vaccine.
ED	Emergency department.
eGFR	Estimated glomerular filtration rate.
Encounter Data	Billing data received from a capitated provider. (Although the MHP does not reimburse the provider for each encounter, submission of encounter data allows the MHP to collect the data for future HEDIS reporting.)
FAR	Following the MHP’s completion of any corrective actions, an auditor completes the final audit report (FAR), documenting all final findings and results of the HEDIS audit. The FAR includes a summary report, IS capabilities assessment, medical record review validation (MRRV) findings, measure results, and the auditor’s audit opinion (the final audit statement).
HEDIS	The Healthcare Effectiveness Data and Information Set (HEDIS), developed and maintained by NCQA, is a set of performance measures used to assess the quality of care provided by managed health care organizations.

Term	Description
HEDIS Repository	The data warehouse where all data used for HEDIS reporting are stored.
HepA	Hepatitis A vaccine.
HepB	Hepatitis B vaccine.
HiB Vaccine	Haemophilus influenza type B vaccine.
HMO	Health maintenance organization.
HPL	High performance level. (For most performance measures, MDHHS defined the HPL as the most recent national Medicaid 90th percentile. For measures such as <i>Comprehensive Diabetes Care—HbA1c Poor Control</i> [$>9.0\%$], in which lower rates indicate better performance, the 10th percentile [rather than the 90th percentile] is considered the HPL.)
HPV	Human papillomavirus.
hrHPV	High-risk human papillomavirus.
HSAG	Health Services Advisory Group, Inc., the State's external quality review organization.
Hybrid Measures	Measures that can be reported using the hybrid method.
IDSS	The Interactive Data Submission System, a tool used to submit data to NCQA.
IPV	Inactivated polio virus vaccine.
IS	Information system: an automated system for collecting, processing, and transmitting data.
IS Standards	Information System (IS) standards: an NCQA-defined set of standards that measure how an organization collects, stores, analyzes, and reports medical, customer service, member, practitioner, and vendor data. ²⁸
LDL	Low-density lipoprotein
LPL	Low performance level. (For most performance measures, MDHHS defined the LPL as the most recent national Medicaid 25th percentile. For measures such as <i>Comprehensive Diabetes Care—HbA1c Poor Control</i> [$>9.0\%$], in which lower rates in indicate better performance, the 75th percentile [rather than the 25th percentile] is considered the LPL).
Material Bias	For most measures reported as a rate, any error that causes a ± 5 percent difference in the reported rate is considered materially biased. For non-rate measures, any error that causes a ± 10 percent difference in the reported rate or calculation is considered materially biased.
Medical Record Validation	The process that the MHP's medical record abstraction staff uses to identify numerator positive cases.

²⁸ National Committee for Quality Assurance. *HEDIS® MY 2023, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures*. Washington D.C.

Term	Description
Medicaid Percentiles	The NCQA national percentiles for each HEDIS measure for the Medicaid product line used to compare the MHP's performance and assess the reliability of the MHP's HEDIS rates.
MA	Medicaid Average.
MDHHS	Michigan Department of Health and Human Services.
MHP	Medicaid health plan.
MME	Morphine milligram equivalent.
MMR	Measles, mumps, and rubella vaccine.
MRR	Medical record review.
MRRV	Medical record review validation.
MWA	Medicaid Weighted Average.
MY	Measurement year.
NA	Small Denominator: indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in an NA designation.
NB	No Benefit: indicates that the required benefit to calculate the measure was not offered.
NCQA	The National Committee for Quality Assurance (NCQA) is a not-for-profit organization that assesses, through accreditation reviews and standardized measures, the quality of care provided by managed healthcare delivery systems; reports results of those assessments to employers, consumers, public purchasers, and regulators; and ultimately seeks to improve the healthcare provided within the managed care industry.
NR	Not Reported: indicates that the MHP chose not to report the required HEDIS 2019 measure indicator rate. This designation was assigned to rates during previous reporting years to indicate one of the following designations: The MHP chose not to report the required measure indicator rate, or the MHP's reported rate was invalid.
Numerator	The number of members in the denominator who received all the services as specified in the measure.
NQ	Not Required: indicates that the MHP was not required to report this measure.
OB/GYN	Obstetrician/Gynecologist.
O/E	Observed/Expected.
PCP	Primary care practitioner.
PCV	Pneumococcal conjugate vaccine.
POP	Eligible population.
Provider Data	Electronic files containing information about physicians such as type of physician, specialty, reimbursement arrangement, and office location.

Term	Description
Quality Compass	NCQA Quality Compass benchmark.
RV	Rotavirus vaccine.
Software Vendor	A third party, with source code certified by NCQA, that contracts with the MHP to write source code for HEDIS measures. (For the measures to be certified, the vendor must submit programming codes associated with the measure to NCQA for automated testing of program logic, and a minimum percentage of the measures must receive a “Pass” or “Pass With Qualifications” designation.)
Tdap	Tetanus, diphtheria toxoids, and acellular pertussis vaccine.
uACR	Urine albumin-creatinine ratio.
UN	Unaudited: indicates that the organization chose to report a measure that is not required to be audited. This result applies only to a limited set of measures.
URI	Upper respiratory infection.
VZV	Varicella zoster virus (chicken pox) vaccine.

Appendix A. Tabular Results

Appendix A presents tabular results for each measure indicator. Where applicable, the results provided include the eligible population and rate as well as the Michigan MWA for HEDIS MY 2021, HEDIS MY 2022, and HEDIS MY 2023. Yellow shading with one cross (+) indicates that the HEDIS MY 2023 rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

Child & Adolescent Care Performance Measure Results

Table A-1—MHP and MWA Results for Childhood Immunization Status (CIS)

Plan	Eligible Population	Combination 3 —Rate	Combination 7 —Rate	Combination 10 —Rate
AET	1,130	48.91%	36.98%	13.87%
BCC	6,756	60.34%	51.09%	23.60%
HCS	765	50.46%	41.31%	17.39%
MCL	5,136	58.88%	49.79%	21.87%
MER	11,232	55.47%	49.39%	23.60%
MOL	8,255	56.93%	48.18%	22.63%
PRI	5,349	68.13% ⁺	59.61% ⁺	34.06% ⁺
UNI	5,274	59.37%	48.66%	19.71%
UPP	1,082	61.74%	50.92%	24.03%
HEDIS MY 2023 MWA		58.72%	50.19%	23.67%
HEDIS MY 2022 MWA		57.62%	49.59%	25.29%
HEDIS MY 2021 MWA		55.46%	46.83%	27.22%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

Table A-2—MHP and MWA Results for Well-Child Visits in the First 30 Months of Life (W30)

Plan	Well-Child Visits in the First 15 Months—Six or More Well-Child Visits—Eligible Population	Well-Child Visits in the First 15 Months—Six or More Well-Child Visits—Rate	Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits—Eligible Population	Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits—Rate
AET	722	49.72%	1,056	50.85%
BCC	4,713	67.71% ⁺	6,337	67.86% ⁺
HCS	457	54.92%	646	59.13%
MCL	3,626	65.75% ⁺	4,880	66.45%
MER	8,130	63.67% ⁺	10,974	66.37%
MOL	6,046	61.48% ⁺	7,771	65.58%
PRI	3,734	66.39% ⁺	5,043	69.86% ⁺
UNI	3,871	64.92% ⁺	5,060	63.62%
UPP	747	72.82% ⁺	1,064	72.18% ⁺
HEDIS MY 2023 MWA		64.33%⁺		66.19%
HEDIS MY 2022 MWA		60.06%		60.86%
HEDIS MY 2021 MWA		58.84%		60.99%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

Table A-3—MHP and MWA Results for Lead Screening in Children (LSC)

Plan	Lead Screening in Children—Eligible Population	Lead Screening in Children—Rate
AET	1,138	50.70%
BCC	6,797	57.22%
HCS	770	55.97%
MCL	5,165	51.89%
MER	11,274	58.30%
MOL	8,307	59.85%
PRI	5,378	65.94% ⁺
UNI	5,307	58.39%
UPP	1,086	59.12%
HEDIS MY 2023 MWA		58.40%
HEDIS MY 2022 MWA		54.78%
HEDIS MY 2021 MWA		54.69%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

Table A-4—MHP and MWA Results for Child and Adolescents Well-Care Visits (WCV) (Table 1 of 2)

Plan	Ages 3 to 11 Years—Eligible Population	Ages 3 to 11 Years—Rate	Ages 12 to 17 Years—Eligible Population	Ages 12 to 17 Years—Rate	Ages 18 to 21 Years—Eligible Population
AET	7,466	54.61%	4,454	44.81%	2,582
BCC	49,171	62.53% ⁺	26,748	51.35% ⁺	14,988
HCS	3,979	51.14%	1,978	37.01%	1,403
MCL	42,975	59.38% ⁺	24,944	47.44%	13,609
MER	102,462	62.34% ⁺	61,665	53.53% ⁺	30,497
MOL	69,217	62.17% ⁺	46,025	54.18% ⁺	24,078
PRI	44,731	62.07% ⁺	26,434	51.91% ⁺	13,759
UNI	50,933	60.23% ⁺	35,143	53.14% ⁺	18,010
UPP	9,083	58.81% ⁺	5,484	50.57% ⁺	2,814
HEDIS MY 2023 MWA		61.33%⁺		52.14%⁺	
HEDIS MY 2022 MWA		59.20%		50.38%	
HEDIS MY 2021 MWA		58.13%		49.93%	

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

Table A-5—MHP and MWA Results for Child and Adolescents Well-Care Visits (WCV) (Table 2 of 2)

	Ages 18 to 21 Years—Rate	Total—Eligible Population	Total—Rate
AET	26.37% ⁺	14,502	46.57%
BCC	31.88% ⁺	90,907	54.19% ⁺
HCS	20.81%	7,360	41.56%
MCL	24.42% ⁺	81,528	49.89% ⁺
MER	30.08% ⁺	194,624	54.49% ⁺
MOL	33.12% ⁺	139,320	54.51% ⁺
PRI	30.69% ⁺	84,924	53.82% ⁺
UNI	32.82% ⁺	104,086	53.09% ⁺
UPP	27.97% ⁺	17,381	51.22% ⁺
HEDIS MY 2023 MWA	30.51%⁺		53.31%⁺
HEDIS MY 2022 MWA	28.31%		50.89%
HEDIS MY 2021 MWA	29.01%		50.49%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

Table A-6—MHP and MWA Results for Immunizations for Adolescents (IMA)

Plan	Eligible Population	Combination 1 (Meningococcal, Tdap)—Rate	Combination 2 (Meningococcal, Tdap, HPV)—Rate
AET	836	77.86%	28.71%
BCC	4,625	78.59%	33.82%
HCS	293	69.28%	22.87%
MCL	4,425	79.32%	29.68%
MER	11,477	80.05%	32.12%
MOL	8,120	82.00% ⁺	36.25% ⁺
PRI	4,621	76.64%	34.06%
UNI	6,468	79.08%	31.14%
UPP	992	75.40%	29.74%
HEDIS MY 2023 MWA		79.43%	32.73%
HEDIS MY 2022 MWA		76.96%	29.35%
HEDIS MY 2021 MWA		76.64%	32.85%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

**Table A-7—MHP and MWA Results for Follow-Up Care for Children Prescribed ADHD Medication (ADD)—
Initiation Phase and Continuation and Maintenance Phase**

Plan	Initiation Phase —Eligible Population	Initiation Phase— Rate	Continuation and Maintenance Phase —Eligible Population	Continuation and Maintenance Phase —Rate
AET	46	41.30%	—	NR
BCC	1,041	51.49% ⁺	457	58.42% ⁺
HCS	65	36.92%	38	42.11%
MCL	1,378	48.04% ⁺	718	55.43% ⁺
MER	7,412	42.82%	4,626	45.11%
MOL	1,642	52.44% ⁺	627	58.37% ⁺
PRI	1,350	38.59%	550	44.18%
UNI	1,292	44.04%	427	54.10%
UPP	356	45.51% ⁺	190	47.89%
HEDIS MY 2023 MWA		44.77%⁺		48.46%
HEDIS MY 2022 MWA		42.47%		47.93%
HEDIS MY 2021 MWA		40.29%		51.24%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

NR indicates that the MHP chose not to report the measure indicator rate or the MHP's reported rate was invalid.

Women—Adult Care Performance Measure Results

Table A-8—MHP and MWA Results for Chlamydia Screening in Women (CHL)¹

Plan	Ages 16 to 20 Years—Eligible Population	Ages 16 to 20 Years—Rate	Ages 21 to 24 Years—Eligible Population	Ages 21 to 24 Years—Rate	Total—Eligible Population	Total—Rate
AET	947	68.53% ⁺	1,030	70.10% ⁺	1,977	69.35% ⁺
BCC	4,967	61.32% ⁺	5,402	66.55% ⁺	10,369	64.05% ⁺
HCS	378	62.96% ⁺	630	65.08% ⁺	1,008	64.29% ⁺
MCL	4,864	52.75% ⁺	4,811	62.65% ⁺	9,675	57.67% ⁺
MER	10,288	55.38% ⁺	8,947	64.49% ⁺	19,235	59.62% ⁺
MOL	8,368	62.80% ⁺	7,021	68.74% ⁺	15,389	65.51% ⁺
PRI	4,804	53.89% ⁺	4,300	63.33% ⁺	9,104	58.35% ⁺
UNI	5,951	59.17% ⁺	4,839	62.51% ⁺	10,790	60.67% ⁺
UPP	1,013	40.28%	888	51.24%	1,901	45.40%
HEDIS MY 2023 MWA		57.65%⁺		64.80%⁺		61.06%⁺
HEDIS MY 2022 MWA		59.35%		66.34%		62.76%
HEDIS MY 2021 MWA		58.09%		64.15%		61.00%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

¹ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

Table A-9—MHP and MWA Results for Cervical Cancer Screening in Women (CCS)

Plan	Cervical Cancer Screening —Eligible Population	Cervical Cancer Screening—Rate
AET	10,706	44.16%
BCC	69,349	55.35%
HCS	8,652	45.23%
MCL	51,548	53.26%
MER	111,953	57.00%
MOL	74,259	55.92%
PRI	49,548	55.04%
UNI	55,193	54.41%
UPP	11,406	54.25%
HEDIS MY 2023 MWA		54.97%
HEDIS MY 2022 MWA		59.16%
HEDIS MY 2021 MWA		58.01%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

Table A-10—MHP and MWA Results for Breast Cancer Screening in Women (BSC-E)

Plan	Breast Cancer Screening— Eligible Population	Breast Cancer Screening—Rate
AET	2,910	49.59%
BCC	12,879	54.29% ⁺
HCS	1,900	55.11% ⁺
MCL	10,503	54.76% ⁺
MER	24,809	55.06% ⁺
MOL	17,647	55.49% ⁺
PRI	10,100	54.52% ⁺
UNI	12,682	55.49% ⁺
UPP	3,123	60.10% ⁺
HEDIS MY 2023 MWA		55.00%⁺
HEDIS MY 2022 MWA		53.61%
HEDIS MY 2021 MWA		53.19%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

Access to Care Performance Measure Results

Table A-11—MHP and MWA Results for Adults' Access to Preventive/Ambulatory Health Services (AAP) (Table 1 of 2)

Plan	Ages 20 to 44 Years—Eligible Population	Ages 20 to 44 Years—Rate	Ages 45 to 64 Years—Eligible Population	Ages 45 to 64 Years—Rate	Ages 65 Years and Older—Eligible Population
AET	16,744	66.87%	8,768	79.82%	3,532
BCC	99,000	74.46% ⁺	51,458	82.04% ⁺	1,061
HCS	14,498	62.38%	7,020	75.57%	2,550
MCL	80,042	70.70% ⁺	38,928	80.87% ⁺	367
MER	160,378	74.64% ⁺	76,721	83.55% ⁺	8,140
MOL	106,004	75.08% ⁺	53,862	84.44% ⁺	6,452
PRI	72,430	71.97% ⁺	34,274	81.65% ⁺	3,110
UNI	80,688	73.02% ⁺	42,491	84.27% ⁺	3,464
UPP	16,505	75.30% ⁺	9,556	83.79% ⁺	1,983
HEDIS MY 2023 MWA		73.23%⁺		82.76%⁺	
HEDIS MY 2022 MWA		72.86%		82.59%	
HEDIS MY 2021 MWA		75.38%		84.06%	

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

Table A-12—MHP and MWA Results for Adults' Access to Preventive/Ambulatory Health Services (AAP) (Table 2 of 2)

Plan	Ages 65 Years and Older—Rate	Total—Eligible Population	Total—Rate
AET	89.72% ⁺	29,044	73.56% ⁺
BCC	72.29%	151,519	77.02% ⁺
HCS	90.08% ⁺	24,068	69.16%
MCL	67.30%	119,337	74.00% ⁺
MER	87.59% ⁺	245,239	77.86% ⁺
MOL	91.83% ⁺	166,318	78.76% ⁺
PRI	88.46% ⁺	109,814	75.46% ⁺
UNI	91.05% ⁺	126,643	77.29% ⁺
UPP	95.16% ⁺	28,044	79.60% ⁺
HEDIS MY 2023 MWA	89.13%⁺		76.80%⁺
HEDIS MY 2022 MWA	89.52%		76.43%
HEDIS MY 2021 MWA	89.55%		78.58%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

Table A-13—MHP and MWA Results for Avoidance of Antibiotic Treatment for Acute Bronchitis (AAB) (Table 1 of 2)

Plan	Ages 3 Months to 17 Years—Eligible Population	Ages 3 Months to 17 Years—Rate	Ages 18 to 64 Years—Eligible Population	Ages 18 to 64 Years—Rate	Ages 65 Years and Older—Eligible Population
AET	445	65.39%	429	39.16%	66
BCC	3,293	69.57%	2,929	39.13%	12
HCS	283	75.97% ⁺	326	38.34%	48
MCL	2,650	74.60% ⁺	2,347	41.29%	3
MER	6,270	68.58%	5,134	39.09%	89
MOL	4,987	61.96%	3,531	38.54%	107
PRI	1,978	79.32% ⁺	1,702	54.17% ⁺	33
UNI	3,051	64.63%	2,696	35.68%	50
UPP	487	82.34% ⁺	372	48.92% ⁺	14
HEDIS MY 2023 MWA		68.70%		40.29%	
HEDIS MY 2022 MWA		66.30%		40.61%	
HEDIS MY 2021 MWA		64.93%		45.77%	

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

Table A-14—MHP and MWA Results for Avoidance of Antibiotic Treatment for Acute Bronchitis (AAB) (Table 2 of 2)

Plan	Ages 65 Years and Older—Rate	Total—Eligible Population	Total—Rate
AET	18.18%	940	50.11%
BCC	NA	6,234	55.26%
HCS	22.92%	657	53.42%
MCL	NA	5,000	58.98%
MER	40.45% ⁺	11,493	55.19%
MOL	23.36%	8,625	51.90%
PRI	66.67% ⁺	3,713	67.68% ⁺
UNI	32.00%	5,797	50.89%
UPP	NA	873	67.47% ⁺
HEDIS MY 2023 MWA	32.94%		55.59%
HEDIS MY 2022 MWA	32.23%		54.40%
HEDIS MY 2021 MWA	40.94%		51.78%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Table A-15—MHP and MWA Results for Appropriate Testing for Pharyngitis (CWP) (Table 1 of 2)

Plan	Ages 3 to 17 Years—Eligible Population	Ages 3 to 17 Years—Rate	Ages 18 to 64 Years—Eligible Population	Ages 18 to 64 Years—Rate	Age 65 Years and Older—Eligible Population
AET	1,088	73.81%	1,032	61.05%	59
BCC	10,183	78.58% ⁺	8,258	64.48% ⁺	17
HCS	587	73.25%	852	66.08% ⁺	48
MCL	11,234	82.08% ⁺	6,346	71.26% ⁺	6
MER	28,230	80.92% ⁺	13,703	68.30% ⁺	75
MOL	18,621	72.73%	9,570	62.19%	83
PRI	7,483	85.85% ⁺	4,191	76.35% ⁺	33
UNI	13,248	73.70%	7,917	55.32%	63
UPP	1,875	89.28% ⁺	945	82.75% ⁺	2
HEDIS MY 2023 MWA		78.56%⁺		65.73%⁺	
HEDIS MY 2022 MWA		69.83%		54.43%	
HEDIS MY 2021 MWA		69.04%		53.55%	

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

Table A-16—MHP and MWA Results for Appropriate Testing for Pharyngitis (CWP) (Table 2 of 2)

Plan	Age 65 Years and Older—Rate	Total—Eligible Population	Total—Rate
AET	20.34%	2,179	66.31%
BCC	NA	18,458	72.22%
HCS	NA	1,464	68.85%
MCL	NA	17,586	78.15% ⁺
MER	25.33% ⁺	42,008	76.71% ⁺
MOL	26.51% ⁺	28,274	69.03%
PRI	NA	11,684	82.42% ⁺
UNI	23.81%	21,228	66.70%
UPP	NA	2,822	87.07% ⁺
HEDIS MY 2023 MWA	27.94%⁺		73.79%⁺
HEDIS MY 2022 MWA	22.51%		62.63%
HEDIS MY 2021 MWA	14.78%		60.58%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Table A-17—MHP and MWA Results for Appropriate Treatment for Upper Respiratory Infection (URI)

Plan	Ages 3 Months to 17 Years—Eligible Population	Ages 3 Months to 17 Years—Rate	Ages 18 to 64 Years—Eligible Population	Ages 18 to 64 Years—Rate	Ages 65 Years and Older—Eligible Population	Ages 65 Years and Older—Rate	Total—Eligible Population	Total—Rate
AET	3,195	90.36%	1,661	77.54%	128	61.72%	4,984	85.35%
BCC	22,896	90.97%	12,098	76.28%	49	81.63% ⁺	35,043	85.88%
HCS	1,924	90.90%	1,227	79.22%	97	61.86%	3,248	85.62%
MCL	17,358	90.10%	8,623	80.05%	12	NA	25,993	86.75%
MER	43,172	91.01%	18,645	78.18%	232	67.67%	62,049	87.07%
MOL	34,353	88.53%	12,972	76.77%	282	64.54%	47,607	85.18%
PRI	17,219	94.37% ⁺	7,588	87.08% ⁺	81	87.65% ⁺	24,888	92.13% ⁺
UNI	25,285	90.49%	10,766	73.91%	173	61.85%	36,224	85.42%
UPP	3,101	92.55%	1,591	86.80% ⁺	37	75.68% ⁺	4,729	90.48%
HEDIS MY 2023 MWA		90.69%		78.32%		67.09%		86.78%
HEDIS MY 2022 MWA		92.48%		81.42%		70.18%		88.99%
HEDIS MY 2021 MWA		94.11%		82.21%		75.51%		89.59%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Obesity Performance Measure Results

**Table A-18—MHP and MWA Results for Weight Assessment and Counseling
for Nutrition and Physical Activity for Children/Adolescents (WCC)**

Plan	Body Mass Index (BMI) Percentile— Total—Eligible Population	Body Mass Index (BMI) Percentile— Total—Rate	Counseling for Nutrition— Total—Eligible Population	Counseling for Nutrition— Total—Rate	Counseling for Physical Activity— Total—Eligible Population	Counseling for Physical Activity— Total—Rate
AET	7,886	85.40% ⁺	7,886	76.40% ⁺	7,886	76.64% ⁺
BCC	56,109	86.20% ⁺	56,109	78.91% ⁺	56,109	77.86% ⁺
HCS	3,204	88.85% ⁺	3,204	83.93% ⁺	3,204	79.34% ⁺
MCL	51,158	71.85%	51,158	65.68%	51,158	64.20%
MER	125,019	84.43% ⁺	125,019	73.72% ⁺	125,019	72.02% ⁺
MOL	88,425	84.44% ⁺	88,425	74.17% ⁺	88,425	72.50% ⁺
PRI	52,713	89.78% ⁺	52,713	82.00% ⁺	52,713	80.05% ⁺
UNI	60,751	90.75% ⁺	60,751	71.78% ⁺	60,751	71.05% ⁺
UPP	11,541	92.94% ⁺	11,541	74.21% ⁺	11,541	72.51% ⁺
HEDIS MY 2023 MWA		84.96%⁺		74.37%⁺		72.90%⁺
HEDIS MY 2022 MWA		80.54%		70.88%		69.40%
HEDIS MY 2021 MWA		76.87%		70.12%		68.90%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

Pregnancy Care Performance Measure Results

Table A-19—MHP and MWA Results for Prenatal and Postpartum Care¹ (PPC)

Plan	Timeliness of Prenatal Care—Eligible Population	Timeliness of Prenatal Care—Rate	Postpartum Care—Eligible Population	Postpartum Care—Rate
AET	744	72.75%	744	65.21%
BCC	5,063	88.16% ⁺	5,063	81.62% ⁺
HCS	592	76.11%	592	65.00%
MCL	3,872	78.36%	3,872	77.78%
MER	8,271	83.21%	8,271	76.16%
MOL	5,968	84.50% ⁺	5,968	73.39%
PRI	3,954	85.40% ⁺	3,954	77.86%
UNI	4,074	83.45%	4,074	71.78%
UPP	744	94.16% ⁺	744	87.35% ⁺
HEDIS MY 2023 MWA		83.81%		76.15%
HEDIS MY 2022 MWA		78.45%		75.33%
HEDIS MY 2021 MWA		79.45%		73.36%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

¹ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

Living With Illness Performance Measure Results

Table A-20—MHP and MWA Results for HbA1c Control for Patients With Diabetes (HBD)

Plan	HbA1c Control (<8.0%)—Eligible Population	HbA1c Control (<8.0%)—Rate	HbA1c Poor Control (>9.0%)—Eligible Population	HbA1c Poor Control (>9.0%)—Rate*
AET	3,615	61.80% ⁺	3,615	29.93% ⁺
BCC	15,859	58.92% ⁺	15,859	35.21% ⁺
HCS	2,609	60.25% ⁺	2,609	32.35% ⁺
MCL	11,868	49.39%	11,868	42.58%
MER	25,567	60.34% ⁺	25,567	30.17% ⁺
MOL	20,001	56.93% ⁺	20,001	37.47% ⁺
PRI	10,651	63.26% ⁺	10,651	28.22% ⁺
UNI	14,994	62.29% ⁺	14,994	27.98% ⁺
UPP	2,711	66.18% ⁺	2,711	25.06% ⁺
HEDIS MY 2023 MWA		59.05%⁺		33.05%⁺
HEDIS MY 2022 MWA		53.53%		39.01%
HEDIS MY 2021 MWA		48.26%		43.04%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

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

**Table A-21—MHP and MWA Results for
Eye Exam for Patients With Diabetes (EED)¹**

Plan	Eye Exam for Patients With Diabetes— Eligible Population	Eye Exam for Patients With Diabetes—Rate
AET	3,615	60.83% ⁺
BCC	15,859	56.97% ⁺
HCS	2,609	53.33% ⁺
MCL	11,868	56.93% ⁺
MER	25,567	61.31% ⁺
MOL	20,001	53.53% ⁺
PRI	10,651	62.04% ⁺
UNI	14,994	52.55% ⁺
UPP	2,711	57.18% ⁺
HEDIS MY 2023 MWA		57.29%⁺
HEDIS MY 2022 MWA		54.81%
HEDIS MY 2021 MWA		54.56%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

¹ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

**Table A-22—MHP and MWA Results for Blood Pressure Control
for Patient With Diabetes (BPD)**

Plan	Blood Pressure Control for Patients With Diabetes— Eligible Population	Blood Pressure Control for Patients With Diabetes— Rate
AET	3,615	62.77%
BCC	15,859	65.77% ⁺
HCS	2,609	66.17% ⁺
MCL	11,868	62.53%
MER	25,567	73.24% ⁺
MOL	20,001	69.59% ⁺
PRI	10,651	77.37% ⁺
UNI	14,994	73.48% ⁺
UPP	2,711	84.67% ⁺
HEDIS MY 2023 MWA		70.49%⁺
HEDIS MY 2022 MWA		66.93%
HEDIS MY 2021 MWA		59.61%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

Table A-23—MHP and MWA Results for Kidney Health Evaluation for People With Diabetes (KED)

Plan	Ages 18 to 64 Years—Eligible Population	Ages 18 to 64 Years—Rate	Ages 65 to 74 Years—Eligible Population	Ages 65 to 74 Years—Rate	Ages 75 to 85 Years—Eligible Population	Ages 75 to 85 Years—Rate	Total—Eligible Population	Total—Rate
AET	2,712	29.35%	612	34.97%	221	33.03%	3,545	30.55%
BCC	15,382	36.39% ⁺	187	41.71% ⁺	73	35.62%	15,642	36.45% ⁺
HCS	2,022	38.72% ⁺	458	42.58% ⁺	200	38.50% ⁺	2,680	39.37% ⁺
MCL	11,596	35.76% ⁺	62	43.55% ⁺	19	NA	11,677	35.81% ⁺
MER	23,431	40.25% ⁺	1,623	37.58% ⁺	411	34.79%	25,465	39.99% ⁺
MOL	17,937	36.57% ⁺	1,362	35.76%	456	34.21%	19,755	36.46% ⁺
PRI	9,817	39.33% ⁺	591	41.12% ⁺	181	46.41% ⁺	10,589	39.55% ⁺
UNI	13,908	41.46% ⁺	804	50.25% ⁺	243	51.85% ⁺	14,955	42.10% ⁺
UPP	2,350	37.83% ⁺	288	39.93% ⁺	86	43.02% ⁺	2,724	38.22% ⁺
HEDIS MY 2023 MWA		38.15%⁺		39.64%⁺		38.57%⁺		38.24%⁺
HEDIS MY 2022 MWA		35.09%		36.52%		34.44%		35.16%
HEDIS MY 2021 MWA		30.62%		29.92%		30.27%		30.57%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Table A-24—MHP and MWA Results for Asthma Medication Ratio (AMR)

Plan	Total—Eligible Population	Total—Rate
AET	634	51.26%
BCC	4,385	50.42%
HCS	333	55.56%
MCL	4,398	49.55%
MER	7,221	61.18%
MOL	5,126	57.57%
PRI	3,490	64.64%
UNI	3,805	63.47%
UPP	965	62.28%
HEDIS MY 2023 MWA		57.78%
HEDIS MY 2022 MWA		57.73%
HEDIS MY 2021 MWA		56.36%

Table A-25—MHP and MWA Results for Controlling High Blood Pressure (CBP)

Plan	Controlling High Blood Pressure— Eligible Population	Controlling High Blood Pressure— Rate
AET	5,457	59.12%
BCC	22,569	64.34% ⁺
HCS	3,985	65.72% ⁺
MCL	17,086	52.80%
MER	37,791	62.04% ⁺
MOL	29,282	61.72% ⁺
PRI	15,596	69.10% ⁺
UNI	20,825	71.78% ⁺
UPP	4,025	78.10% ⁺
HEDIS MY 2023 MWA		63.71%⁺
HEDIS MY 2022 MWA		62.07%
HEDIS MY 2021 MWA		56.14%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

Table A-26—MHP and MWA Results for Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

Plan	Persistence of Beta-Blocker Treatment After a Heart Attack—Eligible Population	Persistence of Beta-Blocker Treatment After a Heart Attack—Rate
AET	15	NA
BCC	101	57.43%
HCS	23	NA
MCL	82	63.41%
MER	140	72.14%
MOL	101	60.40%
PRI	62	74.19%
UNI	72	61.11%
UPP	15	NA
HEDIS MY 2023 MWA		64.65%
HEDIS MY 2022 MWA		86.94%
HEDIS MY 2021 MWA		88.18%

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Table A-27—MHP and MWA Results for Cardiac Rehabilitation (CRE) (Table 1 of 4)

Plan	Achievement— Ages 18 to 64 Years—Eligible Population	Achievement— Ages 18 to 64 Years—Rate	Achievement— Ages 65 Years and Older—Eligible Population	Achievement— Ages 65 Years and Older—Rate	Achievement— Total—Eligible Population	Achievement— Total—Rate
AET	129	4.65% ⁺	26	NA	155	7.10% ⁺
BCC	663	4.52% ⁺	5	NA	668	4.49% ⁺
HCS	93	0.00%	20	NA	113	0.88%
MCL	601	1.50% ⁺	1	NA	602	1.50% ⁺
MER	1,090	1.56% ⁺	71	2.82% ⁺	1,161	1.64% ⁺
MOL	787	0.13%	45	0.00%	832	0.12%
PRI	421	2.14% ⁺	16	NA	437	2.06% ⁺
UNI	569	0.88%	32	6.25% ⁺	601	1.16%
UPP	112	1.79% ⁺	13	NA	125	4.00% ⁺
HEDIS MY 2023 MWA		1.77%⁺		5.68%⁺		1.96%⁺
HEDIS MY 2022 MWA		3.52%		9.89%		3.78%
HEDIS MY 2021 MWA		3.10%		5.95%		3.22%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Table A-28—MHP and MWA Results for Cardiac Rehabilitation (CRE) (Table 2 of 4)

Plan	Engagement 1— Ages 18 to 64 Years—Eligible Population	Engagement 1— Ages 18 to 64 Years—Rate	Engagement 1— Ages 65 Years and Older—Eligible Population	Engagement 1— Ages 65 Years and Older—Rate	Engagement 1— Total—Eligible Population	Engagement 1— Total—Rate	Engagement 2— Ages 18 to 64 Years—Eligible Population
AET	129	5.43% ⁺	26	NA	155	7.10% ⁺	129
BCC	663	7.09% ⁺	5	NA	668	7.19% ⁺	663
HCS	93	5.38% ⁺	20	NA	113	5.31% ⁺	93
MCL	601	7.99% ⁺	1	NA	602	7.97% ⁺	601
MER	1,090	6.24% ⁺	71	11.27% ⁺	1,161	6.55% ⁺	1,090
MOL	787	0.25%	45	2.22%	832	0.36%	787
PRI	421	8.08% ⁺	16	NA	437	8.01% ⁺	421
UNI	569	6.33% ⁺	32	12.50% ⁺	601	6.66% ⁺	569
UPP	112	8.04% ⁺	13	NA	125	11.20% ⁺	112
HEDIS MY 2023 MWA		5.73%⁺		10.92%⁺		5.99%⁺	
HEDIS MY 2022 MWA		7.55%		13.74%		7.79%	
HEDIS MY 2021 MWA		5.72%		5.95%		5.73%	

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Table A-29—MHP and MWA Results for Cardiac Rehabilitation (CRE) (Table 3 of 4)

Plan	Engagement 2— Ages 18 to 64 Years—Rate	Engagement 2— Ages 65 Years and Older—Eligible Population	Engagement 2— Ages 65 Years and Older—Rate	Engagement 2— Total—Eligible Population	Engagement 2— Total—Rate	Initiation— Ages 18 to 64 Years—Eligible Population	Initiation— Ages 18 to 64 Years—Rate
AET	6.20% ⁺	26	NA	155	9.03% ⁺	129	0.78%
BCC	6.03% ⁺	5	NA	668	6.14% ⁺	663	3.47% ⁺
HCS	4.30% ⁺	20	NA	113	4.42% ⁺	93	3.23% ⁺
MCL	5.16% ⁺	1	NA	602	5.15% ⁺	601	6.99% ⁺
MER	4.40% ⁺	71	8.45% ⁺	1,161	4.65% ⁺	1,090	4.86% ⁺
MOL	0.13%	45	0.00%	832	0.12%	787	2.41%
PRI	5.94% ⁺	16	NA	437	6.18% ⁺	421	5.46% ⁺
UNI	4.39% ⁺	32	9.38% ⁺	601	4.66% ⁺	569	4.22% ⁺
UPP	6.25% ⁺	—	NA	125	9.60% ⁺	112	12.50% ⁺
HEDIS MY 2023 MWA	4.23%⁺		10.48%⁺		4.54%⁺		4.52%⁺
HEDIS MY 2022 MWA	6.33%		13.74%		6.62%		5.48%
HEDIS MY 2021 MWA	4.47%		6.75%		4.56%		4.98%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Table A-30—MHP and MWA Results for Cardiac Rehabilitation (CRE) (Table 4 of 4)

Plan	Initiation— Ages 65 Years and Older—Eligible Population	Initiation— Ages 65 Years and Older—Rate	Initiation— Total—Eligible Population	Initiation— Total—Rate
AET	26	NA	155	1.94%
BCC	5	NA	668	3.44% ⁺
HCS	20	NA	113	2.65%
MCL	1	NA	602	6.98% ⁺
MER	71	8.45% ⁺	1,161	5.08% ⁺
MOL	45	4.44% ⁺	832	2.52%
PRI	16	NA	437	5.26% ⁺
UNI	32	6.25% ⁺	601	4.33% ⁺
UPP	13	NA	125	13.60% ⁺
HEDIS MY 2023 MWA		6.55%⁺		4.62%⁺
HEDIS MY 2022 MWA		3.30%		5.39%
HEDIS MY 2021 MWA		3.57%		4.92%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Table A-31—MHP and MWA Results for Antidepressant Medication Management (AMM)¹

Plan	Effective Acute Phase Treatment—Eligible Population	Effective Acute Phase Treatment—Rate	Effective Continuation Phase Treatment—Eligible Population	Effective Continuation Phase Treatment—Rate
AET	208	62.50% ⁺	208	49.52% ⁺
BCC	5,683	68.20% ⁺	5,683	52.30% ⁺
HCS	623	77.85% ⁺	623	64.53% ⁺
MCL	5,249	71.37% ⁺	5,249	54.07% ⁺
MER	17,314	78.14% ⁺	17,314	64.94% ⁺
MOL	4,805	65.87% ⁺	4,805	48.16% ⁺
PRI	4,487	70.45% ⁺	4,487	52.75% ⁺
UNI	4,347	65.13% ⁺	4,347	47.07% ⁺
UPP	1,162	74.78% ⁺	1,162	56.45% ⁺
HEDIS MY 2023 MWA		72.46%⁺		56.84%⁺
HEDIS MY 2022 MWA		70.03%		56.56%
HEDIS MY 2021 MWA		65.68%		49.31%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

¹ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

Table A-32—MHP and MWA Results for Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Plan	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications —Eligible Population	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications —Rate
AET	809	81.71% ⁺
BCC	3,166	83.51% ⁺
HCS	754	82.36% ⁺
MCL	4,660	80.34% ⁺
MER	6,702	82.72% ⁺
MOL	4,269	84.45% ⁺
PRI	3,273	80.63% ⁺
UNI	2,757	85.46% ⁺
UPP	927	87.27% ⁺
HEDIS MY 2023 MWA		82.82%⁺
HEDIS MY 2022 MWA		81.45%
HEDIS MY 2021 MWA		80.95%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

Table A-33—MHP and MWA Results for Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

Plan	Diabetes Monitoring for People With Diabetes and Schizophrenia —Eligible Population	Diabetes Monitoring for People With Diabetes and Schizophrenia —Rate
AET	143	74.13% ⁺
BCC	240	70.42% ⁺
HCS	119	68.07%
MCL	290	70.69% ⁺
MER	587	70.36% ⁺
MOL	663	68.02%
PRI	284	73.24% ⁺
UNI	314	71.02% ⁺
UPP	99	75.76% ⁺
HEDIS MY 2023 MWA		70.50%⁺
HEDIS MY 2022 MWA		66.84%
HEDIS MY 2021 MWA		65.67%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

Table A-34—MHP and MWA Results for Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

Plan	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia—Eligible Population	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia—Rate
AET	14	NA
BCC	32	59.38%
HCS	10	NA
MCL	41	73.17%
MER	71	80.28% ⁺
MOL	97	76.29%
PRI	34	73.53%
UNI	48	75.00%
UPP	9	NA
HEDIS MY 2023 MWA		74.72%
HEDIS MY 2022 MWA		70.31%
HEDIS MY 2021 MWA		66.39%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Table A-35—MHP and MWA Results for Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)

Plan	Adherence to Antipsychotic Medications for Individuals With Schizophrenia—Eligible Population	Adherence to Antipsychotic Medications for Individuals With Schizophrenia—Rate
AET	627	69.38% ⁺
BCC	1,051	59.37%
HCS	498	63.25% ⁺
MCL	1,636	66.81% ⁺
MER	2,326	66.08% ⁺
MOL	2,275	66.15% ⁺
PRI	1,404	64.46% ⁺
UNI	1,215	64.20% ⁺
UPP	392	82.65% ⁺
HEDIS MY 2023 MWA		65.81%⁺
HEDIS MY 2022 MWA		64.33%
HEDIS MY 2021 MWA		65.80%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

Table A-36—MHP and MWA Results for Diagnosed Mental Health Disorders (DMH) (Table 1 of 2)

Plan	Ages 1 to 17 Years —Eligible Population	Ages 1 to 17 Years —Rate	Ages 18 to 64 Years —Eligible Population	Ages 18 to 64 Years —Rate	Ages 65 Years and Older —Eligible Population
AET	14,052	19.01%	28,051	30.07%	3,584
BCC	90,434	23.14% ⁺	165,483	32.90% ⁺	1,233
HCS	7,723	16.99%	23,431	26.61%	2,677
MCL	78,952	28.43% ⁺	132,154	38.45% ⁺	577
MER	189,309	27.02% ⁺	266,257	37.98% ⁺	8,560
MOL	132,758	18.19%	179,756	30.92% ⁺	6,695
PRI	83,060	22.85% ⁺	119,592	36.87% ⁺	3,227
UNI	NR	NR	NR	NR	NR
UPP	16,922	27.90% ⁺	28,895	45.12% ⁺	2,030
HEDIS MY 2023 MWA		23.87%⁺		35.37%⁺	
HEDIS MY 2022 MWA		21.17%		32.84%	

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

— is indicated for all columns in this table due to the MHP not reporting the required measure indicator rates or the MHP's reported rates were invalid.

NR indicates that the MHP chose not to report the required measure indicator rate or the MHP's reported rate was invalid.

Table A-37—MHP and MWA Results for Diagnosed Mental Health Disorders (DMH) (Table 2 of 2)

Plan	Ages 65 Years and Older—Rate	Total—Eligible Population	Total—Rate
AET	38.23% ⁺	45,687	27.31% ⁺
BCC	18.17%	257,150	29.39% ⁺
HCS	36.20% ⁺	33,831	25.18%
MCL	26.17%	211,683	34.68% ⁺
MER	35.91% ⁺	464,126	33.47% ⁺
MOL	37.71% ⁺	319,209	25.77%
PRI	36.07% ⁺	205,879	31.20% ⁺
UNI	NR	NR	NR
UPP	53.20% ⁺	47,847	39.37% ⁺
HEDIS MY 2023 MWA	36.93%⁺		30.95%⁺
HEDIS MY 2022 MWA	37.34%		28.56%

Yellow shading with one cross (+) indicates the HEDIS MY 2023 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2022 MWA national Medicaid 50th percentile.

NR indicates that the MHP chose not to report the required measure indicator rate or the MHP's reported rate was invalid.

Health Plan Diversity and Utilization Measure Results

The Health Plan Diversity and Utilization measures' MHP and MWA results are presented in tabular format in Section 9 and Section 10 of this report, respectively.

Appendix B. Trend Tables

Appendix B includes trend tables for the MHPs. Where applicable, each measure's HEDIS MY 2021, HEDIS MY 2022, and HEDIS MY 2023 rates are presented as well as the HEDIS MY 2022 to HEDIS MY 2023 rate comparison and the HEDIS MY 2023 Performance Level. HEDIS MY 2022 and HEDIS MY 2023 rates were compared based on a Chi-square test of statistical significance with a p value <0.05 . Values in the MY 2022–MY 2023 Comparison column that are shaded green with one cross (+) indicate significant improvement from the previous year. Values in the MY 2022–MY 2023 Comparison column shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

Details regarding the trend analysis and performance ratings are found in Section 2.

Table B-1—AET Trend Table

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Child & Adolescent Care					
Childhood Immunization Status (CIS)					
Combination 3	45.74%	45.01%	48.91%	+3.89	★
Combination 7	35.28%	37.47%	36.98%	-0.49	★
Combination 10	18.00%	16.55%	13.87%	-2.68	★
Well-Child Visits in the First 30 Months of Life (W30)					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	41.30%	46.55%	49.72%	+3.17	★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	41.89%	52.30%	50.85%	-1.45	★
Lead Screening in Children (LSC)					
Lead Screening in Children	52.31%	42.58%	50.70%	+8.12 ⁺	★★
Child and Adolescent Well-Care Visits (WCV)					
Ages 3 to 11 Years	52.37%	52.67%	54.61%	+1.94 ⁺	★★
Ages 12 to 17 Years	44.76%	43.72%	44.81%	+1.09	★★
Ages 18 to 21 Years	24.29%	24.46%	26.37%	+1.91	★★★
Total	44.00%	44.17%	46.57%	+2.41 ⁺	★★
Immunizations for Adolescents (IMA)					
Combination 1 (Meningococcal, Tdap)	69.10%	70.80%	77.86%	+7.06 ⁺	★★
Combination 2 (Meningococcal, Tdap, HPV)	29.20%	24.57%	28.71%	+4.14	★
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)⁴					
Initiation Phase	38.24%	42.86%	41.30%	-1.55	★★
Continuation and Maintenance Phase	NA	NA	NA	NC	NC
Women—Adult Care					
Chlamydia Screening in Women (CHL)⁴					
Ages 16 to 20 Years	65.21%	65.99%	68.53%	+2.54	★★★★★
Ages 21 to 24 Years	65.67%	67.43%	70.10%	+2.67	★★★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Total	65.46%	66.78%	69.35%	+2.57	★★★★★
Cervical Cancer Screening (CCS-E)					
Cervical Cancer Screening	46.47%	47.69%	44.16%	-3.53	★
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening	46.64%	47.53%	49.59%	+2.05	★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Ages 20 to 44 Years	66.48%	64.22%	66.87%	+2.65 ⁺	★★
Ages 45 to 64 Years	78.54%	77.24%	79.82%	+2.58 ⁺	★★
Ages 65 Years and Older	89.64%	89.13%	89.72%	+0.59	★★★★★
Total	72.49%	70.34%	73.56%	+3.22 ⁺	★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)					
Ages 3 Months to 17 Years	68.24%	75.41%	65.39%	-10.02 ⁺⁺	★★
Ages 18 to 64 Years	52.86%	43.19%	39.16%	-4.03	★
Ages 65 Years and Older	NA	12.50%	18.18%	+5.68	★
Total	54.87%	57.11%	50.11%	-7.00 ⁺⁺	★
Appropriate Testing for Pharyngitis (CWP)					
Ages 3 to 17 Years	63.11%	61.97%	73.81%	+11.83 ⁺	★★
Ages 18 to 64 Years	50.94%	51.99%	61.05%	+9.06 ⁺	★★
Ages 65 Years and Older	NA	NA	20.34%	NC	★★
Total	53.84%	55.61%	66.31%	+10.70 ⁺	★★
Appropriate Treatment for Upper Respiratory Infection (URI)					
Ages 3 Months to 17 Years	94.63%	92.53%	90.36%	-2.17 ⁺⁺	★
Ages 18 to 64 Years	84.80%	81.81%	77.54%	-4.27 ⁺⁺	★★
Ages 65 Years and Older	73.81%	64.56%	61.72%	-2.84	★
Total	90.39%	88.55%	85.35%	-3.19 ⁺⁺	★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
Body Mass Index (BMI) Percentile—Total	82.97%	82.00%	85.40%	+3.41	★★★★★
Counseling for Nutrition—Total	73.48%	73.97%	76.40%	+2.43	★★★
Counseling for Physical Activity—Total	71.78%	70.56%	76.64%	+6.08 ⁺	★★★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Pregnancy Care					
Prenatal and Postpartum Care (PPC)⁴					
Timeliness of Prenatal Care	70.07%	64.48%	72.75%	+8.27 ⁺	★
Postpartum Care	58.64%	61.80%	65.21%	+3.41	★
Living With Illness					
Hemoglobin A1c Control for Patients With Diabetes (HBD)					
HbA1c Control (<8.0%)	50.12%	52.55%	61.80%	+9.25 ⁺	★★★★★
HbA1c Poor Control (>9.0%)*	41.36%	37.96%	29.93%	-8.03 ⁺	★★★★★
Blood Pressure Control for Patients With Diabetes (BPD)					
Blood Pressure Control for Patients With Diabetes	51.34%	59.12%	62.77%	+3.65	★★
Eye Exam for Patients With Diabetes (EED)⁴					
Eye Exam for Patients With Diabetes	51.58%	54.26%	60.83%	+6.57	★★★★★
Kidney Health Evaluation for Patients With Diabetes (KED)					
Ages 18 to 64 Years	20.01%	23.13%	29.35%	+6.22 ⁺	★★
Ages 65 to 74 Years	23.71%	28.85%	34.97%	+6.12 ⁺	★★
Ages 75 to 85 Years	23.35%	25.00%	33.03%	+8.03	★★
Total	20.82%	24.11%	30.55%	+6.44 ⁺	★★
Asthma Medication Ratio (AMR)					
Total	50.15%	52.77%	51.26%	-1.50	★
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure	60.10%	57.91%	59.12%	+1.22	★★
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)					
Persistence of Beta-Blocker Treatment After a Heart Attack	88.89%	79.69%	NA	NC	NC
Cardiac Rehabilitation (CRE)					
Initiation—Ages 18 to 64 Years	2.03%	3.25%	0.78%	-2.47	★
Initiation—Ages 65 Years and Older	NA	NA	NA	NC	NC
Initiation—Total	2.65%	3.35%	1.94%	-1.42	★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Engagement 1—Ages 18 to 64 Years	2.54%	2.60%	5.43%	+2.83	★★★
Engagement 1—Ages 65 Years and Older	NA	NA	NA	NC	NC
Engagement 1—Total	3.10%	3.91%	7.10%	+3.19	★★★★★
Engagement 2—Ages 18 to 64 Years	2.03%	1.95%	6.20%	+4.25	★★★★★
Engagement 2—Ages 65 Years and Older	NA	NA	NA	NC	NC
Engagement 2—Total	3.10%	2.79%	9.03%	+6.24 ⁺	★★★★★
Achievement—Ages 18 to 64 Years	1.52%	1.30%	4.65%	+3.35	★★★★★
Achievement—Ages 65 Years and Older	NA	NA	NA	NC	NC
Achievement—Total	2.65%	2.23%	7.10%	+4.86 ⁺	★★★★★
Antidepressant Medication Management (AMM)⁴					
Effective Acute Phase Treatment	67.11%	69.48%	62.50%	-6.98	★★★
Effective Continuation Phase Treatment	51.11%	53.01%	49.52%	-3.49	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	77.48%	78.40%	81.71%	+3.31	★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia	55.97%	54.96%	74.13%	+19.16 ⁺	★★★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	NC	NC

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	61.32%	62.95%	69.38%	+6.43 ⁺	★★★★
Diagnosed Mental Health Disorders (DMH)					
Ages 1 to 17 Years	—	17.96%	19.01%	+1.05 ⁺	★★
Ages 18 to 64 Years	—	27.53%	30.07%	+2.54 ⁺	★★
Ages 65 Years and Older	—	37.31%	38.23%	+0.92	★★★★
Total	—	25.19%	27.31%	+2.12 ⁺	★★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership (RDM)					
White	34.86%	3.70%	33.38%	+29.68	NC
Black or African American	53.11%	3.42%	51.51%	+48.08	NC
American Indian or Alaska Native	0.39%	0.02%	0.38%	+0.35	NC
Asian	0.99%	0.08%	1.40%	+1.32	NC
Native Hawaiian or Other Pacific Islander	0.09%	0.01%	0.08%	+0.07	NC
Some Other Race	0.00%	0.08%	7.07%	+6.99	NC
Two or More Races	0.00%	0.00%	0.00%	0.00	NC
Ethnicity Reporting Category: Hispanic or Latino	0.83%	0.09%	3.74%	+3.65	NC
Unknown	3.99%	92.11%	6.19%	-85.92	NC
Declined	6.57%	0.57%	0.00%	-0.57	NC
Language Diversity of Membership (LDM)					
Spoken Language Preferred for Health Care—English	0.00%	0.00%	0.00%	0.00	NC
Spoken Language Preferred for Health Care—Non-English	0.00%	0.00%	0.00%	0.00	NC
Spoken Language Preferred for Health Care—Unknown	100.00%	100.00%	100.00%	0.00	NC

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—English	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—Non-English	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—Unknown	100.00%	100.00%	100.00%	0.00	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	96.60%	96.25%	96.48%	+0.22	NC
Other Language Needs—Non-English	1.10%	1.28%	1.32%	+0.04	NC
Other Language Needs—Unknown	2.30%	2.47%	2.20%	-0.27	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization³					
Ambulatory Care (AMB)					
Emergency Department Visits*	709.69	712.18	731.27	+19.09	★
Outpatient Visits	4,188.23	4,199.45	4,366.73	+167.28	NC
Inpatient Utilization—General Hospital/Acute Care (IPU)					
Discharges—Total Inpatient—Total All Ages	98.78	84.57	92.99	+8.41	NC
Average Length of Stay—Total Inpatient—Total All Ages	5.59	6.14	6.23	+0.09	NC
Discharges—Maternity—Total All Ages	24.13	21.08	20.68	-0.40	NC
Average Length of Stay—Maternity—Total All Ages	2.42	2.44	2.61	+0.17	NC

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Discharges—Surgery—Total All Ages	25.88	23.33	25.77	+2.44	NC
Average Length of Stay—Surgery—Total All Ages	9.16	9.51	9.95	+0.44	NC
Discharges—Medicine—Total All Ages	54.83	45.48	51.87	+6.40	NC
Average Length of Stay—Medicine—Total All Ages	4.94	5.70	5.45	-0.25	NC
Use of Opioids From Multiple Providers (UOP)*					
Multiple Prescribers	15.63%	16.38%	16.17%	-0.21	★★★
Multiple Pharmacies	2.31%	3.26%	4.32%	+1.06	★
Multiple Prescribers and Multiple Pharmacies	1.78%	2.43%	3.02%	+0.59	★
Use of Opioids at High Dosage (HDO)*					
Use of Opioids at High Dosage	2.65%	2.81%	2.28%	-0.53	★★★
Risk of Continued Opioid Use (COU)*					
At Least 15 Days Covered—Total	9.59%	9.81%	9.13%	-0.68	★
At Least 31 Days Covered—Total	7.13%	7.14%	6.58%	-0.56	★
Plan All-Cause Readmissions (PCR)					
Observed Readmissions—Total	11.99%	13.85%	13.39%	-0.46	NC
Expected Readmissions—Total	10.74%	10.73%	10.73%	0.00	NC
O/E Ratio—Total	1.1158	1.2912	1.2484	-0.04	★

¹HEDIS MY 2022 to HEDIS MY 2023 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2022–MY 2023 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2022–MY 2023 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

²HEDIS MY 2023 Performance Levels were based on comparisons of the HEDIS MY 2023 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2022 benchmark

³Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any Performance Levels for MY 2023 or MY 2022–MY 2023 Comparisons provided for these measures are for information only.

⁴Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

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

— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure.

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

HEDIS MY 2023 Performance Levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Table B-2—BCC Trend Table

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Child & Adolescent Care					
Childhood Immunization Status (CIS)					
Combination 3	55.96%	57.91%	60.34%	+2.43	★★
Combination 7	48.18%	48.66%	51.09%	+2.43	★★
Combination 10	30.66%	26.28%	23.60%	-2.68	★
Well-Child Visits in the First 30 Months of Life (W30)					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	61.80%	67.72%	67.71%	-0.01	★★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	62.98%	63.64%	67.86%	+4.22 ⁺	★★★
Lead Screening in Children (LSC)					
Lead Screening in Children	55.23%	53.28%	57.22%	+3.93	★★
Child and Adolescent Well-Care Visits (WCV)					
Ages 3 to 11 Years	59.20%	59.79%	62.53%	+2.74 ⁺	★★★
Ages 12 to 17 Years	49.83%	48.29%	51.35%	+3.06 ⁺	★★★
Ages 18 to 21 Years	31.08%	29.30%	31.88%	+2.58 ⁺	★★★★
Total	51.22%	50.85%	54.19%	+3.34 ⁺	★★★
Immunizations for Adolescents (IMA)					
Combination 1 (Meningococcal, Tdap)	74.45%	74.42%	78.59%	+4.17	★★
Combination 2 (Meningococcal, Tdap, HPV)	32.12%	28.89%	33.82%	+4.93 ⁺	★★
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)⁴					
Initiation Phase	43.94%	46.65%	51.49%	+4.84 ⁺	★★★★
Continuation and Maintenance Phase	62.04%	61.86%	58.42%	-3.44	★★★
Women—Adult Care					
Chlamydia Screening in Women (CHL)⁴					
Ages 16 to 20 Years	58.41%	60.81%	61.32%	+0.51	★★★★
Ages 21 to 24 Years	63.32%	65.78%	66.55%	+0.77	★★★★
Total	61.08%	63.55%	64.05%	+0.49	★★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Cervical Cancer Screening (CCS-E)					
Cervical Cancer Screening	59.49%	60.30%	55.35%	-4.95 ⁺⁺	★★
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening	52.13%	53.17%	54.29%	+1.12	★★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Ages 20 to 44 Years	76.86%	74.19%	74.46%	+0.27	★★★
Ages 45 to 64 Years	83.45%	81.71%	82.04%	+0.33	★★★
Ages 65 Years and Older	76.97%	76.10%	72.29%	-3.81 ⁺⁺	★
Total	79.06%	76.71%	77.02%	+0.31 ⁺	★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)					
Ages 3 Months to 17 Years	65.57%	64.35%	69.57%	+5.22 ⁺	★★
Ages 18 to 64 Years	43.80%	37.99%	39.13%	+1.14	★
Ages 65 Years and Older	NA	NA	NA	NC	NC
Total	49.46%	51.38%	55.26%	+3.88 ⁺	★
Appropriate Testing for Pharyngitis (CWP)					
Ages 3 to 17 Years	70.29%	66.77%	78.58%	+11.81 ⁺	★★★
Ages 18 to 64 Years	50.67%	52.36%	64.48%	+12.13 ⁺	★★★
Ages 65 Years and Older	NA	NA	NA	NC	NC
Total	57.21%	58.60%	72.22%	+13.63 ⁺	★★
Appropriate Treatment for Upper Respiratory Infection (URI)					
Ages 3 Months to 17 Years	94.71%	92.77%	90.97%	-1.80 ⁺⁺	★
Ages 18 to 64 Years	81.42%	79.72%	76.28%	-3.44 ⁺⁺	★★
Ages 65 Years and Older	NA	NA	81.63%	NC	★★★
Total	88.76%	88.11%	85.88%	-2.23 ⁺⁺	★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
Body Mass Index (BMI) Percentile—Total	83.07%	81.51%	86.20%	+4.69	★★★★
Counseling for Nutrition—Total	76.56%	75.00%	78.91%	+3.91	★★★★
Counseling for Physical Activity—Total	75.26%	72.92%	77.86%	+4.95	★★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Pregnancy Care					
Prenatal and Postpartum Care (PPC) ⁴					
Timeliness of Prenatal Care	88.08%	86.86%	88.16%	+1.30	★★★
Postpartum Care	78.59%	76.40%	81.62%	+5.22	★★★
Living With Illness					
Hemoglobin A1c Control for Patients With Diabetes (HBD)					
HbA1c Control (<8.0%)	50.85%	59.61%	58.92%	-0.69	★★★★
HbA1c Poor Control (>9.0%)*	37.96%	34.06%	35.21%	+1.14	★★★
Blood Pressure Control for Patients With Diabetes (BPD)					
Blood Pressure Control for Patients With Diabetes	59.37%	70.07%	65.77%	-4.30	★★★
Eye Exam for Patients With Diabetes (EED) ⁴					
Eye Exam for Patients With Diabetes	54.99%	54.01%	56.97%	+2.95	★★★
Kidney Health Evaluation for Patients With Diabetes (KED)					
Ages 18 to 64 Years	28.07%	34.76%	36.39%	+1.63 ⁺	★★★
Ages 65 to 74 Years	29.59%	40.39%	41.71%	+1.32	★★★
Ages 75 to 85 Years	25.53%	37.93%	35.62%	-2.31	★★
Total	28.08%	34.85%	36.45%	+1.60 ⁺	★★★
Asthma Medication Ratio (AMR)					
Total	49.01%	49.04%	50.42%	+1.38	★
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure	57.95%	58.81%	64.34%	+5.53	★★★
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)					
Persistence of Beta-Blocker Treatment After a Heart Attack	84.39%	82.63%	57.43%	-25.20 ⁺⁺	★
Cardiac Rehabilitation (CRE)					
Initiation—Ages 18 to 64 Years	2.98%	4.82%	3.47%	-1.35	★★★
Initiation—Ages 65 Years and Older	NA	NA	NA	NC	NC
Initiation—Total	2.96%	4.81%	3.44%	-1.36	★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Engagement 1—Ages 18 to 64 Years	5.82%	7.72%	7.09%	-0.63	★★★★
Engagement 1—Ages 65 Years and Older	NA	NA	NA	NC	NC
Engagement 1—Total	5.78%	7.85%	7.19%	-0.67	★★★★
Engagement 2—Ages 18 to 64 Years	4.87%	6.59%	6.03%	-0.56	★★★★
Engagement 2—Ages 65 Years and Older	NA	NA	NA	NC	NC
Engagement 2—Total	4.84%	6.73%	6.14%	-0.59	★★★★
Achievement—Ages 18 to 64 Years	2.98%	3.22%	4.52%	+1.31	★★★★★
Achievement—Ages 65 Years and Older	NA	NA	NA	NC	NC
Achievement—Total	2.96%	3.21%	4.49%	+1.29	★★★★★
Antidepressant Medication Management (AMM) ⁴					
Effective Acute Phase Treatment	68.44%	66.06%	68.20%	+2.15 ⁺	★★★★
Effective Continuation Phase Treatment	52.44%	48.81%	52.30%	+3.49 ⁺	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.37%	79.85%	83.51%	+3.66 ⁺	★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia	59.60%	63.51%	70.42%	+6.91	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	59.38%	NC	★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	57.08%	57.63%	59.37%	+1.74	★★
Diagnosed Mental Health Disorders (DMH)					
Ages 1 to 17 Years	—	21.43%	23.14%	+1.72 ⁺	★★★★
Ages 18 to 64 Years	—	31.35%	32.90%	+1.55 ⁺	★★★★
Ages 65 Years and Older	—	18.56%	18.17%	-0.39	★
Total	—	27.90%	29.39%	+1.49 ⁺	★★★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership (RDM)					
White	50.27%	51.82%	52.36%	+0.54	NC
Black or African American	34.93%	35.10%	34.39%	-0.72	NC
American Indian or Alaska Native	1.39%	1.28%	1.23%	-0.05	NC
Asian	1.72%	1.97%	2.43%	+0.46	NC
Native Hawaiian or Other Pacific Islander	2.94%	2.58%	2.30%	-0.27	NC
Some Other Race	0.00%	0.01%	0.00%	-0.01	NC
Two or More Races	0.03%	0.02%	0.03%	+0.00	NC
Ethnicity Reporting Category: Hispanic or Latino	2.90%	6.07%	7.60%	+1.52	NC
Unknown	8.73%	7.20%	0.00%	-7.20	NC
Declined	0.00%	0.01%	7.25%	+7.24	NC
Language Diversity of Membership (LDM)					
Spoken Language Preferred for Health Care—English	98.33%	96.48%	96.05%	-0.43	NC
Spoken Language Preferred for Health Care—Non-English	1.66%	3.43%	3.86%	+0.43	NC
Spoken Language Preferred for Health Care—Unknown	0.01%	0.09%	0.10%	+0.00	NC
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—English	98.33%	96.65%	96.24%	-0.41	NC

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Language Preferred for Written Materials—Non-English	1.67%	3.28%	3.69%	+0.40	NC
Language Preferred for Written Materials—Unknown	0.01%	0.07%	0.07%	+0.00	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	98.72%	98.46%	98.23%	-0.23	NC
Other Language Needs—Non-English	1.27%	1.53%	1.76%	+0.23	NC
Other Language Needs—Unknown	0.01%	0.01%	<0.01%	+0.00	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization³					
Ambulatory Care (AMB)					
Emergency Department Visits*	542.29	550.05	552.88	+2.83	★★★★
Outpatient Visits	4,494.71	4,441.93	4,328.00	-113.93	NC
Inpatient Utilization—General Hospital/Acute Care (IPU)					
Discharges—Total Inpatient—Total All Ages	82.28	70.93	66.06	-4.86	NC
Average Length of Stay—Total Inpatient—Total All Ages	4.69	4.92	4.80	-0.12	NC
Discharges—Maternity—Total All Ages	27.22	23.94	23.37	-0.57	NC
Average Length of Stay—Maternity—Total All Ages	2.77	2.87	2.79	-0.07	NC
Discharges—Surgery—Total All Ages	18.15	17.35	16.05	-1.29	NC
Average Length of Stay—Surgery—Total All Ages	7.99	8.19	7.69	-0.50	NC
Discharges—Medicine—Total All Ages	42.85	34.83	31.75	-3.08	NC
Average Length of Stay—Medicine—Total All Ages	4.24	4.40	4.50	+0.09	NC

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Use of Opioids From Multiple Providers (UOP)*					
Multiple Prescribers	17.63%	17.25%	17.14%	-0.11	★★★
Multiple Pharmacies	2.96%	2.42%	3.33%	+0.91 ⁺⁺	★★
Multiple Prescribers and Multiple Pharmacies	2.09%	1.63%	2.07%	+0.44 ⁺⁺	★★
Use of Opioids at High Dosage (HDO)*					
Use of Opioids at High Dosage	1.31%	0.80%	0.84%	+0.05	★★★★★
Risk of Continued Opioid Use (COU)*					
At Least 15 Days Covered—Total	8.14%	7.56%	7.40%	-0.15	★★
At Least 31 Days Covered—Total	5.78%	5.37%	5.09%	-0.28	★
Plan All-Cause Readmissions (PCR)					
Observed Readmissions—Total	9.98%	10.65%	11.55%	+0.89	NC
Expected Readmissions—Total	9.88%	10.25%	10.31%	+0.06	NC
O/E Ratio—Total	1.0096	1.0390	1.1200	+0.08	★

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

¹HEDIS MY 2022 to HEDIS MY 2023 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2021–MY 2023 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. 2022–2023 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

²HEDIS MY 2023 Performance Levels were based on comparisons of the HEDIS MY 2023 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2022 benchmark.

³Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any Performance Levels for MY 2023 or MY 2022–MY 2023 Comparisons provided for these measures are for information only.

⁴Due to changes in the technical specifications for this measure, NCQA recommends trending between MY 2023 and prior years be considered with caution.

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

— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure.

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

HEDIS MY 2023 Performance Levels represent the following percentile comparisons:

Table B-3—HCS Trend Table

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Child & Adolescent Care					
Childhood Immunization Status (CIS)					
Combination 3	37.89%	46.22%	50.46%	+4.24	★
Combination 7	29.64%	39.33%	41.31%	+1.98	★
Combination 10	15.46%	19.83%	17.39%	-2.45	★
Well-Child Visits in the First 30 Months of Life (W30)					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	36.06%	52.44%	54.92%	+2.48	★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	46.05%	47.35%	59.13%	+11.79 ⁺	★
Lead Screening in Children (LSC)					
Lead Screening in Children	44.59%	48.74%	55.97%	+7.23 ⁺	★★
Child and Adolescent Well-Care Visits (WCV)					
Ages 3 to 11 Years	45.80%	47.26%	51.14%	+3.88 ⁺	★★
Ages 12 to 17 Years	34.35%	36.91%	37.01%	+0.10	★
Ages 18 to 21 Years	19.18%	22.12%	20.81%	-1.31	★★
Total	36.69%	38.98%	41.56%	+2.58 ⁺	★
Immunizations for Adolescents (IMA)					
Combination 1 (Meningococcal, Tdap)	60.55%	65.23%	69.28%	+4.05	★
Combination 2 (Meningococcal, Tdap, HPV)	18.81%	17.19%	22.87%	+5.68	★
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)⁴					
Initiation Phase	34.38%	28.13%	36.92%	+8.80	★
Continuation and Maintenance Phase	NA	NA	42.11%	NC	★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Women—Adult Care					
Chlamydia Screening in Women (CHL)⁴					
Ages 16 to 20 Years	55.87%	64.90%	62.96%	-1.94	★★★★
Ages 21 to 24 Years	60.48%	66.17%	65.08%	-1.09	★★★
Total	58.96%	65.78%	64.29%	-1.50	★★★★
Cervical Cancer Screening (CCS-E)					
Cervical Cancer Screening	43.80%	56.45%	45.23%	-11.22 ⁺⁺	★
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening	56.20%	54.60%	55.11%	+0.51	★★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Ages 20 to 44 Years	60.43%	61.17%	62.38%	+1.21 ⁺	★
Ages 45 to 64 Years	74.95%	74.93%	75.57%	+0.64	★★
Ages 65 Years and Older	89.41%	90.91%	90.08%	-0.83	★★★★
Total	68.56%	68.50%	69.16%	+0.66	★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)					
Ages 3 Months to 17 Years	71.05%	62.05%	75.97%	+13.92 ⁺	★★★
Ages 18 to 64 Years	44.90%	38.86%	38.34%	-0.52	★
Ages 65 Years and Older	NA	23.33%	22.92%	-0.42	★
Total	50.98%	48.17%	53.42%	+5.26	★
Appropriate Testing for Pharyngitis (CWP)					
Ages 3 to 17 Years	65.56%	63.32%	73.25%	+9.94 ⁺	★★
Ages 18 to 64 Years	43.81%	55.82%	66.08%	+10.26 ⁺	★★★
Ages 65 Years and Older	NA	NA	NA	NC	NC
Total	48.25%	57.41%	68.85%	+11.45 ⁺	★★
Appropriate Treatment for Upper Respiratory Infection (URI)					
Ages 3 Months to 17 Years	95.76%	92.49%	90.90%	-1.58	★
Ages 18 to 64 Years	81.39%	81.79%	79.22%	-2.57	★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
<i>Ages 65 Years and Older</i>	62.50%	68.92%	61.86%	-7.06	★
<i>Total</i>	88.07%	87.60%	85.62%	-1.98 ⁺⁺	★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
<i>Body Mass Index (BMI) Percentile—Total</i>	81.42%	85.67%	88.85%	+3.18	★★★★★
<i>Counseling for Nutrition—Total</i>	75.14%	78.96%	83.93%	+4.97	★★★★★
<i>Counseling for Physical Activity—Total</i>	73.50%	76.52%	79.34%	+2.82	★★★★★
Pregnancy Care					
Prenatal and Postpartum Care (PPC)⁴					
<i>Timeliness of Prenatal Care</i>	75.88%	79.21%	76.11%	-3.10	★
<i>Postpartum Care</i>	64.57%	68.68%	65.00%	-3.68	★
Living With Illness					
Hemoglobin A1c Control for Patients With Diabetes (HBD)					
<i>HbA1c Control (<8.0%)</i>	44.28%	56.20%	60.25%	+4.04	★★★★★
<i>HbA1c Poor Control (>9.0%)*</i>	50.12%	35.77%	32.35%	-3.42	★★★★★
Blood Pressure Control for Patients With Diabetes (BPD)					
<i>Blood Pressure Control for Patients With Diabetes</i>	53.28%	61.07%	66.17%	+5.10	★★★★
Eye Exam for Patients With Diabetes (EED)⁴					
<i>Eye Exam for Patients With Diabetes</i>	49.88%	58.88%	53.33%	-5.55	★★★★
Kidney Health Evaluation for Patients With Diabetes (KED)					
<i>Ages 18 to 64 Years</i>	31.20%	37.86%	38.72%	+0.86	★★★★
<i>Ages 65 to 74 Years</i>	33.55%	44.93%	42.58%	-2.36	★★★★
<i>Ages 75 to 85 Years</i>	32.35%	43.10%	38.50%	-4.60	★★★★
<i>Total</i>	31.83%	39.52%	39.37%	-0.16	★★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Asthma Medication Ratio (AMR)					
<i>Total</i>	48.30%	52.03%	55.56%	+3.52	★
Controlling High Blood Pressure (CBP)					
<i>Controlling High Blood Pressure</i>	57.32%	62.53%	65.72%	+3.19	★★★★
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)					
<i>Persistence of Beta-Blocker Treatment After a Heart Attack</i>	81.82%	NA	NA	NC	NC
Cardiac Rehabilitation (CRE)					
<i>Initiation—Ages 18 to 64 Years</i>	1.80%	7.87%	3.23%	-4.64	★★★★
<i>Initiation—Ages 65 Years and Older</i>	NA	NA	NA	NC	NC
<i>Initiation—Total</i>	2.44%	8.08%	2.65%	-5.43	★★★
<i>Engagement 1—Ages 18 to 64 Years</i>	1.80%	6.74%	5.38%	-1.37	★★★★
<i>Engagement 1—Ages 65 Years and Older</i>	NA	NA	NA	NC	NC
<i>Engagement 1—Total</i>	2.44%	6.06%	5.31%	-0.75	★★★★
<i>Engagement 2—Ages 18 to 64 Years</i>	1.80%	2.25%	4.30%	+2.05	★★★★
<i>Engagement 2—Ages 65 Years and Older</i>	NA	NA	NA	NC	NC
<i>Engagement 2—Total</i>	3.25%	3.03%	4.42%	+1.39	★★★★
<i>Achievement—Ages 18 to 64 Years</i>	0.90%	1.12%	0.00%	-1.12	★
<i>Achievement—Ages 65 Years and Older</i>	NA	NA	NA	NC	NC
<i>Achievement—Total</i>	2.44%	1.01%	0.88%	-0.13	★★★
Antidepressant Medication Management (AMM)⁴					
<i>Effective Acute Phase Treatment</i>	77.32%	78.79%	77.85%	-0.94	★★★★★
<i>Effective Continuation Phase Treatment</i>	63.41%	67.27%	64.53%	-2.75	★★★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	76.61%	82.16%	82.36%	+0.20	★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia	64.86%	64.20%	68.07%	+3.87	★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	NC	NC
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	63.44%	61.30%	63.25%	+1.95	★★★
Diagnosed Mental Health Disorders (DMH)					
Ages 1 to 17 Years	—	12.95%	16.99%	+4.03 ⁺	★★
Ages 18 to 64 Years	—	23.73%	26.61%	+2.89 ⁺	★★
Ages 65 Years and Older	—	34.25%	36.20%	+1.95	★★★
Total	—	22.40%	25.18%	+2.78 ⁺	★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership (RDM)					
White	41.61%	38.26%	41.05%	+2.80	NC
Black or African American	45.63%	42.88%	45.48%	+2.60	NC
American Indian or Alaska Native	0.50%	0.42%	0.48%	+0.06	NC

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Asian	1.35%	1.30%	2.03%	+0.73	NC
Native Hawaiian or Other Pacific Islander	0.07%	0.11%	0.12%	+0.02	NC
Some Other Race	1.67%	1.11%	2.85%	+1.74	NC
Two or More Races	0.00%	0.00%	0.00%	0.00	NC
Ethnicity Reporting Category: Hispanic or Latino	0.91%	0.50%	3.31%	+2.81	NC
Unknown	9.13%	15.90%	7.95%	-7.95	NC
Declined	0.04%	0.03%	0.03%	+0.01	NC
Language Diversity of Membership (LDM)					
Spoken Language Preferred for Health Care—English	99.10%	98.80%	97.75%	-1.05	NC
Spoken Language Preferred for Health Care—Non-English	0.00%	0.00%	0.92%	+0.92	NC
Spoken Language Preferred for Health Care—Unknown	0.90%	1.20%	1.33%	+0.13	NC
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—English	99.10%	98.80%	97.75%	-1.05	NC
Language Preferred for Written Materials—Non-English	0.00%	0.00%	0.92%	+0.92	NC
Language Preferred for Written Materials—Unknown	0.90%	1.20%	1.33%	+0.13	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	99.10%	98.80%	97.75%	-1.05	NC

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
<i>Other Language Needs—Non-English</i>	0.00%	0.00%	0.92%	+0.92	NC
<i>Other Language Needs—Unknown</i>	0.90%	1.20%	1.33%	+0.13	NC
<i>Other Language Needs—Declined</i>	0.00%	0.00%	0.00%	0.00	NC
Utilization³					
Ambulatory Care (AMB)					
<i>Emergency Department Visits*</i>	613.21	588.19	577.42	-10.77	★★
<i>Outpatient Visits</i>	4,642.90	4,780.73	4,669.76	-110.97	NC
Inpatient Utilization—General Hospital/Acute Care (IPU)					
<i>Discharges—Total Inpatient—Total All Ages</i>	108.36	104.55	94.91	-9.64	NC
<i>Average Length of Stay—Total Inpatient—Total All Ages</i>	6.08	5.77	5.25	-0.51	NC
<i>Discharges—Maternity—Total All Ages</i>	21.81	22.58	19.93	-2.65	NC
<i>Average Length of Stay—Maternity—Total All Ages</i>	2.45	2.48	2.63	+0.15	NC
<i>Discharges—Surgery—Total All Ages</i>	27.93	28.41	24.62	-3.79	NC
<i>Average Length of Stay—Surgery—Total All Ages</i>	9.55	9.55	8.29	-1.26	NC
<i>Discharges—Medicine—Total All Ages</i>	63.69	58.52	54.79	-3.73	NC
<i>Average Length of Stay—Medicine—Total All Ages</i>	5.51	4.92	4.63	-0.29	NC

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Use of Opioids From Multiple Providers (UOP)*					
<i>Multiple Prescribers</i>	17.30%	16.79%	15.41%	-1.38	★★★
<i>Multiple Pharmacies</i>	2.92%	2.73%	2.37%	-0.36	★★
<i>Multiple Prescribers and Multiple Pharmacies</i>	2.37%	1.82%	1.65%	-0.17	★★
Use of Opioids at High Dosage (HDO)*					
<i>Use of Opioids at High Dosage</i>	1.94%	1.27%	1.60%	+0.33	★★★★
Risk of Continued Opioid Use (COU)*					
<i>At Least 15 Days Covered—Total</i>	11.94%	11.71%	11.83%	+0.11	★
<i>At Least 31 Days Covered—Total</i>	6.84%	5.53%	6.56%	+1.03	★
Plan All-Cause Readmissions (PCR)					
<i>Observed Readmissions—Total</i>	9.86%	8.83%	9.60%	+0.77	NC
<i>Expected Readmissions—Total</i>	9.76%	10.44%	10.19%	-0.24	NC
<i>O/E Ratio—Total</i>	1.0099	0.8463	0.9415	+0.10	★★★

¹HEDIS MY 2022 to HEDIS MY 2023 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2022–MY 2023 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2022–MY 2022 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

²HEDIS MY 2023 Performance Levels were based on comparisons of the HEDIS MY 2023 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2022 benchmark.

³Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any Performance Levels for MY 2023 or MY 2022–MY 2023 Comparisons provided for these measures are for information only.

⁴Due to changes in the technical specifications for this measure, NCQA recommends trending between MY 2023 and prior years be considered with caution.

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

— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure.

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.



HEDIS MY 2023 Performance Levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Table B-4—MCL Trend Table

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Child & Adolescent Care					
Childhood Immunization Status (CIS)					
Combination 3	58.88%	54.99%	58.88%	+3.89	★★
Combination 7	51.09%	47.20%	49.79%	+2.58	★
Combination 10	29.68%	23.36%	21.87%	-1.49	★
Well-Child Visits in the First 30 Months of Life (W30)					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	58.66%	65.02%	65.75%	+0.73	★★★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	59.04%	62.08%	66.45%	+4.37 ⁺	★★
Lead Screening in Children (LSC)					
Lead Screening in Children	40.63%	43.33%	51.89%	+8.55 ⁺	★★
Child and Adolescent Well-Care Visits (WCV)					
Ages 3 to 11 Years	54.63%	58.39%	59.38%	+0.99 ⁺	★★★★
Ages 12 to 17 Years	44.47%	47.20%	47.44%	+0.24	★★
Ages 18 to 21 Years	23.41%	23.31%	24.42%	+1.11 ⁺	★★★★
Total	45.88%	48.46%	49.89%	+1.43 ⁺	★★★★
Immunizations for Adolescents (IMA)					
Combination 1 (Meningococcal, Tdap)	77.86%	75.91%	79.32%	+3.41	★★
Combination 2 (Meningococcal, Tdap, HPV)	29.68%	28.47%	29.68%	+1.22	★★
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)⁴					
Initiation Phase	40.70%	46.97%	48.04%	+1.07	★★★★
Continuation and Maintenance Phase	54.96%	58.26%	55.43%	-2.83	★★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Women—Adult Care					
Chlamydia Screening in Women (CHL)⁴					
Ages 16 to 20 Years	53.84%	52.46%	52.75%	+0.29	★★★★
Ages 21 to 24 Years	61.89%	62.53%	62.65%	+0.12	★★★★
Total	57.84%	57.54%	57.67%	+0.14	★★★★
Cervical Cancer Screening (CCS-E)					
Cervical Cancer Screening	56.69%	55.06%	53.26%	-1.81	★★
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening	53.58%	54.57%	54.76%	+0.19	★★★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Ages 20 to 44 Years	73.12%	70.38%	70.70%	+0.32	★★★★
Ages 45 to 64 Years	82.20%	80.64%	80.87%	+0.23	★★★★
Ages 65 Years and Older	72.92%	72.24%	67.30%	-4.93	★
Total	76.07%	73.68%	74.00%	+0.32	★★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)					
Ages 3 Months to 17 Years	62.45%	72.09%	74.60%	+2.51 ⁺	★★★★
Ages 18 to 64 Years	42.27%	43.48%	41.29%	-2.19	★★
Ages 65 Years and Older	NA	NA	NA	NC	NC
Total	48.74%	58.28%	58.98%	+0.70	★★
Appropriate Testing for Pharyngitis (CWP)					
Ages 3 to 17 Years	79.14%	79.96%	82.08%	+2.13 ⁺	★★★★
Ages 18 to 64 Years	67.38%	66.43%	71.26%	+4.83 ⁺	★★★★
Ages 65 Years and Older	NA	NA	NA	NC	NC
Total	73.13%	73.79%	78.15%	+4.36 ⁺	★★★★
Appropriate Treatment for Upper Respiratory Infection (URI)					
Ages 3 Months to 17 Years	93.42%	91.63%	90.10%	-1.53 ⁺⁺	★
Ages 18 to 64 Years	85.30%	83.56%	80.05%	-3.51 ⁺⁺	★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
<i>Ages 65 Years and Older</i>	NA	NA	NA	NC	NC
<i>Total</i>	89.74%	88.75%	86.75%	-1.99 ⁺⁺	★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
<i>Body Mass Index (BMI) Percentile—Total</i>	60.83%	66.83%	71.85%	+5.02	★★
<i>Counseling for Nutrition—Total</i>	52.55%	57.32%	65.68%	+8.36 ⁺	★★
<i>Counseling for Physical Activity—Total</i>	52.31%	56.59%	64.20%	+7.61 ⁺	★★
Pregnancy Care					
Prenatal and Postpartum Care (PPC) ⁴					
<i>Timeliness of Prenatal Care</i>	77.86%	71.86%	78.36%	+6.50 ⁺	★
<i>Postpartum Care</i>	67.40%	75.96%	77.78%	+1.82	★★
Living With Illness					
Hemoglobin A1c Control for Patients With Diabetes (HBD)					
<i>HbA1c Control (<8.0%)</i>	38.20%	34.79%	49.39%	+14.60 ⁺	★★
<i>HbA1c Poor Control (>9.0%)*</i>	54.74%	58.64%	42.58%	-16.06 ⁺	★★
Blood Pressure Control for Patients With Diabetes (BPD)					
<i>Blood Pressure Control for Patients With Diabetes</i>	43.31%	47.69%	62.53%	+14.84 ⁺	★★
Eye Exam for Patients With Diabetes (EED) ⁴					
<i>Eye Exam for Patients With Diabetes</i>	50.61%	52.55%	56.93%	+4.38	★★★★
Kidney Health Evaluation for Patients With Diabetes (KED)					
<i>Ages 18 to 64 Years</i>	29.11%	30.99%	35.76%	+4.77 ⁺	★★★★
<i>Ages 65 to 74 Years</i>	42.42%	20.63%	43.55%	+22.91 ⁺	★★★★
<i>Ages 75 to 85 Years</i>	NA	NA	NA	NC	NC

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
<i>Total</i>	29.22%	30.94%	35.81%	+4.86 ⁺	★★★★
Asthma Medication Ratio (AMR)					
<i>Total</i>	54.64%	54.48%	49.55%	-4.93 ⁺⁺	★
Controlling High Blood Pressure (CBP)					
<i>Controlling High Blood Pressure</i>	45.26%	46.47%	52.80%	+6.33	★
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)					
<i>Persistence of Beta-Blocker Treatment After a Heart Attack</i>	89.40%	87.08%	63.41%	-23.67 ⁺⁺	★
Cardiac Rehabilitation (CRE)					
<i>Initiation—Ages 18 to 64 Years</i>	8.40%	6.09%	6.99%	+0.90	★★★★★
<i>Initiation—Ages 65 Years and Older</i>	NA	NA	NA	NC	NC
<i>Initiation—Total</i>	8.37%	6.06%	6.98%	+0.92	★★★★★
<i>Engagement 1—Ages 18 to 64 Years</i>	11.11%	11.34%	7.99%	-3.35	★★★★★
<i>Engagement 1—Ages 65 Years and Older</i>	NA	NA	NA	NC	NC
<i>Engagement 1—Total</i>	11.21%	11.45%	7.97%	-3.47 ⁺⁺	★★★★★
<i>Engagement 2—Ages 18 to 64 Years</i>	9.97%	11.51%	5.16%	-6.35 ⁺⁺	★★★★
<i>Engagement 2—Ages 65 Years and Older</i>	NA	NA	NA	NC	NC
<i>Engagement 2—Total</i>	10.07%	11.62%	5.15%	-6.47 ⁺⁺	★★★★
<i>Achievement—Ages 18 to 64 Years</i>	7.12%	7.78%	1.50%	-6.29 ⁺⁺	★★★★
<i>Achievement—Ages 65 Years and Older</i>	NA	NA	NA	NC	NC
<i>Achievement—Total</i>	7.23%	7.91%	1.50%	-6.42 ⁺⁺	★★★★
Antidepressant Medication Management (AMM) ⁴					
<i>Effective Acute Phase Treatment</i>	68.64%	69.22%	71.37%	+2.15 ⁺	★★★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
<i>Effective Continuation Phase Treatment</i>	52.44%	54.25%	54.07%	-0.18	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)					
<i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</i>	77.64%	79.13%	80.34%	+1.22	★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
<i>Diabetes Monitoring for People With Diabetes and Schizophrenia</i>	65.00%	64.78%	70.69%	+5.91	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
<i>Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia</i>	65.96%	69.57%	73.17%	+3.61	★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)					
<i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia</i>	65.14%	64.81%	66.81%	+2.00	★★★
Diagnosed Mental Health Disorders (DMH)					
<i>Ages 1 to 17 Years</i>	—	26.67%	28.43%	+1.76 ⁺	★★★★
<i>Ages 18 to 64 Years</i>	—	36.86%	38.45%	+1.59 ⁺	★★★★
<i>Ages 65 Years and Older</i>	—	23.95%	26.17%	+2.22	★★
<i>Total</i>	—	33.10%	34.68%	+1.58 ⁺	★★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Health Plan Diversity					
Race/Ethnicity Diversity of Membership (RDM)					
<i>White</i>	68.31%	69.28%	69.06%	-0.23	NC
<i>Black or African American</i>	21.23%	21.16%	21.14%	-0.02	NC
<i>American Indian or Alaska Native</i>	1.06%	1.05%	1.11%	+0.06	NC
<i>Asian</i>	0.69%	1.08%	1.08%	+0.00	NC
<i>Native Hawaiian or Other Pacific Islander</i>	0.11%	0.12%	0.12%	+0.01	NC
<i>Some Other Race</i>	0.41%	6.76%	0.00%	-6.76	NC
<i>Two or More Races</i>	0.00%	0.00%	0.00%	0.00	NC
<i>Ethnicity Reporting Category: Hispanic or Latino</i>	0.41%	6.32%	6.75%	+0.43	NC
<i>Unknown</i>	8.19%	0.56%	7.49%	+6.93	NC
<i>Declined</i>	0.00%	0.00%	0.00%	0.00	NC
Language Diversity of Membership (LDM)					
<i>Spoken Language Preferred for Health Care—English</i>	47.65%	99.08%	98.73%	-0.36	NC
<i>Spoken Language Preferred for Health Care—Non-English</i>	0.35%	0.92%	1.10%	+0.18	NC
<i>Spoken Language Preferred for Health Care—Unknown</i>	52.00%	0.00%	0.18%	+0.17	NC
<i>Spoken Language Preferred for Health Care—Declined</i>	0.00%	0.00%	0.00%	0.00	NC
<i>Language Preferred for Written Materials—English</i>	0.00%	98.97%	98.73%	-0.25	NC
<i>Language Preferred for Written Materials—Non-English</i>	0.00%	0.92%	1.10%	+0.18	NC

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Language Preferred for Written Materials—Unknown	100.00%	0.11%	0.18%	+0.06	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—Non-English	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—Unknown	100.00%	100.00%	100.00%	0.00	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization³					
Ambulatory Care (AMB)					
Emergency Department Visits*	667.06	675.09	617.88	-57.21	★★
Outpatient Visits	8,195.79	8,194.31	4,865.68	-3328.63	NC
Inpatient Utilization—General Hospital/Acute Care (IPU)					
Discharges—Total Inpatient—Total All Ages	88.23	77.31	70.55	-6.76	NC
Average Length of Stay—Total Inpatient—Total All Ages	4.21	4.27	4.45	+0.18	NC
Discharges—Maternity—Total All Ages	26.01	24.60	22.01	-2.59	NC
Average Length of Stay—Maternity—Total All Ages	1.71	1.67	2.44	+0.78	NC
Discharges—Surgery—Total All Ages	21.10	19.51	18.38	-1.13	NC

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Average Length of Stay—Surgery—Total All Ages	7.00	6.86	6.68	-0.18	NC
Discharges—Medicine—Total All Ages	47.09	38.65	34.99	-3.67	NC
Average Length of Stay—Medicine—Total All Ages	4.02	4.26	4.26	+0.01	NC
Use of Opioids From Multiple Providers (UOP)*					
Multiple Prescribers	14.19%	14.32%	15.13%	+0.81	★★★★
Multiple Pharmacies	2.13%	1.74%	3.02%	+1.28 ⁺⁺	★★
Multiple Prescribers and Multiple Pharmacies	1.21%	0.91%	1.45%	+0.53 ⁺⁺	★★
Use of Opioids at High Dosage (HDO)*					
Use of Opioids at High Dosage	2.43%	1.33%	1.22%	-0.11	★★★★
Risk of Continued Opioid Use (COU)*					
At Least 15 Days Covered—Total	7.22%	6.41%	6.45%	+0.04	★★
At Least 31 Days Covered—Total	5.20%	4.60%	4.55%	-0.04	★
Plan All-Cause Readmissions (PCR)					
Observed Readmissions—Total	9.60%	9.56%	8.52%	-1.04 ⁺	NC
Expected Readmissions—Total	9.71%	9.63%	9.38%	-0.25	NC
O/E Ratio—Total	0.9891	0.9936	0.9089	-0.08	★★★★

¹HEDIS MY 2022 to HEDIS MY 2023 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2022–MY 2023 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2022–MY 2023 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

²HEDIS MY 2023 Performance Levels were based on comparisons of the HEDIS MY 2023 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks, with the exception

of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2022 benchmark.

³Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any Performance Levels for MY 2023 or MY 2022–MY 2023 Comparisons provided for these measures are for information only.

⁴ Due to changes in the technical specifications for this measure, NCQA recommends trending between MY 2023 and prior years be considered with caution.

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

— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

HEDIS MY 2023 Performance Levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Table B-5—MER Trend Table

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Child & Adolescent Care					
Childhood Immunization Status (CIS)					
Combination 3	54.26%	58.88%	55.47%	-3.41	★
Combination 7	45.01%	52.31%	49.39%	-2.92	★
Combination 10	23.36%	25.30%	23.60%	-1.70	★
Well-Child Visits in the First 30 Months of Life (W30)					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	60.85%	55.37%	63.67%	+8.30 ⁺	★★★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	61.93%	59.29%	66.37%	+7.08 ⁺	★★
Lead Screening in Children (LSC)					
Lead Screening in Children	56.36%	55.72%	58.30%	+2.58	★★
Child and Adolescent Well-Care Visits (WCV)					
Ages 3 to 11 Years	58.18%	59.96%	62.34%	+2.37 ⁺	★★★★
Ages 12 to 17 Years	49.86%	51.05%	53.53%	+2.48 ⁺	★★★★
Ages 18 to 21 Years	27.39%	27.32%	30.08%	+2.76 ⁺	★★★★★
Total	50.75%	51.78%	54.49%	+2.71 ⁺	★★★★
Immunizations for Adolescents (IMA)					
Combination 1 (Meningococcal, Tdap)	73.97%	78.59%	80.05%	+1.46	★★
Combination 2 (Meningococcal, Tdap, HPV)	32.60%	27.49%	32.12%	+4.62	★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)⁴					
Initiation Phase	39.12%	39.94%	42.82%	+2.88	★★
Continuation and Maintenance Phase	46.75%	40.66%	45.11%	+4.46	★
Women—Adult Care					
Chlamydia Screening in Women (CHL)⁴					
Ages 16 to 20 Years	55.97%	61.07%	55.38%	-5.68 ⁺⁺	★★★★
Ages 21 to 24 Years	64.36%	70.85%	64.49%	-6.36 ⁺⁺	★★★★
Total	59.89%	65.64%	59.62%	-6.02 ⁺⁺	★★★★
Cervical Cancer Screening (CCS-E)					
Cervical Cancer Screening	56.83%	60.34%	57.00%	-3.34	★★
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening	NA	NA	55.06%	NC	★★★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Ages 20 to 44 Years	76.87%	74.69%	74.64%	-0.05	★★★★
Ages 45 to 64 Years	85.06%	83.70%	83.55%	-0.14	★★★★
Ages 65 Years and Older	88.07%	88.39%	87.59%	-0.80	★★★★
Total	79.82%	77.94%	77.86%	-0.09	★★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)					
Ages 3 Months to 17 Years	65.46%	68.23%	68.58%	+0.35	★★
Ages 18 to 64 Years	46.01%	40.18%	39.09%	-1.08	★
Ages 65 Years and Older	55.56%	40.86%	40.45%	-0.41	★★★★
Total	52.27%	55.30%	55.19%	-0.11	★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Appropriate Testing for Pharyngitis (CWP)					
Ages 3 to 17 Years	71.61%	72.53%	80.92%	+8.39 ⁺	★★★★
Ages 18 to 64 Years	56.54%	56.44%	68.30%	+11.86 ⁺	★★★★
Ages 65 Years and Older	NA	21.21%	25.33%	+4.12	★★★★
Total	64.04%	65.57%	76.71%	+11.13 ⁺	★★★★
Appropriate Treatment for Upper Respiratory Infection (URI)					
Ages 3 Months to 17 Years	94.17%	92.54%	91.01%	-1.53 ⁺⁺	★
Ages 18 to 64 Years	82.61%	81.88%	78.18%	-3.70 ⁺⁺	★★
Ages 65 Years and Older	86.42%	66.98%	67.67%	+0.70	★★
Total	89.89%	89.23%	87.07%	-2.16 ⁺⁺	★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
Body Mass Index (BMI) Percentile—Total	72.99%	81.02%	84.43%	+3.41	★★★★
Counseling for Nutrition—Total	65.45%	69.34%	73.72%	+4.38	★★★★
Counseling for Physical Activity—Total	64.72%	68.86%	72.02%	+3.16	★★★★
Pregnancy Care					
Prenatal and Postpartum Care (PPC)⁴					
Timeliness of Prenatal Care	74.70%	74.45%	83.21%	+8.76 ⁺	★★
Postpartum Care	73.97%	75.91%	76.16%	+0.24	★★
Living With Illness					
Hemoglobin A1c Control for Patients With Diabetes (HBD)					
HbA1c Control (<8.0%)	40.63%	54.99%	60.34%	+5.35	★★★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
HbA1c Poor Control (>9.0%)*	52.07%	38.93%	30.17%	-8.76 ⁺	★★★★★
Blood Pressure Control for Patients With Diabetes (BPD)					
Blood Pressure Control for Patients With Diabetes	55.72%	67.88%	73.24%	+5.35	★★★★★
Eye Exam for Patients With Diabetes (EED)⁴					
Eye Exam for Patients With Diabetes	51.34%	55.23%	61.31%	+6.08	★★★★★
Kidney Health Evaluation for Patients With Diabetes (KED)					
Ages 18 to 64 Years	30.15%	39.26%	40.25%	+0.99 ⁺	★★★★
Ages 65 to 74 Years	23.50%	34.38%	37.58%	+3.21 ⁺	★★★★
Ages 75 to 85 Years	23.60%	29.30%	34.79%	+5.50	★★
Total	29.61%	38.78%	39.99%	+1.21 ⁺	★★★★
Asthma Medication Ratio (AMR)					
Total	58.80%	61.16%	61.18%	+0.03	★★
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure	48.91%	62.77%	62.04%	-0.73	★★★★
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)					
Persistence of Beta-Blocker Treatment After a Heart Attack	82.16%	88.94%	72.14%	-16.80 ⁺⁺	★
Cardiac Rehabilitation (CRE)					
Initiation—Ages 18 to 64 Years	5.01%	4.52%	4.86%	+0.35	★★★★
Initiation—Ages 65 Years and Older	2.38%	1.92%	8.45%	+6.53	★★★★★
Initiation—Total	4.87%	4.40%	5.08%	+0.68	★★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Engagement 1—Ages 18 to 64 Years	0.86%	6.50%	6.24%	-0.27	★★★
Engagement 1—Ages 65 Years and Older	1.19%	9.62%	11.27%	+1.65	★★★★★
Engagement 1—Total	0.87%	6.64%	6.55%	-0.10	★★★★★
Engagement 2—Ages 18 to 64 Years	0.33%	5.15%	4.40%	-0.75	★★★
Engagement 2—Ages 65 Years and Older	1.19%	9.62%	8.45%	-1.16	★★★★★
Engagement 2—Total	0.37%	5.35%	4.65%	-0.70	★★★
Achievement—Ages 18 to 64 Years	0.26%	2.08%	1.56%	-0.52	★★★
Achievement—Ages 65 Years and Older	0.00%	5.77%	2.82%	-2.95	★★★
Achievement—Total	0.25%	2.24%	1.64%	-0.61	★★★
Antidepressant Medication Management (AMM)⁴					
Effective Acute Phase Treatment	61.75%	72.10%	78.14%	+6.05 ⁺	★★★★★
Effective Continuation Phase Treatment	46.38%	69.38%	64.94%	-4.44 ⁺⁺	★★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.01%	83.41%	82.72%	-0.69	★★★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia	66.28%	75.84%	70.36%	-5.49 ⁺⁺	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	62.50%	75.34%	80.28%	+4.94	★★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	70.36%	64.90%	66.08%	+1.18	★★★
Diagnosed Mental Health Disorders (DMH)					
Ages 1 to 17 Years	—	NA	27.02%	NC	★★★★★
Ages 18 to 64 Years	—	NA	37.98%	NC	★★★★★
Ages 65 Years and Older	—	NA	35.91%	NC	★★★
Total	—	NA	33.47%	NC	★★★★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership (RDM)					
White	65.87%	61.54%	64.51%	+2.97	NC
Black or African American	23.86%	22.52%	23.64%	+1.11	NC
American Indian or Alaska Native	0.88%	0.86%	0.93%	+0.07	NC
Asian	0.83%	1.16%	1.20%	+0.04	NC
Native Hawaiian or Other Pacific Islander	0.10%	0.09%	0.11%	+0.01	NC

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
<i>Some Other Race</i>	0.00%	6.06%	6.90%	+0.84	NC
<i>Two or More Races</i>	0.00%	0.00%	0.00%	0.00	NC
<i>Ethnicity Reporting Category: Hispanic or Latino</i>	0.00%	0.01%	0.10%	+0.09	NC
<i>Unknown</i>	8.46%	7.27%	2.71%	-4.55	NC
<i>Declined</i>	0.00%	0.50%	0.00%	-0.50	NC
Language Diversity of Membership (LDM)					
<i>Spoken Language Preferred for Health Care—English</i>	98.39%	97.36%	97.79%	+0.43	NC
<i>Spoken Language Preferred for Health Care—Non-English</i>	0.68%	1.57%	1.65%	+0.07	NC
<i>Spoken Language Preferred for Health Care—Unknown</i>	0.93%	1.07%	0.57%	-0.50	NC
<i>Spoken Language Preferred for Health Care—Declined</i>	0.00%	0.00%	0.00%	0.00	NC
<i>Language Preferred for Written Materials—English</i>	98.39%	97.36%	97.79%	+0.43	NC

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
<i>Language Preferred for Written Materials—Non-English</i>	0.68%	1.57%	1.65%	+0.07	NC
<i>Language Preferred for Written Materials—Unknown</i>	0.93%	1.07%	0.57%	-0.50	NC
<i>Language Preferred for Written Materials—Declined</i>	0.00%	0.00%	0.00%	0.00	NC
<i>Other Language Needs—English</i>	96.75%	97.36%	97.79%	+0.43	NC
<i>Other Language Needs—Non-English</i>	0.65%	1.57%	1.65%	+0.07	NC
<i>Other Language Needs—Unknown</i>	2.60%	1.07%	0.57%	-0.50	NC
<i>Other Language Needs—Declined</i>	0.00%	0.00%	0.00%	0.00	NC
Utilization³					
Ambulatory Care (AMB)					
<i>Emergency Department Visits*</i>	575.66	625.72	626.26	+0.54	★★
<i>Outpatient Visits</i>	5,124.16	4,535.66	4,528.93	-6.73	NC
Inpatient Utilization—General Hospital/Acute Care (IPU)					
<i>Discharges—Total Inpatient—Total All Ages</i>	73.64	70.50	69.86	-0.64	NC
<i>Average Length of Stay—Total Inpatient—Total All Ages</i>	4.78	4.96	4.75	-0.21	NC

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Discharges—Maternity—Total All Ages	25.68	23.73	22.27	-1.46	NC
Average Length of Stay—Maternity—Total All Ages	2.76	2.71	2.78	+0.07	NC
Discharges—Surgery—Total All Ages	16.75	13.14	17.44	+4.30	NC
Average Length of Stay—Surgery—Total All Ages	8.15	7.96	7.67	-0.29	NC
Discharges—Medicine—Total All Ages	38.04	39.75	35.72	-4.03	NC
Average Length of Stay—Medicine—Total All Ages	4.30	4.96	4.25	-0.72	NC
Use of Opioids From Multiple Providers (UOP)*					
Multiple Prescribers	14.26%	13.18%	13.12%	-0.06	★★★★★
Multiple Pharmacies	1.94%	3.37%	1.90%	-1.47 ⁺	★★
Multiple Prescribers and Multiple Pharmacies	1.16%	1.55%	1.01%	-0.54 ⁺	★★★
Use of Opioids at High Dosage (HDO)*					
Use of Opioids at High Dosage	1.98%	1.56%	1.04%	-0.52 ⁺	★★★★★
Risk of Continued Opioid Use (COU)*					
At Least 15 Days Covered—Total	8.04%	16.04%	14.83%	-1.21 ⁺	★
At Least 31 Days Covered—Total	5.51%	9.27%	9.67%	+0.40	★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Plan All-Cause Readmissions (PCR)					
Observed Readmissions—Total	8.43%	10.85%	11.29%	+0.44	NC
Expected Readmissions—Total	9.53%	10.47%	10.40%	-0.07	NC
O/E Ratio—Total	0.8844	1.0361	1.0855	+0.05	★

¹HEDIS MY 2022 to HEDIS MY 2023 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2021–MY 2023 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2022–MY 2023 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

²HEDIS MY 2023 Performance Levels were based on comparisons of the HEDIS MY 2023 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2022 benchmark.

³Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any Performance Levels for MY 2023 or MY 2022–MY 2023 Comparisons provided for these measures are for information only.

⁴Due to changes in the technical specifications for this measure, NCQA recommends trending between MY 2023 and prior years be considered with caution.

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

— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure.

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

HEDIS MY 2023 Performance Levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Table B-6—MOL Trend Table

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Child & Adolescent Care					
Childhood Immunization Status (CIS)					
Combination 3	54.83%	57.18%	56.93%	-0.24	★
Combination 7	46.38%	48.91%	48.18%	-0.73	★
Combination 10	26.33%	23.84%	22.63%	-1.22	★
Well-Child Visits in the First 30 Months of Life (W30)					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	55.95%	60.34%	61.48%	+1.14	★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	60.53%	62.30%	65.58%	+3.27 ⁺	★★
Lead Screening in Children (LSC)					
Lead Screening in Children	59.61%	57.66%	59.85%	+2.19	★★
Child and Adolescent Well-Care Visits (WCV)					
Ages 3 to 11 Years	59.60%	59.81%	62.17%	+2.36 ⁺	★★★
Ages 12 to 17 Years	52.34%	52.58%	54.18%	+1.60 ⁺	★★★
Ages 18 to 21 Years	31.90%	30.90%	33.12%	+2.22 ⁺	★★★★
Total	52.26%	52.05%	54.51%	+2.46 ⁺	★★★
Immunizations for Adolescents (IMA)					
Combination 1 (Meningococcal, Tdap)	77.32%	77.09%	82.00%	+4.91 ⁺	★★★
Combination 2 (Meningococcal, Tdap, HPV)	32.54%	29.88%	36.25%	+6.37 ⁺	★★★
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)⁴					
Initiation Phase	46.10%	43.84%	52.44%	+8.60 ⁺	★★★★
Continuation and Maintenance Phase	57.07%	56.28%	58.37%	+2.10	★★★
Women—Adult Care					
Chlamydia Screening in Women (CHL)⁴					
Ages 16 to 20 Years	62.05%	62.27%	62.80%	+0.53	★★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Ages 21 to 24 Years	65.63%	67.89%	68.74%	+0.85	★★★★
Total	63.67%	64.89%	65.51%	+0.62	★★★★
Cervical Cancer Screening (CCS-E)					
Cervical Cancer Screening	57.21%	59.37%	55.92%	-3.45	★★
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening	NA	53.34%	55.49%	+2.16 ⁺	★★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Ages 20 to 44 Years	76.83%	74.44%	75.08%	+0.63 ⁺	★★★★
Ages 45 to 64 Years	85.37%	84.26%	84.44%	+0.18	★★★★
Ages 65 Years and Older	91.58%	91.93%	91.83%	-0.10	★★★★
Total	80.21%	78.22%	78.76%	+0.54 ⁺	★★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)					
Ages 3 Months to 17 Years	64.02%	60.54%	61.96%	+1.42	★
Ages 18 to 64 Years	46.11%	37.83%	38.54%	+0.71	★
Ages 65 Years and Older	34.09%	27.16%	23.36%	-3.80	★
Total	52.23%	51.01%	51.90%	+0.88	★
Appropriate Testing for Pharyngitis (CWP)					
Ages 3 to 17 Years	61.07%	64.87%	72.73%	+7.86 ⁺	★★
Ages 18 to 64 Years	48.19%	50.69%	62.19%	+11.51 ⁺	★★
Ages 65 Years and Older	26.32%	25.00%	26.51%	+1.51	★★★
Total	54.42%	58.85%	69.03%	+10.18 ⁺	★★
Appropriate Treatment for Upper Respiratory Infection (URI)					
Ages 3 Months to 17 Years	92.82%	91.45%	88.53%	-2.92 ⁺⁺	★
Ages 18 to 64 Years	79.99%	79.77%	76.77%	-3.01 ⁺⁺	★★
Ages 65 Years and Older	73.11%	65.98%	64.54%	-1.44	★★
Total	88.38%	88.19%	85.18%	-3.00 ⁺⁺	★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Obesity					
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)</i>					
Body Mass Index (BMI) Percentile—Total	75.67%	78.10%	84.44%	+6.34 ⁺	★★★★
Counseling for Nutrition—Total	71.29%	69.59%	74.17%	+4.58	★★★★
Counseling for Physical Activity—Total	68.13%	68.37%	72.50%	+4.13	★★★★
Pregnancy Care					
<i>Prenatal and Postpartum Care (PPC)</i> ⁴					
Timeliness of Prenatal Care	78.35%	81.02%	84.50%	+3.48	★★★★
Postpartum Care	70.07%	71.53%	73.39%	+1.86	★
Living With Illness					
<i>Hemoglobin A1c Control for Patients With Diabetes (HBD)</i>					
HbA1c Control (<8.0%)	51.82%	50.61%	56.93%	+6.33	★★★★
HbA1c Poor Control (>9.0%)*	39.90%	41.85%	37.47%	-4.38	★★★★
<i>Blood Pressure Control for Patients With Diabetes (BPD)</i>					
Blood Pressure Control for Patients With Diabetes	62.77%	67.64%	69.59%	+1.95	★★★★
<i>Eye Exam for Patients With Diabetes (EED)</i> ⁴					
Eye Exam for Patients With Diabetes	57.18%	53.53%	53.53%	0.00	★★★★
<i>Kidney Health Evaluation for Patients With Diabetes (KED)</i>					
Ages 18 to 64 Years	27.62%	28.90%	36.57%	+7.67 ⁺	★★★★
Ages 65 to 74 Years	30.61%	31.82%	35.76%	+3.93 ⁺	★★
Ages 75 to 85 Years	31.92%	26.87%	34.21%	+7.34 ⁺	★★
Total	27.91%	29.07%	36.46%	+7.39 ⁺	★★★★
<i>Asthma Medication Ratio (AMR)</i>					
Total	54.32%	55.51%	57.57%	+2.05 ⁺	★
<i>Controlling High Blood Pressure (CBP)</i>					
Controlling High Blood Pressure	55.96%	63.26%	61.72%	-1.54	★★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
<i>Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)</i>					
Persistence of Beta-Blocker Treatment After a Heart Attack	95.22%	86.26%	60.40%	-25.86 ⁺⁺	★
<i>Cardiac Rehabilitation (CRE)</i>					
Initiation—Ages 18 to 64 Years	4.85%	6.90%	2.41%	-4.48 ⁺⁺	★★
Initiation—Ages 65 Years and Older	3.57%	2.70%	4.44%	+1.74	★★★★★
Initiation—Total	4.79%	6.71%	2.52%	-4.18 ⁺⁺	★★
Engagement 1—Ages 18 to 64 Years	9.27%	9.07%	0.25%	-8.81 ⁺⁺	★
Engagement 1—Ages 65 Years and Older	10.71%	21.62%	2.22%	-19.40 ⁺⁺	★★
Engagement 1—Total	9.33%	9.63%	0.36%	-9.27 ⁺⁺	★
Engagement 2—Ages 18 to 64 Years	7.91%	7.41%	0.13%	-7.28 ⁺⁺	★
Engagement 2—Ages 65 Years and Older	7.14%	18.92%	0.00%	-18.92 ⁺⁺	★
Engagement 2—Total	7.87%	7.93%	0.12%	-7.81 ⁺⁺	★
Achievement—Ages 18 to 64 Years	6.63%	4.85%	0.13%	-4.73 ⁺⁺	★
Achievement—Ages 65 Years and Older	7.14%	16.22%	0.00%	-16.22 ⁺⁺	★★
Achievement—Total	6.66%	5.37%	0.12%	-5.25 ⁺⁺	★
<i>Antidepressant Medication Management (AMM)</i> ⁴					
Effective Acute Phase Treatment	64.51%	66.20%	65.87%	-0.33	★★★★
Effective Continuation Phase Treatment	47.25%	48.69%	48.16%	-0.53	★★★★
<i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)</i>					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.71%	81.31%	84.45%	+3.14 ⁺	★★★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia	64.42%	64.49%	68.02%	+3.54	★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	64.36%	71.28%	76.29%	+5.01	★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	65.79%	66.14%	66.15%	+0.01	★★★★
Diagnosed Mental Health Disorders (DMH)					
Ages 1 to 17 Years	—	17.10%	18.19%	+1.09 ⁺	★★
Ages 18 to 64 Years	—	29.65%	30.92%	+1.27 ⁺	★★★★
Ages 65 Years and Older	—	38.02%	37.71%	-0.31	★★★★
Total	—	24.65%	25.77%	+1.12 ⁺	★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership (RDM)					
White	46.75%	41.55%	25.29%	-16.26	NC
Black or African American	34.09%	27.75%	0.52%	-27.23	NC
American Indian or Alaska Native	0.36%	0.33%	10.94%	+10.62	NC
Asian	0.24%	0.16%	1.00%	+0.84	NC
Native Hawaiian or Other Pacific Islander	0.00%	0.00%	0.01%	+0.01	NC
Some Other Race	0.00%	0.00%	0.00%	0.00	NC
Two or More Races	0.00%	0.00%	0.00%	0.00	NC
Ethnicity Reporting Category: Hispanic or Latino	5.99%	5.03%	7.06%	+2.03	NC
Unknown	18.56%	30.21%	62.23%	+32.02	NC

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Declined	0.00%	0.00%	0.00%	0.00	NC
Language Diversity of Membership (LDM)					
Spoken Language Preferred for Health Care—English	98.47%	98.33%	98.10%	-0.23	NC
Spoken Language Preferred for Health Care—Non-English	1.51%	1.65%	1.88%	+0.23	NC
Spoken Language Preferred for Health Care—Unknown	0.02%	0.02%	0.02%	+0.00	NC
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—English	98.47%	98.33%	98.10%	-0.23	NC
Language Preferred for Written Materials—Non-English	1.51%	1.65%	1.88%	+0.23	NC
Language Preferred for Written Materials—Unknown	0.02%	0.02%	0.02%	+0.00	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	98.47%	98.33%	98.10%	-0.23	NC
Other Language Needs—Non-English	1.51%	1.65%	1.88%	+0.23	NC
Other Language Needs—Unknown	0.02%	0.02%	0.02%	+0.00	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization³					
Ambulatory Care (AMB)					
Emergency Department Visits*	593.40	588.66	586.22	-2.43	★★
Outpatient Visits	4,559.05	4,350.58	3,818.73	-531.85	NC

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Inpatient Utilization—General Hospital/Acute Care (IPU)					
Discharges—Total Inpatient—Total All Ages	80.46	65.87	63.80	-2.06	NC
Average Length of Stay—Total Inpatient—Total All Ages	5.08	5.15	4.98	-0.17	NC
Discharges—Maternity—Total All Ages	27.53	25.25	23.61	-1.63	NC
Average Length of Stay—Maternity—Total All Ages	2.83	2.91	2.79	-0.12	NC
Discharges—Surgery—Total All Ages	17.38	14.50	14.79	+0.30	NC
Average Length of Stay—Surgery—Total All Ages	9.16	9.84	8.73	-1.11	NC
Discharges—Medicine—Total All Ages	42.66	32.52	31.31	-1.21	NC
Average Length of Stay—Medicine—Total All Ages	4.49	4.35	4.44	+0.09	NC
Use of Opioids From Multiple Providers (UOP)*					
Multiple Prescribers	13.12%	14.44%	15.40%	+0.96 ⁺⁺	★★★
Multiple Pharmacies	2.11%	1.98%	2.93%	+0.95 ⁺⁺	★★
Multiple Prescribers and Multiple Pharmacies	1.43%	1.34%	1.85%	+0.51 ⁺⁺	★★
Use of Opioids at High Dosage (HDO)*					
Use of Opioids at High Dosage	6.68%	1.40%	1.12%	-0.28	★★★★
Risk of Continued Opioid Use (COU)*					
At Least 15 Days Covered—Total	19.58%	11.66%	10.85%	-0.82 ⁺	★
At Least 31 Days Covered—Total	12.07%	5.97%	5.73%	-0.24	★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Plan All-Cause Readmissions (PCR)					
Observed Readmissions—Total	8.98%	8.82%	8.38%	-0.44	NC
Expected Readmissions—Total	9.76%	9.65%	9.67%	+0.02	NC
O/E Ratio—Total	0.9205	0.9145	0.8666	-0.05	★★★★

¹HEDIS MY 2022 to HEDIS MY 2023 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2022–MY 2023 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2022–MY 2023 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

²HEDIS MY 2021 Performance Levels were based on comparisons of the HEDIS MY 2023 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2022 benchmark.

³Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any Performance Levels for MY 2023 or MY 2022–MY 2023 Comparisons provided for these measures are for information only.

⁴Due to changes in the technical specifications for this measure, NCQA recommends trending between MY 2023 and prior years be considered with caution.

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

— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure.

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark. HEDIS MY 2023 Performance Levels represent the following percentile comparisons:

★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Table B-7—PRI Trend Table

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Child & Adolescent Care					
Childhood Immunization Status (CIS)					
Combination 3	61.26%	63.50%	68.13%	+4.62	★★★★
Combination 7	52.72%	55.72%	59.61%	+3.89	★★★★
Combination 10	35.68%	32.85%	34.06%	+1.22	★★★★
Well-Child Visits in the First 30 Months of Life (W30)					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	59.18%	53.15%	66.39%	+13.24 ⁺	★★★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	65.58%	59.86%	69.86%	+10.00 ⁺	★★★★
Lead Screening in Children (LSC)					
Lead Screening in Children	56.02%	60.83%	65.94%	+5.11	★★★★
Child and Adolescent Well-Care Visits (WCV)					
Ages 3 to 11 Years	60.53%	61.72%	62.07%	+0.35	★★★★
Ages 12 to 17 Years	51.89%	51.71%	51.91%	+0.20	★★★★
Ages 18 to 21 Years	30.06%	29.23%	30.69%	+1.46 ⁺	★★★★★
Total	52.67%	52.87%	53.82%	+0.95 ⁺	★★★★
Immunizations for Adolescents (IMA)					
Combination 1 (Meningococcal, Tdap)	81.51%	77.99%	76.64%	-1.35	★★
Combination 2 (Meningococcal, Tdap, HPV)	36.74%	33.60%	34.06%	+0.46	★★
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)⁴					
Initiation Phase	31.21%	34.74%	38.59%	+3.86 ⁺	★
Continuation and Maintenance Phase	38.21%	35.45%	44.18%	+8.73 ⁺	★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Women—Adult Care					
Chlamydia Screening in Women (CHL)⁴					
Ages 16 to 20 Years	60.52%	57.75%	53.89%	-3.86 ⁺⁺	★★★★
Ages 21 to 24 Years	66.59%	65.55%	63.33%	-2.23 ⁺⁺	★★★★
Total	63.39%	61.47%	58.35%	-3.12 ⁺⁺	★★★★
Cervical Cancer Screening (CCS-E)					
Cervical Cancer Screening	63.99%	61.31%	55.04%	-6.27 ⁺⁺	★★
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening	56.40%	53.70%	54.52%	+0.83	★★★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Ages 20 to 44 Years	73.78%	70.74%	71.97%	+1.23 ⁺	★★★★
Ages 45 to 64 Years	83.17%	81.44%	81.65%	+0.22	★★★★
Ages 65 Years and Older	90.26%	89.64%	88.46%	-1.19	★★★★★
Total	77.22%	74.58%	75.46%	+0.88 ⁺	★★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)					
Ages 3 Months to 17 Years	72.04%	77.98%	79.32%	+1.34	★★★★
Ages 18 to 64 Years	52.75%	53.86%	54.17%	+0.31	★★★★★
Ages 65 Years and Older	NA	NA	66.67%	NC	★★★★★
Total	58.50%	66.36%	67.68%	+1.32	★★★★
Appropriate Testing for Pharyngitis (CWP)					
Ages 3 to 17 Years	71.38%	75.37%	85.85%	+10.47 ⁺	★★★★★
Ages 18 to 64 Years	59.77%	62.66%	76.35%	+13.70 ⁺	★★★★★
Ages 65 Years and Older	NA	NA	NA	NC	NC
Total	64.77%	68.84%	82.42%	+13.58 ⁺	★★★★★
Appropriate Treatment for Upper Respiratory Infection (URI)					
Ages 3 Months to 17 Years	96.10%	95.72%	94.37%	-1.35 ⁺⁺	★★★★
Ages 18 to 64 Years	88.79%	90.21%	87.08%	-3.12 ⁺⁺	★★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
<i>Ages 65 Years and Older</i>	87.50%	90.28%	87.65%	-2.62	★★★★★
<i>Total</i>	93.48%	94.01%	92.13%	-1.88 ⁺⁺	★★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
<i>Body Mass Index (BMI) Percentile—Total</i>	91.97%	88.56%	89.78%	+1.22	★★★★★
<i>Counseling for Nutrition—Total</i>	83.70%	80.29%	82.00%	+1.70	★★★★★
<i>Counseling for Physical Activity—Total</i>	82.73%	79.32%	80.05%	+0.73	★★★★★
Pregnancy Care					
Prenatal and Postpartum Care (PPC)⁴					
<i>Timeliness of Prenatal Care</i>	79.56%	80.78%	85.40%	+4.62	★★★
<i>Postpartum Care</i>	75.91%	80.05%	77.86%	-2.19	★★
Living With Illness					
Hemoglobin A1c Control for Patients With Diabetes (HBD)					
<i>HbA1c Control (<8.0%)</i>	55.72%	57.66%	63.26%	+5.60	★★★★★
<i>HbA1c Poor Control (>9.0%)*</i>	34.31%	30.41%	28.22%	-2.19	★★★★★
Blood Pressure Control for Patients With Diabetes (BPD)					
<i>Blood Pressure Control for Patients With Diabetes</i>	69.59%	68.61%	77.37%	+8.76 ⁺	★★★★★
Eye Exam for Patients With Diabetes (EED)⁴					
<i>Eye Exam for Patients With Diabetes</i>	61.31%	54.48%	62.04%	+7.56 ⁺	★★★★★
Kidney Health Evaluation for Patients With Diabetes (KED)					
<i>Ages 18 to 64 Years</i>	34.91%	35.93%	39.33%	+3.40 ⁺	★★★
<i>Ages 65 to 74 Years</i>	34.09%	39.29%	41.12%	+1.83	★★★
<i>Ages 75 to 85 Years</i>	29.77%	41.40%	46.41%	+5.01	★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
<i>Total</i>	34.79%	36.20%	39.55%	+3.36 ⁺	★★★
Asthma Medication Ratio (AMR)					
<i>Total</i>	62.79%	65.61%	64.64%	-0.96	★★
Controlling High Blood Pressure (CBP)					
<i>Controlling High Blood Pressure</i>	66.42%	73.24%	69.10%	-4.14	★★★★★
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)					
<i>Persistence of Beta-Blocker Treatment After a Heart Attack</i>	87.50%	89.81%	74.19%	-15.62 ⁺⁺	★
Cardiac Rehabilitation (CRE)					
<i>Initiation—Ages 18 to 64 Years</i>	4.55%	8.43%	5.46%	-2.97	★★★★★
<i>Initiation—Ages 65 Years and Older</i>	NA	NA	NA	NC	NC
<i>Initiation—Total</i>	4.56%	8.29%	5.26%	-3.02	★★★★★
<i>Engagement 1—Ages 18 to 64 Years</i>	7.09%	8.43%	8.08%	-0.35	★★★★★
<i>Engagement 1—Ages 65 Years and Older</i>	NA	NA	NA	NC	NC
<i>Engagement 1—Total</i>	7.19%	8.84%	8.01%	-0.83	★★★★★
<i>Engagement 2—Ages 18 to 64 Years</i>	4.55%	4.94%	5.94%	+1.00	★★★★★
<i>Engagement 2—Ages 65 Years and Older</i>	NA	NA	NA	NC	NC
<i>Engagement 2—Total</i>	4.91%	5.52%	6.18%	+0.65	★★★★★
<i>Achievement—Ages 18 to 64 Years</i>	2.55%	2.03%	2.14%	+0.10	★★★
<i>Achievement—Ages 65 Years and Older</i>	NA	NA	NA	NC	NC
<i>Achievement—Total</i>	2.81%	2.49%	2.06%	-0.43	★★★
Antidepressant Medication Management (AMM)⁴					
<i>Effective Acute Phase Treatment</i>	68.78%	78.81%	70.45%	-8.36 ⁺⁺	★★★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
<i>Effective Continuation Phase Treatment</i>	51.45%	66.20%	52.75%	-13.45 ⁺⁺	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)					
<i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</i>	83.40%	78.57%	80.63%	+2.06 ⁺	★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
<i>Diabetes Monitoring for People With Diabetes and Schizophrenia</i>	72.60%	64.94%	73.24%	+8.30 ⁺	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
<i>Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia</i>	NA	NA	73.53%	NC	★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)					
<i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia</i>	66.79%	64.13%	64.46%	+0.33	★★★
Diagnosed Mental Health Disorders (DMH)					
<i>Ages 1 to 17 Years</i>	—	22.40%	22.85%	+0.45 ⁺	★★★
<i>Ages 18 to 64 Years</i>	—	35.62%	36.87%	+1.25 ⁺	★★★
<i>Ages 65 Years and Older</i>	—	37.96%	36.07%	-1.89	★★★
<i>Total</i>	—	30.35%	31.20%	+0.85 ⁺	★★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership (RDM)					
<i>White</i>	59.24%	59.70%	62.32%	+2.62	NC

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
<i>Black or African American</i>	26.40%	25.99%	26.24%	+0.25	NC
<i>American Indian or Alaska Native</i>	0.78%	0.82%	0.85%	+0.04	NC
<i>Asian</i>	0.92%	0.94%	1.95%	+1.01	NC
<i>Native Hawaiian or Other Pacific Islander</i>	0.11%	0.12%	0.12%	0.00	NC
<i>Some Other Race</i>	0.01%	7.66%	0.00%	-7.66	NC
<i>Two or More Races</i>	0.00%	0.00%	0.00%	0.00	NC
<i>Ethnicity Reporting Category: Hispanic or Latino</i>	0.62%	8.37%	8.96%	+0.59	NC
<i>Unknown</i>	12.09%	4.76%	8.51%	+3.75	NC
<i>Declined</i>	0.46%	0.00%	0.00%	0.00	NC
Language Diversity of Membership (LDM)					
<i>Spoken Language Preferred for Health Care—English</i>	1.09%	0.00%	0.00%	0.00	NC
<i>Spoken Language Preferred for Health Care—Non-English</i>	0.00%	0.00%	0.00%	0.00	NC
<i>Spoken Language Preferred for Health Care—Unknown</i>	98.91%	100.00%	100.00%	0.00	NC
<i>Spoken Language Preferred for Health Care—Declined</i>	0.00%	0.00%	0.00%	0.00	NC
<i>Language Preferred for Written Materials—English</i>	1.09%	0.00%	0.00%	0.00	NC
<i>Language Preferred for Written Materials—Non-English</i>	0.00%	0.00%	0.00%	0.00	NC
<i>Language Preferred for Written Materials—Unknown</i>	98.91%	100.00%	100.00%	0.00	NC

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	1.09%	0.00%	0.00%	0.00	NC
Other Language Needs—Non-English	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—Unknown	98.91%	100.00%	100.00%	0.00	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization³					
Ambulatory Care (AMB)					
Emergency Department Visits*	626.26	621.26	626.37	+5.11	★★
Outpatient Visits	3,822.72	4,752.17	6,002.21	+1250.04	NC
Inpatient Utilization—General Hospital/Acute Care (IPU)					
Discharges—Total Inpatient—Total All Ages	69.42	58.89	56.94	-1.95	NC
Average Length of Stay—Total Inpatient—Total All Ages	4.72	5.01	4.80	-0.21	NC
Discharges—Maternity—Total All Ages	25.85	24.48	22.43	-2.06	NC
Average Length of Stay—Maternity—Total All Ages	2.88	2.85	2.90	+0.05	NC
Discharges—Surgery—Total All Ages	16.37	13.82	14.14	+0.33	NC
Average Length of Stay—Surgery—Total All Ages	7.59	8.53	7.94	-0.59	NC
Discharges—Medicine—Total All Ages	33.92	26.77	25.92	-0.85	NC

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Average Length of Stay—Medicine—Total All Ages	4.38	4.68	4.33	-0.35	NC
Use of Opioids From Multiple Providers (UOP)*					
Multiple Prescribers	17.20%	18.94%	19.84%	+0.90	★★
Multiple Pharmacies	2.38%	1.68%	2.09%	+0.41	★★
Multiple Prescribers and Multiple Pharmacies	1.34%	0.99%	1.09%	+0.10	★★★
Use of Opioids at High Dosage (HDO)*					
Use of Opioids at High Dosage	11.32%	1.71%	1.59%	-0.12	★★★★
Risk of Continued Opioid Use (COU)*					
At Least 15 Days Covered—Total	14.30%	13.11%	10.37%	-2.75 ⁺	★
At Least 31 Days Covered—Total	8.23%	6.66%	5.22%	-1.44 ⁺	★
Plan All-Cause Readmissions (PCR)					
Observed Readmissions—Total	8.51%	8.61%	7.59%	-1.02 ⁺	NC
Expected Readmissions—Total	9.75%	9.64%	9.69%	+0.05	NC
O/E Ratio—Total	0.8721	0.8936	0.7829	-0.11	★★★★★

¹HEDIS MY 2022 to HEDIS MY 2023 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2022–MY 2023 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2021–MY 2023 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

²HEDIS MY 2023 Performance Levels were based on comparisons of the HEDIS MY 2023 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2022 benchmark.

³Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any Performance Levels for MY 2023 or MY 2022–MY 2023 Comparisons provided for these measures are for information only.

⁴Due to changes in the technical specifications for this measure, NCQA recommends trending between MY 2023 and prior years be considered with caution.

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

— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure.



NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

HEDIS MY 2023 Performance Levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Table B-8—UNI Trend Table

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Child & Adolescent Care					
Childhood Immunization Status (CIS)					
Combination 3	52.40%	54.42%	59.37%	+4.95	★★
Combination 7	43.81%	45.21%	48.66%	+3.45	★
Combination 10	24.91%	22.19%	19.71%	-2.48	★
Well-Child Visits in the First 30 Months of Life (W30)					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	57.52%	63.74%	64.92%	+1.17	★★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	58.08%	60.54%	63.62%	+3.08 ⁺	★★
Lead Screening in Children (LSC)					
Lead Screening in Children	58.88%	59.12%	58.39%	-0.73	★★
Child and Adolescent Well-Care Visits (WCV)					
Ages 3 to 11 Years	57.53%	57.05%	60.23%	+3.18 ⁺	★★★
Ages 12 to 17 Years	50.23%	50.53%	53.14%	+2.61 ⁺	★★★
Ages 18 to 21 Years	32.09%	30.71%	32.82%	+2.11 ⁺	★★★★
Total	50.60%	50.04%	53.09%	+3.06 ⁺	★★★
Immunizations for Adolescents (IMA)					
Combination 1 (Meningococcal, Tdap)	78.83%	76.89%	79.08%	+2.19	★★
Combination 2 (Meningococcal, Tdap, HPV)	34.31%	31.14%	31.14%	0.00	★★
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)⁴					
Initiation Phase	38.96%	44.45%	44.04%	-0.41	★★
Continuation and Maintenance Phase	56.71%	51.35%	54.10%	+2.75	★★
Women—Adult Care					
Chlamydia Screening in Women (CHL)⁴					
Ages 16 to 20 Years	60.01%	59.47%	59.17%	-0.31	★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Ages 21 to 24 Years	65.18%	63.50%	62.51%	-0.99	★★★
Total	62.36%	61.33%	60.67%	-0.67	★★★
Cervical Cancer Screening (CCS-E)					
Cervical Cancer Screening	58.88%	58.88%	54.41%	-4.47	★★
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening	50.96%	53.28%	55.49%	+2.21 ⁺	★★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Ages 20 to 44 Years	75.44%	73.00%	73.02%	+0.02	★★★
Ages 45 to 64 Years	85.50%	84.17%	84.27%	+0.10	★★★★
Ages 65 Years and Older	91.11%	90.27%	91.05%	+0.78	★★★★
Total	79.02%	77.02%	77.29%	+0.27	★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)					
Ages 3 Months to 17 Years	62.35%	60.75%	64.63%	+3.89 ⁺	★
Ages 18 to 64 Years	43.88%	36.89%	35.68%	-1.21	★
Ages 65 Years and Older	NA	27.27%	32.00%	+4.73	★★
Total	50.25%	50.05%	50.89%	+0.84	★
Appropriate Testing for Pharyngitis (CWP)					
Ages 3 to 17 Years	62.16%	62.95%	73.70%	+10.75 ⁺	★★
Ages 18 to 64 Years	41.68%	42.32%	55.32%	+13.00 ⁺	★
Ages 65 Years and Older	NA	17.31%	23.81%	+6.50	★★
Total	50.73%	53.32%	66.70%	+13.38 ⁺	★★
Appropriate Treatment for Upper Respiratory Infection (URI)					
Ages 3 Months to 17 Years	94.24%	91.92%	90.49%	-1.44 ⁺⁺	★
Ages 18 to 64 Years	77.10%	76.01%	73.91%	-2.10 ⁺⁺	★
Ages 65 Years and Older	65.85%	71.70%	61.85%	-9.85	★
Total	88.40%	87.36%	85.42%	-1.94 ⁺⁺	★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
Body Mass Index (BMI) Percentile—Total	79.56%	83.94%	90.75%	+6.81 ⁺	★★★★★
Counseling for Nutrition—Total	74.94%	73.97%	71.78%	-2.19	★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
<i>Counseling for Physical Activity—Total</i>	74.94%	70.56%	71.05%	+0.49	★★★
Pregnancy Care					
Prenatal and Postpartum Care (PPC)⁴					
<i>Timeliness of Prenatal Care</i>	82.48%	77.37%	83.45%	+6.08 ⁺	★★
<i>Postpartum Care</i>	74.70%	74.70%	71.78%	-2.92	★
Living With Illness					
Hemoglobin A1c Control for Patients With Diabetes (HBD)					
<i>HbA1c Control (<8.0%)</i>	56.93%	59.12%	62.29%	+3.16	★★★★★
<i>HbA1c Poor Control (>9.0%)*</i>	33.09%	33.09%	27.98%	-5.11	★★★★★
Blood Pressure Control for Patients With Diabetes (BPD)					
<i>Blood Pressure Control for Patients With Diabetes</i>	67.15%	75.18%	73.48%	-1.70	★★★★
Eye Exam for Patients With Diabetes (EED)⁴					
<i>Eye Exam for Patients With Diabetes</i>	55.47%	56.93%	52.55%	-4.38	★★★
Kidney Health Evaluation for Patients With Diabetes (KED)					
<i>Ages 18 to 64 Years</i>	37.55%	40.62%	41.46%	+0.84	★★★★
<i>Ages 65 to 74 Years</i>	43.35%	51.15%	50.25%	-0.90	★★★★
<i>Ages 75 to 85 Years</i>	47.69%	57.46%	51.85%	-5.61	★★★★
<i>Total</i>	37.87%	41.30%	42.10%	+0.80	★★★★
Asthma Medication Ratio (AMR)					
<i>Total</i>	59.94%	62.79%	63.47%	+0.68	★★
Controlling High Blood Pressure (CBP)					
<i>Controlling High Blood Pressure</i>	64.72%	65.45%	71.78%	+6.33	★★★★
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)					
<i>Persistence of Beta-Blocker Treatment After a Heart Attack</i>	91.41%	89.47%	61.11%	-28.36 ⁺⁺	★
Cardiac Rehabilitation (CRE)					
<i>Initiation—Ages 18 to 64 Years</i>	3.99%	4.15%	4.22%	+0.07	★★★
<i>Initiation—Ages 65 Years and Older</i>	NA	NA	6.25%	NC	★★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
<i>Initiation—Total</i>	4.00%	4.19%	4.33%	+0.14	★★★
<i>Engagement 1—Ages 18 to 64 Years</i>	5.19%	4.51%	6.33%	+1.81	★★★
<i>Engagement 1—Ages 65 Years and Older</i>	NA	NA	12.50%	NC	★★★★★
<i>Engagement 1—Total</i>	5.29%	5.06%	6.66%	+1.59	★★★★★
<i>Engagement 2—Ages 18 to 64 Years</i>	3.06%	4.33%	4.39%	+0.06	★★★
<i>Engagement 2—Ages 65 Years and Older</i>	NA	NA	9.38%	NC	★★★★★
<i>Engagement 2—Total</i>	3.35%	5.06%	4.66%	-0.40	★★★
<i>Achievement—Ages 18 to 64 Years</i>	1.33%	2.35%	0.88%	-1.47	★★
<i>Achievement—Ages 65 Years and Older</i>	NA	NA	6.25%	NC	★★★★★
<i>Achievement—Total</i>	1.68%	2.97%	1.16%	-1.80 ⁺⁺	★★
Antidepressant Medication Management (AMM)⁴					
<i>Effective Acute Phase Treatment</i>	61.65%	61.19%	65.13%	+3.93 ⁺	★★★
<i>Effective Continuation Phase Treatment</i>	45.20%	43.28%	47.07%	+3.79 ⁺	★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)					
<i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</i>	84.31%	85.09%	85.46%	+0.36	★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
<i>Diabetes Monitoring for People With Diabetes and Schizophrenia</i>	65.26%	65.57%	71.02%	+5.45	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
<i>Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia</i>	66.04%	65.96%	75.00%	+9.04	★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	61.53%	60.59%	64.20%	+3.61	★★★
Diagnosed Mental Health Disorders (DMH)					
Ages 1 to 17 Years	—	—	NR	NC	NC
Ages 18 to 64 Years	—	—	NR	NC	NC
Ages 65 Years and Older	—	—	NR	NC	NC
Total	—	—	NR	NC	NC
Health Plan Diversity					
Race/Ethnicity Diversity of Membership (RDM)					
White	55.96%	54.52%	57.09%	+2.57	NC
Black or African American	30.84%	30.12%	30.60%	+0.48	NC
American Indian or Alaska Native	0.60%	0.60%	0.64%	+0.05	NC
Asian	1.79%	1.76%	2.47%	+0.71	NC
Native Hawaiian or Other Pacific Islander	0.10%	0.11%	0.13%	+0.03	NC
Some Other Race	0.00%	0.00%	8.83%	+8.83	NC
Two or More Races	0.00%	0.00%	0.00%	0.00	NC
Ethnicity Reporting Category: Hispanic or Latino	1.23%	0.92%	6.79%	+5.87	NC
Unknown	10.70%	12.90%	0.24%	-12.66	NC
Declined	0.00%	0.00%	0.00%	0.00	NC
Language Diversity of Membership (LDM)					
Spoken Language Preferred for Health Care—English	96.20%	95.91%	95.99%	+0.07	NC
Spoken Language Preferred for Health Care—Non-English	3.80%	3.92%	4.00%	+0.08	NC
Spoken Language Preferred for Health Care—Unknown	0.00%	0.17%	<0.01%	-0.16	NC

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—English	96.20%	95.91%	0.00%	-95.91	NC
Language Preferred for Written Materials—Non-English	3.80%	3.92%	0.00%	-3.92	NC
Language Preferred for Written Materials—Unknown	0.00%	0.17%	100.00%	+99.83	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	96.20%	95.91%	0.00%	-95.91	NC
Other Language Needs—Non-English	3.80%	3.92%	0.00%	-3.92	NC
Other Language Needs—Unknown	0.00%	0.17%	100.00%	+99.83	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization³					
Ambulatory Care (AMB)					
Emergency Department Visits*	592.23	613.40	608.23	-5.17	★★
Outpatient Visits	4,265.71	4,352.40	4,350.71	-1.69	NC
Inpatient Utilization—General Hospital/Acute Care (IPU)					
Discharges—Total Inpatient—Total All Ages	58.78	57.21	59.57	+2.36	NC
Average Length of Stay—Total Inpatient—Total All Ages	5.11	5.30	4.78	-0.52	NC
Discharges—Maternity—Total All Ages	22.13	21.89	20.28	-1.61	NC
Average Length of Stay—Maternity—Total All Ages	2.46	2.43	2.45	+0.02	NC

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Discharges—Surgery—Total All Ages	14.22	13.76	14.56	+0.79	NC
Average Length of Stay—Surgery—Total All Ages	8.56	9.30	7.76	-1.54	NC
Discharges—Medicine—Total All Ages	27.83	26.73	29.43	+2.70	NC
Average Length of Stay—Medicine—Total All Ages	4.94	5.04	4.53	-0.51	NC
Use of Opioids From Multiple Providers (UOP)*					
Multiple Prescribers	15.22%	15.70%	15.85%	+0.16	★★★
Multiple Pharmacies	1.70%	1.64%	2.44%	+0.80 ⁺⁺	★★
Multiple Prescribers and Multiple Pharmacies	1.15%	1.11%	1.25%	+0.14	★★
Use of Opioids at High Dosage (HDO)*					
Use of Opioids at High Dosage	2.76%	1.95%	1.86%	-0.08	★★★
Risk of Continued Opioid Use (COU)*					
At Least 15 Days Covered—Total	9.06%	8.96%	8.74%	-0.23	★
At Least 31 Days Covered—Total	6.51%	6.27%	6.00%	-0.27	★
Plan All-Cause Readmissions (PCR)					
Observed Readmissions—Total	10.76%	10.49%	10.24%	-0.25	NC
Expected Readmissions—Total	10.75%	10.88%	10.65%	-0.23	NC
O/E Ratio—Total	1.0007	0.9645	0.9619	0.00	★★★

¹HEDIS MY 2022 to HEDIS MY 2023 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2022–2023 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2022–2023 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

²HEDIS MY 2023 Performance Levels were based on comparisons of the HEDIS MY 2023 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2022 benchmark.

³Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any Performance Levels for MY 2023 or MY 2022–MY 2022 Comparisons provided for these measures are for information only.

⁴ Due to changes in the technical specifications for this measure, NCQA recommends trending between MY 2023 and prior years be considered with caution.

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

— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure.

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

HEDIS MY 2023 Performance Levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Table B-9—UPP Trend Table

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Child & Adolescent Care					
Childhood Immunization Status (CIS)					
Combination 3	60.69%	65.69%	61.74%	-3.96	★★
Combination 7	50.58%	53.28%	50.92%	-2.36	★★
Combination 10	36.32%	31.39%	24.03%	-7.36 ⁺⁺	★
Well-Child Visits in the First 30 Months of Life (W30)					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	67.53%	70.23%	72.82%	+2.59	★★★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	67.43%	68.09%	72.18%	+4.09 ⁺	★★★★
Lead Screening in Children (LSC)					
Lead Screening in Children	39.75%	52.07%	59.12%	+7.05 ⁺	★★
Child and Adolescent Well-Care Visits (WCV)					
Ages 3 to 11 Years	57.85%	56.40%	58.81%	+2.41 ⁺	★★★★
Ages 12 to 17 Years	51.87%	50.27%	50.57%	+0.29	★★★★
Ages 18 to 21 Years	23.44%	23.73%	27.97%	+4.24 ⁺	★★★★
Total	49.99%	48.65%	51.22%	+2.57 ⁺	★★★★
Immunizations for Adolescents (IMA)					
Combination 1 (Meningococcal, Tdap)	79.30%	76.40%	75.40%	-1.00	★★
Combination 2 (Meningococcal, Tdap, HPV)	34.53%	28.47%	29.74%	+1.27	★★
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)⁴					
Initiation Phase	38.40%	51.91%	45.51%	-6.41	★★★★
Continuation and Maintenance Phase	43.30%	54.62%	47.89%	-6.72	★
Women—Adult Care					
Chlamydia Screening in Women (CHL)⁴					
Ages 16 to 20 Years	41.06%	43.20%	40.28%	-2.93	★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Ages 21 to 24 Years	51.13%	48.69%	51.24%	+2.55	★
Total	45.73%	45.75%	45.40%	-0.35	★
Cervical Cancer Screening (CCS-E)					
Cervical Cancer Screening	61.31%	61.80%	54.25%	-7.55 ⁺⁺	★★
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening	59.11%	59.68%	60.10%	+0.42	★★★★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Ages 20 to 44 Years	76.69%	75.03%	75.30%	+0.28	★★★★★
Ages 45 to 64 Years	84.68%	83.39%	83.79%	+0.40	★★★★
Ages 65 Years and Older	95.29%	94.52%	95.16%	+0.64	★★★★★
Total	80.61%	79.06%	79.60%	+0.53	★★★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)					
Ages 3 Months to 17 Years	64.47%	78.11%	82.34%	+4.23	★★★★★
Ages 18 to 64 Years	45.14%	45.85%	48.92%	+3.08	★★★★
Ages 65 Years and Older	NA	NA	NA	NC	NC
Total	50.77%	62.25%	67.47%	+5.21 ⁺	★★★★
Appropriate Testing for Pharyngitis (CWP)					
Ages 3 to 17 Years	85.35%	85.29%	89.28%	+3.99 ⁺	★★★★★
Ages 18 to 64 Years	76.03%	78.52%	82.75%	+4.23 ⁺	★★★★★
Ages 65 Years and Older	NA	NA	NA	NC	NC
Total	80.23%	81.70%	87.07%	+5.37 ⁺	★★★★★
Appropriate Treatment for Upper Respiratory Infection (URI)					
Ages 3 Months to 17 Years	94.19%	93.17%	92.55%	-0.62	★★
Ages 18 to 64 Years	88.85%	85.01%	86.80%	+1.79	★★★★
Ages 65 Years and Older	NA	68.42%	75.68%	+7.25	★★★★
Total	92.24%	90.24%	90.48%	+0.25	★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
Body Mass Index (BMI) Percentile—Total	89.54%	92.94%	92.94%	0.00	★★★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
<i>Counseling for Nutrition—Total</i>	75.18%	75.43%	74.21%	-1.22	★★★
<i>Counseling for Physical Activity—Total</i>	72.02%	70.32%	72.51%	+2.19	★★★
Pregnancy Care					
<i>Prenatal and Postpartum Care (PPC)</i>⁴					
<i>Timeliness of Prenatal Care</i>	92.21%	92.94%	94.16%	+1.22	★★★★★
<i>Postpartum Care</i>	88.08%	89.29%	87.35%	-1.95	★★★★★
Living With Illness					
<i>Hemoglobin A1c Control for Patients With Diabetes (HBD)</i>					
<i>HbA1c Control (<8.0%)</i>	55.47%	61.07%	66.18%	+5.11	★★★★★
<i>HbA1c Poor Control (>9.0%)*</i>	33.33%	30.17%	25.06%	-5.11	★★★★★
<i>Blood Pressure Control for Patients With Diabetes (BPD)</i>					
<i>Blood Pressure Control for Patients With Diabetes</i>	82.48%	82.00%	84.67%	+2.68	★★★★★
<i>Eye Exam for Patients With Diabetes (EED)</i>⁴					
<i>Eye Exam for Patients With Diabetes</i>	59.61%	60.83%	57.18%	-3.65	★★★
<i>Kidney Health Evaluation for Patients With Diabetes (KED)</i>					
<i>Ages 18 to 64 Years</i>	34.50%	36.10%	37.83%	+1.73	★★★
<i>Ages 65 to 74 Years</i>	39.38%	36.67%	39.93%	+3.26	★★★
<i>Ages 75 to 85 Years</i>	35.06%	29.58%	43.02%	+13.45	★★★
<i>Total</i>	34.98%	35.99%	38.22%	+2.22	★★★
<i>Asthma Medication Ratio (AMR)</i>					
<i>Total</i>	57.59%	57.67%	62.28%	+4.61 ⁺	★★
<i>Controlling High Blood Pressure (CBP)</i>					
<i>Controlling High Blood Pressure</i>	79.08%	79.08%	78.10%	-0.97	★★★★★
<i>Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)</i>					
<i>Persistence of Beta-Blocker Treatment After a Heart Attack</i>	91.30%	87.50%	NA	NC	NC
<i>Cardiac Rehabilitation (CRE)</i>					
<i>Initiation—Ages 18 to 64 Years</i>	10.99%	3.88%	12.50%	+8.62 ⁺	★★★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
<i>Initiation—Ages 65 Years and Older</i>	NA	NA	NA	NC	NC
<i>Initiation—Total</i>	9.90%	3.36%	13.60%	+10.24 ⁺	★★★★★
<i>Engagement 1—Ages 18 to 64 Years</i>	6.04%	5.83%	8.04%	+2.21	★★★★★
<i>Engagement 1—Ages 65 Years and Older</i>	NA	NA	NA	NC	NC
<i>Engagement 1—Total</i>	5.45%	5.04%	11.20%	+6.16	★★★★★
<i>Engagement 2—Ages 18 to 64 Years</i>	3.85%	4.85%	6.25%	+1.40	★★★★★
<i>Engagement 2—Ages 65 Years and Older</i>	NA	NA	NA	NC	NC
<i>Engagement 2—Total</i>	3.47%	4.20%	9.60%	+5.40	★★★★★
<i>Achievement—Ages 18 to 64 Years</i>	1.10%	2.91%	1.79%	-1.13	★★★
<i>Achievement—Ages 65 Years and Older</i>	NA	NA	NA	NC	NC
<i>Achievement—Total</i>	0.99%	2.52%	4.00%	+1.48	★★★★★
<i>Antidepressant Medication Management (AMM)</i>⁴					
<i>Effective Acute Phase Treatment</i>	64.14%	73.09%	74.78%	+1.70	★★★★★
<i>Effective Continuation Phase Treatment</i>	46.68%	55.69%	56.45%	+0.77	★★★★★
<i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)</i>					
<i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</i>	86.36%	86.61%	87.27%	+0.66	★★★★★
<i>Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)</i>					
<i>Diabetes Monitoring for People With Diabetes and Schizophrenia</i>	85.71%	73.49%	75.76%	+2.26	★★★★★

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	NC	NC
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	85.09%	82.69%	82.65%	-0.03	★★★★★
Diagnosed Mental Health Disorders (DMH)					
Ages 1 to 17 Years	—	26.57%	27.90%	+1.33 ⁺	★★★★★
Ages 18 to 64 Years	—	43.57%	45.12%	+1.55 ⁺	★★★★★
Ages 65 Years and Older	—	52.61%	53.20%	+0.59	★★★★★
Total	—	37.95%	39.37%	+1.42 ⁺	★★★★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership (RDM)					
White	87.82%	89.89%	89.97%	+0.09	NC
Black or African American	1.77%	1.85%	1.98%	+0.13	NC
American Indian or Alaska Native	3.70%	3.84%	4.04%	+0.20	NC
Asian	0.28%	0.51%	0.52%	+0.01	NC
Native Hawaiian or Other Pacific Islander	0.13%	0.16%	0.16%	+0.00	NC
Some Other Race	0.19%	3.56%	0.08%	-3.47	NC
Two or More Races	0.00%	0.03%	0.00%	-0.03	NC
Ethnicity Reporting Category: Hispanic or Latino	0.19%	2.34%	2.50%	+0.16	NC
Unknown	0.00%	0.00%	0.00%	0.00	NC
Declined	6.11%	0.16%	3.24%	+3.08	NC
Language Diversity of Membership (LDM)					
Spoken Language Preferred for Health Care—English	99.88%	99.86%	99.85%	-0.01	NC

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Spoken Language Preferred for Health Care—Non-English	0.10%	0.12%	0.13%	+0.01	NC
Spoken Language Preferred for Health Care—Unknown	0.02%	0.02%	0.01%	0.00	NC
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—English	99.88%	99.86%	99.85%	-0.01	NC
Language Preferred for Written Materials—Non-English	0.10%	0.12%	0.13%	+0.01	NC
Language Preferred for Written Materials—Unknown	0.02%	0.02%	0.01%	0.00	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—Non-English	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—Unknown	100.00%	100.00%	100.00%	0.00	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization³					
Ambulatory Care (AMB)					
Emergency Department Visits*	581.69	603.86	602.62	-1.25	★★
Outpatient Visits	4,127.91	3,986.58	4,017.25	+30.68	NC
Inpatient Utilization—General Hospital/Acute Care (IPU)					
Discharges—Total Inpatient—Total All Ages	72.76	66.38	68.08	+1.70	NC

Measure	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023	MY 2022–MY 2023 Comparison ¹	MY 2023 Performance Level ²
Average Length of Stay—Total Inpatient—Total All Ages	4.65	4.96	5.06	+0.10	NC
Discharges—Maternity—Total All Ages	22.01	19.11	18.02	-1.09	NC
Average Length of Stay—Maternity—Total All Ages	2.61	2.54	2.58	+0.04	NC
Discharges—Surgery—Total All Ages	21.70	19.36	20.25	+0.88	NC
Average Length of Stay—Surgery—Total All Ages	6.80	7.56	7.55	-0.01	NC
Discharges—Medicine—Total All Ages	34.58	32.61	34.22	+1.61	NC
Average Length of Stay—Medicine—Total All Ages	4.27	4.48	4.57	+0.09	NC
Use of Opioids From Multiple Providers (UOP)*					
Multiple Prescribers	17.73%	17.04%	18.25%	+1.22	★★★
Multiple Pharmacies	6.83%	6.19%	7.04%	+0.84	★
Multiple Prescribers and Multiple Pharmacies	5.17%	4.03%	4.46%	+0.43	★
Use of Opioids at High Dosage (HDO)*					
Use of Opioids at High Dosage	2.38%	2.42%	2.41%	-0.01	★★★
Risk of Continued Opioid Use (COU)*					
At Least 15 Days Covered—Total	7.87%	7.64%	7.75%	+0.11	★★
At Least 31 Days Covered—Total	5.30%	4.91%	4.97%	+0.06	★
Plan All-Cause Readmissions (PCR)					
Observed Readmissions—Total	9.06%	7.69%	7.12%	-0.57	NC
Expected Readmissions—Total	9.99%	9.82%	9.70%	-0.12	NC
O/E Ratio—Total	0.9076	0.7834	0.7340	-0.05	★★★★★

¹HEDIS MY 2023 to HEDIS MY 2022 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2022–MY 2023 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2022–MY 2023 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

²HEDIS MY 2023 Performance Levels were based on comparisons of the HEDIS MY 2023 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2022 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2022 benchmark.

³Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any Performance Levels for MY 2023 or MY 2022–MY 2023 Comparisons provided for these measures are for information only.

⁴Due to changes in the technical specifications for this measure, NCQA recommends trending between MY 2023 and prior years be considered with caution.

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

— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure.

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

HEDIS MY 2023 Performance Levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Appendix C. Performance Summary Stars

Introduction

This section presents the MHPs' performance summary stars for each measure within the following measure domains:

- Child & Adolescent Care
- Women—Adult Care
- Access to Care
- Obesity
- Living With Illness
- Utilization

Performance ratings were assigned by comparing the MHPs' HEDIS MY 2023 rates to the HEDIS MY 2022 MWA Quality Compass national Medicaid benchmarks (from ★ representing *Poor Performance* to ★★★★★ representing *Excellent Performance*). Measures in the Health Plan Diversity domain and utilization-based measure rates were not evaluated based on comparisons to national benchmarks; however, rates for these measure indicators are presented in Appendix B. Additional details about the performance comparisons and star ratings are found in Section 2.

Child & Adolescent Care Performance Summary Stars

Table C-1—Child & Adolescent Care Performance Summary Stars (Table 1 of 3)

MHP	Childhood Immunization Status (CIS)—Combination 3	Childhood Immunization Status (CIS)—Combination 7	Childhood Immunization Status (CIS)—Combination 10	Well-Child Visits in the First 15 Months— Six or More Well- Child Visits— Well-Child Visits in the First 30 Months of Life (W30)	Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits—Well-Child Visits in the First 30 Months of Life (W30)	Lead Screening in Children (LSC)
AET	★	★	★	★	★	★★
BCC	★★	★★	★	★★★★	★★★	★★
HCS	★	★	★	★★	★	★★
MCL	★★	★	★	★★★★	★★	★★
MER	★	★	★	★★★★	★★	★★
MOL	★	★	★	★★★	★★	★★
PRI	★★★★	★★★★	★★★★	★★★★	★★★	★★★★
UNI	★★	★	★	★★★★	★★	★★
UPP	★★	★★	★	★★★★★	★★★★	★★

Table C-2—Child & Adolescent Care Performance Summary Stars (Table 2 of 3)

MHP	Child and Adolescent Well-Care Visits (WCV)—Ages 3 to 11 Years	Child and Adolescent Well-Care Visits (WCV)—Ages 12 to 17 Years	Child and Adolescent Well-Care Visits (WCV)—Ages 18 to 21 Years	Child and Adolescent Well-Care Visits (WCV)—Total	Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap)	Immunizations for Adolescents (IMA)—Combination 2 (Meningococcal, Tdap, HPV)
AET	★★	★★	★★★	★★	★★	★
BCC	★★★	★★★	★★★★	★★★	★★	★★
HCS	★★	★	★★	★	★	★
MCL	★★★	★★	★★★	★★★	★★	★★
MER	★★★	★★★	★★★★	★★★	★★	★★
MOL	★★★	★★★	★★★★	★★★	★★★	★★★
PRI	★★★	★★★	★★★★	★★★	★★	★★
UNI	★★★	★★★	★★★★	★★★	★★	★★
UPP	★★★	★★★	★★★	★★★	★★	★★

Table C-3—Child & Adolescent Care Performance Summary Stars (Table 3 of 3)¹

MHP	Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD)—Initiation Phase	Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD)—Continuation and Maintenance Phase
AET	★★	NA
BCC	★★★★	★★★★
HCS	★	★
MCL	★★★	★★★★
MER	★★	★
MOL	★★★★	★★★★
PRI	★	★
UNI	★★	★★
UPP	★★★	★

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

¹ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

Women—Adult Care Performance Summary Stars

Table C-4—Women—Adult Care Performance Summary Stars

MHP	Chlamydia Screening in Women (CHL)—Ages 16 to 20 Years ¹	Chlamydia Screening in Women (CHL)—Ages 21 to 24 Years ¹	Chlamydia Screening in Women (CHL)—Total ¹	Cervical Cancer Screening (CCS-E)	Breast Cancer Screening (BCS-E)
AET	★★★★★	★★★★	★★★★★	★	★★
BCC	★★★★★	★★★★	★★★★★	★★	★★★
HCS	★★★★★	★★★	★★★★★	★	★★★
MCL	★★★	★★★	★★★	★★	★★★
MER	★★★	★★★	★★★	★★	★★★
MOL	★★★★★	★★★★	★★★★★	★★	★★★
PRI	★★★	★★★	★★★	★★	★★★
UNI	★★★	★★★	★★★	★★	★★★
UPP	★	★	★	★★	★★★★

¹ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

Access to Care Performance Summary Stars

Table C-5—Access to Care Performance Summary Stars (Table 1 of 3)

MHP	Ages 20 to 44 Years Adults' Access to Preventive Ambulatory Health Services (AAP)	Ages 45 to 64 Years Adults' Access to Preventive Ambulatory Health Services (AAP)	Ages 65 Years and Older Adults' Access to Preventive Ambulatory Health Services (AAP)	Total Adults' Access to Preventive Ambulatory Health Services (AAP)	Ages 3 Months to 17 Years Avoidance of Antibiotic Treatment for Acute Bronchitis Bronchiolitis (AAB)	Ages 18 to 64 Years Avoidance of Antibiotic Treatment for Acute Bronchitis Bronchiolitis (AAB)
AET	★★	★★	★★★★	★★★	★★	★
BCC	★★★	★★★	★	★★★	★★	★
HCS	★	★★	★★★★	★★	★★★	★
MCL	★★★	★★★	★	★★★	★★★	★★
MER	★★★	★★★	★★★	★★★	★★	★
MOL	★★★★	★★★★	★★★★	★★★★	★	★
PRI	★★★	★★★	★★★★	★★★	★★★	★★★★
UNI	★★★	★★★★	★★★★	★★★	★	★
UPP	★★★★	★★★	★★★★★	★★★★	★★★★	★★★

Table C-6—Access to Care Performance Summary Stars (Table 2 of 3)

MHP	Avoidance of Antibiotic Treatment for Acute Bronchitis Bronchiolitis (AAB)—Ages 65 Years and Older	Avoidance of Antibiotic Treatment for Acute Bronchitis Bronchiolitis (AAB)—Total	Appropriate Testing for Pharyngitis (CWP)—Ages 3 to 17 Years	Appropriate Testing for Pharyngitis (CWP)—Ages 18 to 64 Years	Appropriate Testing for Pharyngitis (CWP)—Ages 65 Years and Older	Appropriate Testing for Pharyngitis (CWP)—Total
AET	★	★	★★	★★	★★	★★
BCC	NA	★	★★★	★★★	NA	★★
HCS	★	★	★★	★★★	NA	★★
MCL	NA	★★	★★★	★★★	NA	★★★
MER	★★★	★	★★★	★★★	★★★	★★★
MOL	★	★	★★	★★	★★★	★★
PRI	★★★★	★★★	★★★★	★★★★★	NA	★★★★★
UNI	★★	★	★★	★	★★	★★
UPP	NA	★★★	★★★★★	★★★★★	NA	★★★★★

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Table C-7—Access to Care Performance Summary Stars (Table 3 of 3)

MHP	Appropriate Treatment for Upper Respiratory Infection (URI)—Ages 3 Months to 17 Years	Appropriate Treatment for Upper Respiratory Infection (URI)—Ages 18 to 64 Years	Appropriate Treatment for Upper Respiratory Infection (URI)—Ages 65 Years and Older	Appropriate Treatment for Upper Respiratory Infection (URI)—Total
AET	★	★★	★	★
BCC	★	★★	★★★	★
HCS	★	★★	★	★
MCL	★	★★	NA	★
MER	★	★★	★★	★
MOL	★	★★	★★	★
PRI	★★★	★★★	★★★★	★★★
UNI	★	★	★	★
UPP	★★	★★★	★★★	★★

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Obesity Performance Summary Stars

Table C-8—Obesity Performance Summary Stars

MHP	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children Adolescents (WCC)—Body Mass Index (BMI) Percentile—Total</i>	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children Adolescents (WCC)—Counseling for Nutrition—Total</i>	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children Adolescents (WCC)—Counseling for Physical Activity—Total</i>
AET	★★★★★	★★★	★★★★★
BCC	★★★★★	★★★★★	★★★★★
HCS	★★★★★	★★★★★	★★★★★
MCL	★★	★★	★★
MER	★★★	★★★	★★★
MOL	★★★	★★★	★★★
PRI	★★★★★	★★★★★	★★★★★
UNI	★★★★★	★★★	★★★
UPP	★★★★★	★★★	★★★

Pregnancy Care Performance Summary Stars

Table C-9—Pregnancy Care Performance Summary Stars

MHP	Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care	Prenatal and Postpartum Care (PPC)—Postpartum Care
AET	★	★
BCC	★★★★	★★★★
HCS	★	★
MCL	★	★★
MER	★★	★★
MOL	★★★★	★
PRI	★★★★	★★
UNI	★★	★
UPP	★★★★★	★★★★★

¹ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

Living With Illness Performance Summary Stars

Table C-10—Living With Illness Performance Summary Stars (Table 1 of 6)

MHP	Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Control (<8.0%)	Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Poor Control (>9.0%)*	Blood Pressure Control for Patients With Diabetes (BPD)	Eye Exam for Patients With Diabetes (EED) ¹	Kidney Health Evaluation for Patients With Diabetes (KED)—Ages 18 to 64 Years	Kidney Health Evaluation for Patients With Diabetes (KED)—Ages 65 to 74 Years
AET	★★★★★	★★★★	★★	★★★★	★★	★★
BCC	★★★★	★★★	★★★	★★★	★★★	★★★
HCS	★★★★	★★★★	★★★	★★★	★★★	★★★
MCL	★★	★★	★★	★★★	★★★	★★★
MER	★★★★★	★★★★	★★★★	★★★★	★★★	★★★
MOL	★★★	★★★	★★★	★★★	★★★	★★
PRI	★★★★★	★★★★★	★★★★★	★★★★	★★★	★★★
UNI	★★★★★	★★★★★	★★★★	★★★	★★★★	★★★★
UPP	★★★★★	★★★★★	★★★★★	★★★	★★★	★★★

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

¹ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

Table C-11—Living With Illness Performance Summary Stars (Table 2 of 6)

MHP	Kidney Health Evaluation for Patients With Diabetes (KED)—Ages 75 to 85 Years	Kidney Health Evaluation for Patients With Diabetes (KED)—Total	Asthma Medication Ratio (AMR)—Total	Controlling High Blood Pressure (CBP)	Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Cardiac Rehabilitation (CRE)—Initiation—Ages 18 to 64 Years
AET	★★	★★	★	★★	NA	★
BCC	★★	★★★★	★	★★★★	★	★★★★
HCS	★★★★	★★★★	★	★★★★	NA	★★★★
MCL	NA	★★★★	★	★	★	★★★★
MER	★★	★★★★	★★	★★★★	★	★★★★
MOL	★★	★★★★	★	★★★★	★	★★
PRI	★★★★	★★★★	★★	★★★★	★	★★★★
UNI	★★★★	★★★★	★★	★★★★	★	★★★★
UPP	★★★★	★★★★	★★	★★★★	NA	★★★★

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Table C-12—Living With Illness Performance Summary Stars (Table 3 of 6)

MHP	Cardiac Rehabilitation (CRE) —Initiation—Ages 65 Years and Older	Cardiac Rehabilitation (CRE) —Initiation—Total	Cardiac Rehabilitation (CRE) —Engagement 1— Ages 18 to 64 Years	Cardiac Rehabilitation (CRE) —Engagement 1— Ages 65 Years and Older	Cardiac Rehabilitation (CRE) —Engagement 1— Total	Cardiac Rehabilitation (CRE) —Engagement 2— Ages 18 to 64 Years
AET	NA	★★	★★★	NA	★★★★	★★★★
BCC	NA	★★★	★★★★	NA	★★★★	★★★★
HCS	NA	★★	★★★	NA	★★★	★★★
MCL	NA	★★★★	★★★★	NA	★★★★	★★★
MER	★★★★★	★★★★	★★★	★★★★	★★★★	★★★
MOL	★★★★	★★	★	★★	★	★
PRI	NA	★★★★	★★★★	NA	★★★★	★★★★
UNI	★★★★	★★★	★★★	★★★★	★★★★	★★★
UPP	NA	★★★★★	★★★★	NA	★★★★★	★★★★

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Table C-13—Living With Illness Performance Summary Stars (Table 4 of 6)

MHP	Cardiac Rehabilitation (CRE) —Engagement 2 —Ages 65 Years and Older	Cardiac Rehabilitation (CRE) —Engagement 2 —Total	Cardiac Rehabilitation (CRE) —Achievement —Ages 18 to 64 Years	Cardiac Rehabilitation (CRE) —Achievement —Ages 65 Years and Older	Cardiac Rehabilitation (CRE) —Achievement —Total	Antidepressant Medication Management (AMM)—Effective Acute Phase Treatment ¹
AET	NA	★★★★★	★★★★★	NA	★★★★★	★★★
BCC	NA	★★★★	★★★★★	NA	★★★★★	★★★★★
HCS	NA	★★★	★	NA	★★	★★★★★
MCL	NA	★★★	★★★	NA	★★★	★★★★★
MER	★★★★	★★★	★★★	★★★	★★★	★★★★★
MOL	★	★	★	★★	★	★★★
PRI	NA	★★★★	★★★	NA	★★★	★★★★★
UNI	★★★★	★★★	★★	★★★★	★★	★★★
UPP	NA	★★★★★	★★★	NA	★★★★★	★★★★★

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

¹ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

Table C-14—Living With Illness Performance Summary Stars (Table 5 of 6)

MHP	Treatment Antidepressant Medication Management (AMM)—Effective Continuation Phase ¹	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Diagnosed Mental Health Disorders (DMH)—Ages 1 to 17 Years
AET	★★★★	★★★	★★★★	NA	★★★★	★★
BCC	★★★★	★★★★	★★★	★	★★	★★★
HCS	★★★★★	★★★★	★★	NA	★★★	★★
MCL	★★★★	★★★	★★★	★★	★★★	★★★★
MER	★★★★★	★★★★	★★★	★★★	★★★	★★★★
MOL	★★★	★★★★	★★	★★	★★★	★★
PRI	★★★★	★★★	★★★	★★	★★★	★★★
UNI	★★★	★★★★	★★★	★★	★★★	NA
UPP	★★★★	★★★★★	★★★★	NA	★★★★★	★★★★

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

¹ Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

Table C-15—Living With Illness Performance Summary Stars (Table 6 of 6)

MHP	Diagnosed Mental Health Disorders (DMH)—Ages 18 to 64 Years	Diagnosed Mental Health Disorders (DMH)—Ages 65 Years and Older	Diagnosed Mental Health Disorders (DMH)—Total
AET	★★	★★★★	★★★
BCC	★★★	★	★★★
HCS	★★	★★★	★★
MCL	★★★★	★★	★★★★
MER	★★★★	★★★	★★★★
MOL	★★★	★★★	★★
PRI	★★★	★★★	★★★
UNI	NA	NA	NA
UPP	★★★★★	★★★★★	★★★★★

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Utilization Performance Summary Stars

Table C-16—Utilization Performance Summary Stars (Table 1 of 2)¹

MHP	Emergency Department Visits Ambulatory Care (AMB)	Use of Opioids From Multiple Providers (UOP)—Multiple Prescribers	Use of Opioids From Multiple Providers (UOP)—Multiple Pharmacies	Use of Opioids From Multiple Providers (UOP)—Multiple Prescribers and Multiple Pharmacies	Use of Opioids at High Dosage (HDO)	Risk of Continued Opioid Use (COU)—At Least 15 Days Covered—Total
AET	★	★★★	★	★	★★★	★
BCC	★★★★	★★★	★★	★★	★★★★★	★★
HCS	★★	★★★	★★	★★	★★★★★	★
MCL	★★	★★★★★	★★	★★	★★★★★	★★
MER	★★	★★★★★	★★	★★★★	★★★★★	★
MOL	★★	★★★	★★	★★	★★★★★	★
PRI	★★	★★	★★	★★★★	★★★★★	★
UNI	★★	★★★	★★	★★	★★★	★
UPP	★★	★★★	★	★	★★★	★★

¹A lower rate may indicate more favorable performance for these measure indicators (e.g., low rates of ED services may indicate better utilization of services). Therefore, percentiles were reversed to align with performance (e.g., the 10th percentile [a lower rate] was inverted to become the 90th percentile, indicating better performance).

Table C-17—Utilization Performance Summary Stars (Table 2 of 2)

MHP	Risk of Continued Opioid Use (COU) —At Least 31 Days Covered—Total ¹	Plan All-Cause Readmissions (PCR) —O/E Ratio—Total
AET	★	★
BCC	★	★
HCS	★	★★★
MCL	★	★★★
MER	★	★
MOL	★	★★★★
PRI	★	★★★★★
UNI	★	★★★
UPP	★	★★★★★

¹A lower rate may indicate more favorable performance for this measure indicator. Therefore, percentiles were reversed to align with performance (e.g., the 10th percentile [a lower rate] was inverted to become the 90th percentile, indicating better performance).

MI SFY 2024 Technical Report: Erratum Notice Medicaid Health Plans (MHPs)

Erratum Notice

Original report date: Submitted prior to April 30, 2025

Correction issued: June 18, 2025

Summary

HSAG identified inconsistencies in how certain cases were reviewed, which affected the results presented in the originally published report. The tables impacted by this issue are listed below:

- **Section 3: Assessment of Medicaid Health Plan Performance**
 - Table 3-20—Key Findings for **Aetna Better Health of Michigan (AET)**
 - Table 3-37—Key Findings for **Blue Cross Complete of Michigan (BCC)**
 - Table 3-54—Key Findings for **HAP CareSource (HCS)**
 - Table 3-71—Key Findings for **McLaren Health Plan (MCL)**
 - Table 3-88—Key Findings for **Meridian Health Plan of Michigan (MER)**
 - Table 3-105—Key Findings for **Molina Healthcare of Michigan (MOL)**
 - Table 3-122—Key Findings for **Priority Health Choice (PRI)**
 - Table 3-139—Key Findings for **UnitedHealthcare Community Plan (UNI)**
 - Table 3-156—Key Findings for **Upper Peninsula Health Plan (UPP)**

The following replacement tables reflect updated values based on a revised review of the medical record and corresponding encounter data. The corrections do not impact the overall conclusions of the report.

Replacement Table 3-20—Key Findings for AET

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	<ul style="list-style-type: none"> The medical record procurement rate was 97.6 percent, indicating that most requested records were successfully procured and submitted.
Second Date of Service Submission Rate	<ul style="list-style-type: none"> Among the procured medical records, 42.4 percent included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	<ul style="list-style-type: none"> The <i>Procedure Code</i> and <i>Procedure Code Modifier</i> had relatively high medical record omission rates at 13.1⁺ percent and 15.5⁺ percent, respectively. This indicates that the procedure codes and the modifiers in the encounter data were not adequately supported by the members' medical records.
Encounter Data Omission Rate	<ul style="list-style-type: none"> All key data elements exhibited relatively low encounter data omission rates, with the <i>Procedure Code</i> having the highest omission rate at 3.4⁺ percent.
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Diagnosis Codes</i> were accurate in 99.9 percent of instances where codes were present in both the medical records and encounter data, with all errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Codes</i> were accurate in 97.4 percent of instances where codes were present in both the medical records and encounter data, with all errors related to inaccurate coding.
Procedure Code Modifier Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code Modifiers</i> were accurate in 99.7 percent of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	<ul style="list-style-type: none"> Dates of service with accurate values for all key data elements (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, and <i>Procedure Code Modifier</i>) were observed in 77.6⁺ percent of the dates of service present in both data sources (i.e., encounter data and medical records).

Note: Rates in green font⁺ indicate a change in the calculated rate.

Replacement Table 3-37—Key Findings for BCC

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	<ul style="list-style-type: none"> The medical procurement rate was 99.5 percent, indicating that nearly all requested records were successfully procured and submitted.
Second Date of Service Submission Rate	<ul style="list-style-type: none"> Among the procured medical records, 42.1 percent included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	<ul style="list-style-type: none"> The <i>Procedure Code</i> and <i>Procedure Code Modifier</i> had relatively high medical record omission rates at 8.8⁺ percent and 12.3⁺ percent, respectively. This indicates that the procedure codes and the modifiers in the encounter data were not adequately supported by the members' medical records.
Encounter Data Omission Rate	<ul style="list-style-type: none"> All key data elements exhibited relatively low encounter data omission rates, with the <i>Date of Service</i> having the highest encounter data omission rate at 6.2 percent.
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Diagnosis Codes</i> were accurate in 99.7 percent of instances where codes were present in both the medical records and encounter data, with most errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Codes</i> were accurate in 97.8 percent of instances where codes were present in both the medical records and encounter data; most errors were related to inaccurate coding, while some were attributed to providers submitting higher-level service codes than those supported in the medical records.
Procedure Code Modifier Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code Modifiers</i> were accurate in 100 percent of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	<ul style="list-style-type: none"> Dates of service with accurate values for all key data elements (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, and <i>Procedure Code Modifier</i>) were observed in 75.9⁺ percent of the dates of service present in both data sources (i.e., encounter data and medical records).

Note: Rates in green font⁺ indicate a change in the calculated rate.

Replacement Table 3-54—Key Findings for HCS

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	<ul style="list-style-type: none"> The medical procurement rate was 82.0 percent, indicating that nearly 20.0 percent of the requested records were not successfully procured and submitted. Of the medical records not submitted, nearly 84 percent were not submitted due to non-responsive providers or provider did not respond in a timely manner.
Second Date of Service Submission Rate	<ul style="list-style-type: none"> Among the procured medical records, 50.4 percent included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	<ul style="list-style-type: none"> All key data elements (i.e., <i>Date of Service</i>, <i>Diagnosis Code</i>, <i>Procedure Code</i>, and <i>Procedure Code Modifier</i>) had relatively high medical record omission rates, ranging from 13.6 percent (<i>Date of Service</i>) to 27.4+ percent (<i>Procedure Code Modifier</i>). This suggests that the data elements in the encounter data were not adequately supported by the members' medical records. The high medical record omission rates for all key data elements were partially influenced by medical record non-submission. In cases where no medical records were submitted for a requested case, all associated data elements were categorized as medical record omissions.
Encounter Data Omission Rate	<ul style="list-style-type: none"> All key data elements exhibited relatively low encounter data omission rates with the <i>Date of Service</i> having the highest omission rate at 4.4 percent.
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Diagnosis Codes</i> were accurate in 99.8 percent of instances where codes were present in both the medical records and encounter data, with all errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Codes</i> were accurate in 96.9 percent of instances where codes were present in both the medical records and encounter data; most errors were related to inaccurate coding, while some were attributed to providers submitting higher-level service codes than those supported in the medical records.
Procedure Code Modifier Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code Modifiers</i> were accurate in 100 percent of instances where modifiers were present in both the medical records and encounter data.

Analysis	Key Findings
All-Element Accuracy Rate	<ul style="list-style-type: none"> Dates of service with accurate values for all key data elements (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, and <i>Procedure Code Modifier</i>) were observed in 74.7⁺ percent of the dates of service present in both data sources (i.e., encounter data and medical records).

Note: Rates in green font⁺ indicate a change in the calculated rate.

Replacement Table 3-71—Key Findings for MCL

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	<ul style="list-style-type: none"> The medical record rate was 94.4 percent, indicating that most of the requested records were procured and submitted. Of the medical records not submitted, all were not submitted due to non-responsive provider or provider did not respond in a timely manner.
Second Date of Service Submission Rate	<ul style="list-style-type: none"> Among the procured medical records, 59.8 percent included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	<ul style="list-style-type: none"> The <i>Procedure Code</i> and <i>Procedure Code Modifier</i> had relatively high medical record omission rates at 13.2⁺ percent and 18.3⁺ percent, respectively. This indicates that the procedure codes and the modifiers in the encounter data were not adequately supported by the members' medical records.
Encounter Data Omission Rate	<ul style="list-style-type: none"> All key data elements exhibited relatively low encounter data omission rates, with the <i>Date of Service</i> having the highest encounter data omission rate at 5.1 percent.
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Diagnosis Codes</i> were accurate in 99.7 percent of instances where codes were present in both the medical records and encounter data, with all errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Codes</i> were accurate in 98.1 percent of instances where codes were present in both the medical records and encounter data; most errors were related to inaccurate coding, while some were attributed to providers submitting higher-level service codes than those supported in medical records.

Analysis	Key Findings
Procedure Code Modifier Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code Modifiers</i> were accurate in 100 percent of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	<ul style="list-style-type: none"> Dates of service with accurate values for all key data elements (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, and <i>Procedure Code Modifier</i>) were observed in 78.7⁺ percent of the dates of service present in both data sources (i.e., encounter data and medical records).

Note: Rates in green font⁺ indicate a change in the calculated rate.

Replacement Table 3-88—Key Findings for MER

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	<ul style="list-style-type: none"> The medical record procurement rate was 92.2 percent, indicating that most of the requested records were procured and submitted. Of the medical records not submitted, nearly 70 percent were not submitted due to non-responsive providers or provider did not respond in a timely manner.
Second Date of Service Submission Rate	<ul style="list-style-type: none"> Among the procured medical records, 26.4 percent included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	<ul style="list-style-type: none"> All key data elements, except for <i>Date of Service</i>, had relatively high medical record omission rates, ranging from 6.9 percent (<i>Date of Service</i>) to 19.4⁺ percent (<i>Procedure Code Modifier</i>). This suggests that the data elements in the encounter data were not adequately supported by the members' medical records. The high medical record omission rates for those data elements were partially influenced by medical record non-submission. In cases where no medical records were submitted for a requested case, all associated data elements were categorized as medical record omissions.
Encounter Data Omission Rate	<ul style="list-style-type: none"> All key data elements exhibited relatively low encounter data omission rates with the <i>Date of Service</i> having the highest encounter data omission rate at 4.8⁺ percent.

Analysis	Key Findings
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Diagnosis Codes</i> were accurate in 99.8 percent of instances where codes were present in both the medical records and encounter data, with all errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Codes</i> were accurate in 97.8 percent of instances where codes were present in both the medical records and encounter data, with all errors related to inaccurate coding.
Procedure Code Modifier Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code Modifiers</i> were accurate in 99.7 percent of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	<ul style="list-style-type: none"> Dates of service with accurate values for all key data elements (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, and <i>Procedure Code Modifier</i>) were observed in 74.7⁺ percent of the dates of service present in both data sources (i.e., encounter data and medical records).

Note: Rates in green font⁺ indicate a change in the calculated rate.

Replacement Table 3-105—Key Findings for MOL

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	<ul style="list-style-type: none"> The medical record procurement rate was 85.6 percent, indicating that nearly 15 percent of the requested records were not procured and submitted. Of the medical records not submitted, approximately 86 percent were not submitted due to non-responsive providers or provider did not respond in a timely manner.
Second Date of Service Submission Rate	<ul style="list-style-type: none"> Among the procured medical record, 59.7 percent included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	<ul style="list-style-type: none"> All key data elements (i.e., <i>Date of Service</i>, <i>Diagnosis Code</i>, <i>Procedure Code</i>, and <i>Procedure Code Modifier</i>) had relatively high medical record omission rates, ranging from 10.7 percent (<i>Date of Service</i>) to 26.0⁺ percent (<i>Procedure Code Modifier</i>). The high medical record omission rates for all key data elements were partially influenced by medical record non-submission. In cases where no medical records were submitted for a requested case, all associated data elements were categorized as medical record omissions.

Analysis	Key Findings
Encounter Data Omission Rate	<ul style="list-style-type: none"> All key data elements exhibited relatively low encounter data omission rates with the <i>Date of Service</i> having the highest encounter data omission rate at 6.2 percent.
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Diagnosis Codes</i> were accurate in 99.6 percent of instances where codes were present in both the medical records and encounter data, with all errors related to inaccurate coding.
Procedure Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Codes</i> were accurate in 98.5 percent of instances where codes were present in both the medical records and encounter data, with all errors related to inaccurate coding.
Procedure Code Modifier Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code Modifiers</i> were accurate in 100 percent of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	<ul style="list-style-type: none"> Dates of service with accurate values for all key data elements (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, and <i>Procedure Code Modifier</i>) were observed in 71.8⁺ percent of the dates of service present in both data sources (i.e., encounter data and medical records).

Note: Rates in green font⁺ indicate a change in the calculated rate.

Replacement Table 3-122—Key Findings for PRI

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	<ul style="list-style-type: none"> The record procurement rate was 99.0 percent, indicating that nearly all of the requested records were successfully procured and submitted.
Second Date of Service Submission Rate	<ul style="list-style-type: none"> Among the procured medical records, 40.3 percent included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	<ul style="list-style-type: none"> All key data elements, with the exception of <i>Procedure Code Modifier</i>, had relatively low medical record omission rates, ranging from 1.3 percent (<i>Date of Service</i>) to 13.4⁺ percent (<i>Procedure Code Modifier</i>).
Encounter Data Omission Rate	<ul style="list-style-type: none"> All key data elements exhibited relatively low encounter data omission rates with the <i>Procedure Code</i> having the largest encounter data omission rate at 3.4⁺ percent.

Analysis	Key Findings
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Diagnosis Codes</i> were accurate in 99.7 percent of instances where codes were present in both the medical records and encounter data, with all errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Codes</i> were accurate in 98.2 percent of instances where codes were present in both the medical records and encounter data; most errors were related to inaccurate coding, while some were attributed to providers submitting higher-level service codes than those supported in the medical records.
Procedure Code Modifier Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code Modifiers</i> were accurate in 99.7 percent of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	<ul style="list-style-type: none"> Dates of service with accurate values for all key data elements (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, and <i>Procedure Code Modifier</i>) were observed in 78.6⁺ percent of the dates of service present in both data sources (i.e., encounter data and medical records).

Note: Rates in green font⁺ indicate a change in the calculated rate.

Replacement Table 3-139—Key Findings for UNI

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	<ul style="list-style-type: none"> The medical procurement rate was 98.3 percent, indicating that most requested records were successfully procured and submitted.
Second Date of Service Submission Rate	<ul style="list-style-type: none"> Among the procured medical records, 52.5 percent included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	<ul style="list-style-type: none"> The <i>Procedure Code</i> and <i>Procedure Code Modifier</i> had relatively high medical record omission rates at 11.8⁺ percent and 20.3⁺ percent, respectively. This indicates that the procedure codes and the modifiers in the encounter data were not adequately supported by the members' medical records.
Encounter Data Omission Rate	<ul style="list-style-type: none"> All key data elements exhibited low encounter data omission rates, with the <i>Procedure Code</i> having the highest omission rate at 2.8⁺ percent.

Analysis	Key Findings
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Diagnosis Codes</i> were accurate in 99.7 percent of instances where codes were present in both the medical records and encounter data, with all errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Codes</i> were accurate in 97.6 percent of instances where codes were present in both the medical records and encounter data, with all errors related to inaccurate coding.
Procedure Code Modifier Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code Modifiers</i> were accurate in 100 percent of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	<ul style="list-style-type: none"> Dates of service with accurate values for all key data elements (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, and <i>Procedure Code Modifier</i>) were observed in 72.6⁺ percent of the dates of service present in both data sources (i.e., encounter data and medical records).

Note: Rates in green font⁺ indicate a change in the calculated rate.

Replacement Table 3-156—Key Findings for UPP

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	<ul style="list-style-type: none"> The medical procurement rate was 99.3 percent, indicating that nearly all requested records were successfully procured and submitted.
Second Date of Service Submission Rate	<ul style="list-style-type: none"> Among procured medical records, 45.8 percent included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	<ul style="list-style-type: none"> All key data elements, with the exception of <i>Procedure Code Modifier</i> had low medical record omission rates, ranging from 1.1 percent (<i>Date of Service</i>) to 12.1⁺ percent (<i>Procedure Code Modifier</i>).
Encounter Data Omission Rate	<ul style="list-style-type: none"> All key data elements exhibited relatively low encounter data omission rates, with both the <i>Date of Service</i> and <i>Procedure Code</i> showing the highest encounter data omission rate at 4.2⁺ percent each.

Analysis	Key Findings
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Diagnosis Codes</i> were accurate in 99.9 percent of instances where codes were present in both the medical records and encounter data, with all errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Codes</i> were accurate in 99.6 percent of instances where codes were present in both the medical records and encounter data. Of the identified errors, half were due to inaccurate coding, while the other half were attributed to providers submitting higher-level service codes than those supported in the medical records.
Procedure Code Modifier Accuracy Rate	<ul style="list-style-type: none"> The <i>Procedure Code Modifiers</i> were accurate in 100 percent of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	<ul style="list-style-type: none"> Dates of service with accurate values for all key data elements (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, and <i>Procedure Code Modifier</i>) were observed in 87.8⁺ percent of the dates of service present in both data sources (i.e., encounter data and medical records).

Note: Rates in green font⁺ indicate a change in the calculated rate.