



# **State Fiscal Year 2024 External Quality Review Technical Report**

## ***for Integrated Care Organizations***

*April 2025*



## Table of Contents

<b>1. Executive Summary.....</b>	<b>1-1</b>
Purpose and Overview of Report .....	1-1
Scope of External Quality Review Activities.....	1-2
MI Health Link Program Conclusions and Recommendations .....	1-3
<b>2. Overview of the Integrated Care Organizations .....</b>	<b>2-1</b>
Managed Care in Michigan .....	2-1
MI Health Link Program .....	2-3
Overview of Integrated Care Organizations.....	2-3
Quality Strategy.....	2-6
Quality Initiatives and Interventions .....	2-8
<b>3. Assessment of Integrated Care Organization Performance .....</b>	<b>3-1</b>
Objectives of External Quality Review Activities .....	3-1
Validation of Quality Improvement Projects .....	3-2
Performance Measure Validation.....	3-3
Compliance Review .....	3-6
Network Adequacy Validation.....	3-7
Encounter Data Validation .....	3-9
Consumer Assessment of Healthcare Providers and Systems Analysis.....	3-10
External Quality Review Activity Results .....	3-11
Aetna Better Health Premier Plan .....	3-11
AmeriHealth Caritas VIP Care Plus .....	3-39
HAP CareSource .....	3-68
MeridianComplete.....	3-95
Molina Dual Options MI Health Link .....	3-123
Upper Peninsula Health Plan MI Health Link.....	3-151
<b>4. Follow-Up on Prior External Quality Review Recommendations for Integrated Care Organizations .....</b>	<b>4-1</b>
Aetna Better Health Premier Plan .....	4-1
AmeriHealth Caritas VIP Care Plus .....	4-13
HAP CareSource .....	4-26
MeridianComplete.....	4-36
Molina Dual Options MI Health Link .....	4-49
Upper Peninsula Health Plan MI Health Link.....	4-62
<b>5. Integrated Care Organization Comparative Information .....</b>	<b>5-1</b>
Integrated Care Organization External Quality Review Activity Results.....	5-1
Validation of Quality Improvement Projects .....	5-2
Performance Measure Validation.....	5-4
Compliance Review .....	5-10
Network Adequacy Validation.....	5-12
Encounter Data Validation .....	5-18

Consumer Assessment of Healthcare Providers and Systems Analysis.....	5-22
<b>6. Programwide Conclusions and Recommendations .....</b>	<b>6-1</b>
<b>Appendix A. External Quality Review Activity Methodologies .....</b>	<b>A-1</b>
Methods for Conducting EQR Activities .....	A-1
Validation of Quality Improvement Projects .....	A-1
Performance Measure Validation .....	A-5
Performance Measure Rates .....	A-9
Compliance Review .....	A-10
Network Adequacy Validation .....	A-15
Encounter Data Validation .....	A-28
Consumer Assessment of Healthcare Providers and Systems Analysis.....	A-33
<b>SFY 2024 Technical Report: Erratum Notice .....</b>	<b>1</b>

## 1. Executive Summary

### Purpose and Overview of Report

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

The Behavioral and Physical Health and Aging Services Administration (BPHASA) within MDHHS administers and oversees the Michigan Medicaid managed care program, including the MI Health Link program, which contracts with six MCEs, referred to as integrated care organizations (ICOs), to provide Medicare and Medicaid benefits to dual-eligible members in Michigan. The ICOs contracted with MDHHS during state fiscal year (SFY) 2024 are displayed in Table 1-1.

**Table 1-1—ICOs in Michigan**

ICO Name	Abbreviation
Aetna Better Health Premier Plan	AET
AmeriHealth Caritas VIP Care Plus	AMI
HAP CareSource	HCS
MeridianComplete	MER
Molina Dual Options MI Health Link	MOL
Upper Peninsula Health Plan MI Health Link	UPP

## Scope of External Quality Review Activities

To conduct the annual assessment, HSAG used the results of mandatory and optional EQR activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by the Centers for Medicare & Medicaid Services (CMS) (referred to as the CMS EQR Protocols).<sup>1</sup> The purpose of these activities, in general, is to improve states' ability to oversee and manage MCEs they contract with for services, and help MCEs improve their performance with respect to the quality, timeliness, and accessibility of care and services. Effective implementation of the EQR-related activities will facilitate state efforts to purchase cost-effective, high-value care and to achieve higher performing healthcare delivery systems for their dual-eligible Medicare-Medicaid members. For the SFY 2024 assessment, no ICOs were exempt from the external quality review 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 ICO. Detailed information about each activity's methodology is provided in Appendix A of this report.

**Table 1-2—EQR Activities**

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

<sup>1</sup> 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: Feb 24, 2025.

<sup>2</sup> MCEs that participate in Medicare and/or Medicaid are required by regulation to develop and implement quality/performance improvement projects. Medicare plans are required to conduct and report on quality improvement projects (QIPs), and Medicaid plans are required to conduct and report on performance improvement projects (PIPs). Because both Medicare and Medicaid plans are referenced in this report, QIPs and PIPs will be referenced throughout the report.

Activity	Description	CMS EQR Protocol
Network Adequacy Validation (NAV)	This activity assesses the extent to which an ICO 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)	This activity validates the accuracy and completeness of encounter data submitted by an ICO.	Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan (CMS EQR Protocol 5)
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) <sup>3</sup> Analysis	This activity assesses member experience with an ICO and its providers, and the quality of care they receive.	Protocol 6. Administration or Validation of Quality of Care Surveys (CMS EQR Protocol 6)

## MI Health Link Program Conclusions and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from the SFY 2024 activities to comprehensively assess the ICOs' performance in providing quality, timely, and accessible healthcare services to dual-eligible members. For each ICO reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the ICO's performance, which can be found in Section 3 of this report. The overall findings and conclusions for all ICOs were also compared and analyzed to develop overarching conclusions and recommendations for MDHHS and the MI Health Link program. Table 1-3 highlights substantive conclusions and actionable, state-specific recommendations, when applicable, for MDHHS to drive progress toward achieving the goals of Michigan's Comprehensive Quality Strategy (CQS)<sup>4</sup> and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to 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 MI Health Link program's progress toward achieving the applicable goals and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to 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 MI Health Link population.

<sup>3</sup> CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

<sup>4</sup> 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](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: Feb 24, 2025.

Table 1-3—MI Health Link Program Substantive Findings

Performance Impact on Goals and Objectives <sup>5</sup>		Performance Domain
<b>Goal #1—Ensure high quality and high levels of access to care</b>		
m	<b>CQS Objective 1.1:</b> The MI Health Link program made minimal progress towards reaching the statewide 2026 performance target to achieve 65 percent for the <i>MI7.3 Annual Dental Visit</i> quality measure. While no ICOs reached the goal, four of the six ICOs demonstrated improvement from the prior year.	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
✓	<b>CQS Objective 1.1:</b> The MI Health Link program reached the statewide 2026 performance target to achieve 56 percent for the <i>FUH—Follow-Up After Hospitalization for Mental Illness (30 Days)</i> quality measure. The MI Health Link program rate was 58.83 percent.	
m	<b>CQS Objective 1.1:</b> The MI Health Link program made minimal progress towards reaching the statewide 2026 performance target to achieve 72 percent for the <i>COL—Colorectal Cancer Screening</i> quality measure. While the MI Health Link program rate was 68.85 percent, the rate increased in performance from the prior year.	
m	<b>CQS Objective 1.2:</b> The MI Health Link program made minimal progress towards reaching the statewide 2026 performance target to achieve 71 percent for the <i>CBP—Controlling High Blood Pressure</i> quality measure. While the MI Health Link program rate was 60.82 percent, the rate increased in performance from the prior year.	
✗	<b>CQS Objective 1.2:</b> The MI Health Link program did not make progress towards reaching the statewide 2026 performance target to achieve 1.00 for the <i>PCR—Plan All-Cause Readmission</i> based on the results of the <i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)</i> performance measure demonstrating no improvement from the prior year.	
m	<b>CQS Objective 1.2:</b> The MI Health Link program made minimal progress towards reaching the statewide 2026 performance target to achieve 72 percent for the <i>COL—Colorectal Cancer Screening</i> quality measure. While the MI Health Link program rate was 68.85 percent, the rate increased in performance from the prior year.	
—	<b>CQS Objective 1.3:</b> The EQR activities do not produce data to assess the impact of the <i>Annual Flu Vaccine</i> quality measure under this objective.	
✓	<b>CQS Objective 1.3:</b> The MI Health Link program made progress towards reaching the statewide 2026 performance target to achieve 85 percent for the <i>MI5.6 Medication Review—All Populations</i> quality measure. Four of the six ICOs achieved the 85 percent target and five of the six ICOs demonstrated improvement from the prior year.	
m	<b>CQS Objective 1.3:</b> The MI Health Link program made minimal progress towards reaching the statewide 2026 performance target to achieve 65 percent for the <i>TRC - Transitions of Care—Medication Reconciliation Post-Discharge</i> quality measure. While the	

<sup>5</sup> 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 <sup>5</sup>		Performance Domain
	MI Health Link program rate was 56.17 percent, the rate increased in performance from the prior year.	
–	<b>CQS Objective 1.3:</b> The EQR activities do not produce data to assess the impact of the <i>PM13 Number and percent of enrollees whose IICSP addressed their assessed health and safety risks (HCBS C-Waiver population)</i> quality measure under this objective.	
–	<b>CQS Objective 1.3:</b> The EQR activities do not produce data to assess the impact of the <i>PM15 Number &amp; percent of enrollees with an individualized contingency/back-up plan addressing caregiver absences, severe weather, fire/other emergencies (HCBS C-Waiver population)</i> quality measure under this objective.	
–	<b>CQS Objective 1.3:</b> The EQR activities do not produce data to assess the impact of the <i>PM24 Number and percent of files that show enrollee/family/legal guardians (as appropriate) received information and education on how to report abuse, neglect, exploitation, and other critical incidents within 60 days of waiver enrollment</i> quality measure under this objective.	
✓	Based on the results of the ISCA's combined with the detailed validation of each NAV indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and whether the ICOs' interpretation of data was accurate. All six of the ICOs received <i>High Confidence</i> for both provider capacity and time and distance indicators. <sup>6</sup>	
✓	The MI Health Link program met minimum network requirements, or an exception was granted, for all but one Medicaid and long-term services and supports (LTSS) provider types. <sup>6</sup>	
✗	While the average wait time for an initial dental appointment was 13 calendar days and within MDHHS' appointment wait time standard of eight weeks, only 83.5 percent of members were offered an appointment within the wait time standard. Further, only 68.3 percent of dental providers included in the secret shopper activity confirmed accepting new patients and only 62.3 percent offered an appointment. <sup>6</sup>	
✗	During the process of generating sample cases for the EDV review, HSAG encountered significant challenges with the completeness and accuracy of provider information within the MDHHS encounter data. Specifically, the data often lacked fully populated National Provider Identifiers (NPIs), which are crucial for accurately identifying providers that met the criteria for a specific service category. Additionally, the encounter data did not include detailed provider taxonomy codes that are vital for determining the eligibility of providers for specific services relevant for the review. The lack of detailed taxonomy information hindered HSAG's ability to categorize and analyze data based on provider specialty and service type. <sup>6</sup>	

<sup>6</sup> 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 <sup>5</sup>		Performance Domain
Goal #2—Strengthen person and family-centered approaches		
–	<b>CQS Objective 2.1:</b> The EQR activities do not produce data to assess the impact of the <i>MI2.3 Members with documented discussions of care goals</i> quality measures under this objective.	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
m	<b>CQS Objective 2.1:</b> The MI Health Link program made minimal progress towards reaching the statewide 2026 performance target to achieve 1.5 for the <i>Core 9.3 Minimizing Facility Length of Stay—Ratio of Observed to Expected Discharge Rates</i> quality measure. Five of the six ICOs achieved the target; however, three ICOs demonstrated a decrease in performance from the prior year.	
–	<b>CQS Objective 2.1:</b> The EQR activities do not produce data to assess the impact of the <i>PM17 Number and percent of enrollee IICSPs that are updated as the enrollee's needs change</i> quality measure under this objective.	
–	<b>CQS Objective 2.2:</b> The EQR activities do not produce data to assess the impact of the <i>SNS-E Social Needs Screening &amp; Intervention</i> quality measure under this objective.	
Goal #3—Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)		
✓	<b>CQS Objective 3.1:</b> The MI Health Link program reached the statewide 2026 performance target to achieve 56 percent for the <i>FUH—Follow-Up After Hospitalization for Mental Illness (30 Days)</i> quality measure. The MI Health Link program rate was 58.83 percent.	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
✓	<b>CQS Objective 3.2:</b> The MI Health Link program made progress towards reaching the statewide 2026 performance target to achieve 65 percent for the <i>MI2.6 Timely transmission of care transition record to health care professional</i> quality measure. One ICO achieved the target, while four additional ICOs demonstrated improvement from the prior year with rates increasing between 8 and 26 percentage points.	
Goal #4—Reduce racial and ethnic disparities in healthcare and health outcomes		
✓	<b>CQS Objective 4.1:</b> The MI Health Link program made progress towards reaching the statewide 2026 performance target to achieve a statistically significant reduction in disparity for the <i>Aetna—Comprehensive Diabetes Care—HbA1cTest: Decreasing the Disparity Between White and African American Members</i> quality measure. While the disparity was not eliminated, the ICO demonstrated statistically significant improvement over the baseline performance for the disparate population during second remeasurement period.	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
✓	<b>CQS Objective 4.1:</b> The MI Health Link program made progress towards reaching the statewide 2026 performance target to achieve a statistically significant reduction in disparity for the <i>HCS—Reducing Controlling Blood Pressure Disparity Between Black/African American and White/Caucasian Members</i> quality measure. The disparate subgroup sustained statistically significant improvement over the baseline performance for the second remeasurement period and the state-specific goal of eliminating the existing disparity was achieved.	

Performance Impact on Goals and Objectives <sup>5</sup>		Performance Domain
✓	<b>CQS Objective 4.1:</b> The MI Health Link program made progress towards reaching the statewide 2026 performance target to achieve a statistically significant reduction in disparity for the <i>Molina—Addressing Disparities in Controlling High Blood Pressure Between Black/African American and White Members</i> quality measure. The ICO sustained statistically significant improvement over the baseline performance for both performance indicators during the second remeasurement period and eliminated the existing disparity between the two subgroups.	
✗	<b>CQS Objective 4.1:</b> The MI Health Link program made progress towards reaching the statewide 2026 performance target to achieve a statistically significant reduction in disparity for the <i>AmeriHealth—Transitions of Care, Medication Reconciliation Post-Discharge: Black/African American vs White</i> quality measure. The ICO did not eliminate the disparity and demonstrated statistically significant declines in performance as compared to the baseline rate for both the disparate and comparison populations.	
✗	<b>CQS Objective 4.1:</b> The MI Health Link program did not make progress towards reaching the statewide 2026 performance target to achieve a statistically significant reduction in disparity for the <i>Meridian—Statin Therapy for Patients with Diabetes—Decreasing the Disparity Between White and African American Members</i> quality measure. The ICO did not achieve the state-specific goal of eliminating the existing disparity between the two subgroups with the second remeasurement period, and the comparison subgroup demonstrated a decline in performance as compared to the baseline	
✗	<b>CQS Objective 4.1:</b> The MI Health Link program did not make progress towards reaching the statewide 2026 performance target to achieve a statistically significant reduction in disparity for the <i>UPHP—MI 7.3 Annual Dental Visit: AI/AN (American Indian/Alaskan Native) vs White</i> quality measure. The ICO did not achieve the state-specific goal of eliminating the existing disparity between the two subgroups with the second remeasurement period, and both subgroups demonstrated declines in performance as compared to the baseline.	
Goal #5—Improve quality outcomes through value-based initiatives and payment reform		
—	<b>CQS Objective 5.1:</b> The CQS does not include quality measures for the MI Health Link Program under Goal #5.	<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 access to healthcare services furnished to MI Health Link members:</p> <ul style="list-style-type: none"><li>Comparing applicable data elements in the ICOs’ provider and member data against external data sources will help to ensure the quality of the ICOs’ data. Enhanced data verification processes may apply to future network analyses and/or NAV activities, including, but not limited to, the following:</li></ul>		

Performance Impact on Goals and Objectives <sup>5</sup>	Performance Domain
<ul style="list-style-type: none"> <li>– MDHHS may consider further defining provider categories to ensure consistency between ICOs in aligning contracted providers with the Medicaid and LTSS provider categories. For example, MDHHS may define dental care providers based on taxonomy codes or other standardized provider category and specialty designations during the enrollment process.</li> <li>– MDHHS may consider comparing ICOs’ provider data to external data sources to evaluate the accuracy of each ICO’s data values for NPIs, provider service locations, and provider categories. For example, ICOs’ National Provider Identifier (NPI) data could be compared to the National Plan and Provider Enumeration System (NPPES) database to determine whether the ICOs’ NPI values align with active providers.</li> <li>– MDHHS may consider working with the ICOs and/or its EQRO to determine how ICOs identify non-participating providers that may be available to contract with the ICO. MDHHS may utilize internally available provider data to identify instances where an ICO is missing opportunities to contract with known providers that would allow them to meet network standards.</li> <li>– MDHHS may consider providing ICO-specific technical assistance aimed at improving ICO understanding of reporting expectations and data submission requirements.</li> </ul> <ul style="list-style-type: none"> <li>• Accurate and complete encounter data are critical to the success of a managed care program. MDHHS relies on the quality of encounter data submissions from the ICOs to accurately and effectively monitor and improve the program’s quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information. To address the challenges identified during the EDV activity and improve the integrity of future data analyses, HSAG proposes the following strategic recommendations: <ul style="list-style-type: none"> <li>– MDHHS should mandate the inclusion of complete NPI and provider taxonomy codes in all encounter data submissions.</li> <li>– Introduce robust data verification processes at the point of entry. This step will help in early detection and rectification of incomplete or inaccurate provider data, maintaining the integrity of the database.</li> <li>– Develop a centralized, easily accessible repository for provider data that can be referenced and updated regularly. This will facilitate more efficient data linkage and retrieval, improving the ease and reliability of data analysis.</li> <li>– Implement a regular review and feedback system to monitor the improvements in data quality post-implementation of these changes. This will not only help in measuring the success of the implemented strategies but also in making continuous improvements.</li> </ul> </li> <li>• As the MI Health Link program is ending and transitioning to the MI Coordinated Health (MICH) program through contracted highly integrated dual eligible specials needs plans (HIDE-SNPs) effective January 1, 2026, HSAG recommends that MDHHS consider the results of all EQR activities conducted for the MI Health Link program when initiating future EQR activities with the MICH program.</li> <li>• As the MI Health Link program transitions to the MICH program, HSAG recommends that MDHHS review the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) Medicaid and Children’s Health Insurance Program Managed Care Access, Finance, and Quality Final Rule (CMS-2439-F) and ensure its contract with the HIDE-SNPs meet all applicable future regulations (e.g., seven calendar day service authorization time frame, public reporting of prior authorization metrics, maximum appointment wait time standards).</li> </ul>	

## 2. Overview of the Integrated Care Organizations

### Managed Care in Michigan

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

**Table 2-1—Medicaid Managed Care Programs in Michigan**

Medicaid Managed Care Program	MCE Type	Managed Care Authority	Date Initiated	Populations Served
<b>Comprehensive Health Care Program (CHCP)</b>				
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"> <li>MICHild (CHIP)</li> </ul>		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"> <li>Children's Special Health Care Services (CSHCS)</li> </ul>		Michigan Medicaid State Plan	October 2012	CSHCS is a program within MDHHS for children and some adults with special health care needs and their families.
<ul style="list-style-type: none"> <li>Foster Children</li> </ul>		1915(b)	November 2010	Most categories of foster children are mandatorily enrolled in managed care.
<ul style="list-style-type: none"> <li>Pregnant Individuals</li> </ul>		1915(b)	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 (ICOs)	ICO	1915(b) & 1915(c)	March 2015	Persons fully eligible and enrolled in both Medicare and Medicaid who are over the age of 21 and reside in one of the four regions where the program is available.

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

Medicaid Managed Care Program	MCE Type	Managed Care Authority	Date Initiated	Populations Served
		Disturbance Waiver (SEDW)		

## MI Health Link Program

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

## Overview of Integrated Care Organizations

During the SFY 2024 review period, MDHHS contracted with six ICOs. These ICOs were responsible for the provision of services to MI Health Link members. Table 2-2 provides a profile for each ICO. Figure 2-1 shows a visual representation of the counties included in each region served.

**Table 2-2—ICO Profiles and Enrollment Data**

ICO	Covered Services <sup>7</sup>	Service Area/Regions Served <sup>8</sup>	Member Enrollment <sup>9, 10</sup>
<b>AET</b>	MI Health Link benefits include: <ul style="list-style-type: none"> <li>No co-pays for in-network services, including medications</li> <li>No deductibles for in-network services</li> </ul>	Regions 4, 7, and 9	8,162
<b>AMI</b>		Regions 7 and 9	2,619
<b>HCS</b>		Regions 7 and 9	3,812
<b>MER</b>		Regions 4, 7, and 9	5,775

<sup>7</sup> Michigan Department of Health and Human Services. *MI Health Link*. Available at: [https://www.michigan.gov/mdhhs/0,5885,7-339-71551\\_2945\\_64077---,00.html](https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64077---,00.html). Accessed on: Feb 24, 2025.

<sup>8</sup> Michigan Department of Health and Human Services. Integrated Care Division. *Integrated Care Organization (ICOs) Health Plan Telephone Numbers, Websites, and County Service Areas*. Available at: [https://www.michigan.gov/mdhhs/0,5885,7-339-71551\\_2945\\_64077-354084--,00.html](https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64077-354084--,00.html). Accessed on: Feb 24, 2025.

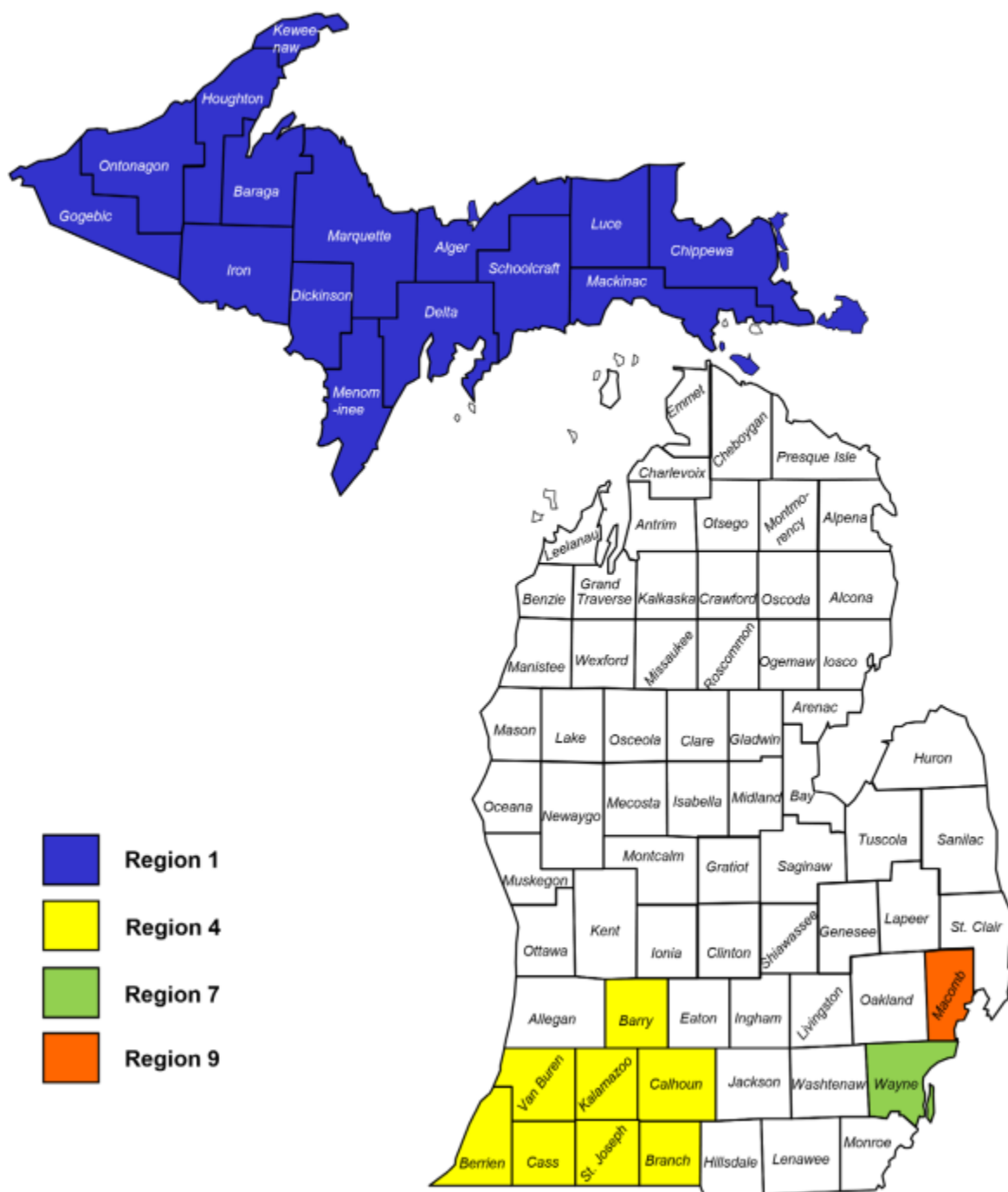
<sup>9</sup> Michigan Department of Health and Human Services. Integrated Care Division. *MI Health Link Enrollment Dashboard*. Available at: <https://app.powerbigov.us/view?r=eyJrIjoieYzEzM2VkYWQ0NWU5LTlmZDMtMTU2YTlkNmY2MDJlIiwidCI6ImQ1ZmI3MDg3LTm3NzctNDJhZC05NjZhLTg5MmVmNDcyMjVhMSJ9>. Accessed on: Feb 24, 2025.

<sup>10</sup> The MI Health Link Enrollment Dashboard is updated the first week of every month; therefore, the member enrollment counts displayed in the dashboard after February 24, 2025 will be updated from the member enrollment counts displayed in this report.

ICO	Covered Services <sup>7</sup>	Service Area/Regions Served <sup>8</sup>	Member Enrollment <sup>9, 10</sup>
MOL	<ul style="list-style-type: none"> <li>• Medications</li> <li>• Care coordination</li> <li>• Behavioral healthcare</li> <li>• Dental care</li> <li>• Hearing care</li> <li>• Medicare care</li> <li>• Vision care</li> <li>• Home and Community-Based Services (HCBS)</li> <li>• Transportation for covered medical services</li> <li>• Medical equipment and supplies</li> <li>• Nursing facility care</li> </ul>	Regions 7 and 9	9,486
UPP		Region 1	4,072



Figure 2-1—ICO Regions<sup>11</sup>



<sup>11</sup> Michigan Department of Community Health. *MI Health Link Regions*. Available at: [https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder2/Folder93/Folder1/Folder193/MI\\_Health\\_Link\\_Counties.pdf?rev=e625ee0535d44526aa94b885636b3e47&hash=3305162FEE2BB48400F71D25B885FB68](https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder2/Folder93/Folder1/Folder193/MI_Health_Link_Counties.pdf?rev=e625ee0535d44526aa94b885636b3e47&hash=3305162FEE2BB48400F71D25B885FB68). Accessed on: Feb 24, 2025.

## 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, 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 MDHHS CQS Goals and Objectives**

Aligned NQS Goals	MDHHS 2023–2027 Strategic Priorities	Objectives
<b>Goal #1: Ensure high quality and high levels of access to care</b>		
<ul style="list-style-type: none"> <li>Goal 1: Embed Quality into the Care Journey</li> <li>Goal 2: Advance Health Equity</li> <li>Goal 3: Promote Safety</li> </ul>	<ul style="list-style-type: none"> <li>Public health investment</li> <li>Racial equity</li> <li>Address food and nutrition, housing, and other social determinants of health (SDOH)</li> <li>Improve the behavioral health service system for children and families</li> <li>Improve maternal-infant health and reduce outcome disparities</li> <li>Reduce lead exposure for children</li> <li>Reduce child maltreatment and improve rate of permanency within 12 months</li> <li>Expand and simplify safety net access</li> <li>Reduce opioid and drug-related deaths</li> </ul>	<b>Objective 1.1:</b> Monitor, track and trend the quality, timeliness and availability of care and services.
		<b>Objective 1.2:</b> Promote prevention, treatment, services, and supports to address acute and chronic conditions in at-risk populations.
		<b>Objective 1.3:</b> 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"><li>Goal 1: Embed Quality into the Care Journey</li><li>Goal 2: Advance Health Equity</li><li>Goal 4: Foster Engagement</li></ul>	<ul style="list-style-type: none"><li>Racial equity</li><li>Address food and nutrition, housing, and other SDOH</li><li>Improve the behavioral health service system for children and families</li><li>Ensure all administrations are managing outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances</li></ul>	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"><li>Goal 4: Foster Engagement</li><li>Goal 5: Strengthen Resiliency</li><li>Goal 6: Embrace the Digital Age</li></ul>	<ul style="list-style-type: none"><li>Expand and simplify safety net access</li><li>Address food and nutrition, housing, and other SDOH</li><li>Integrate services, including physical and behavioral health, and medical care with LTSS</li><li>Fully implement the Families First Preservation Services Act (FFPSA) state plan</li><li>Ensure all administrations are managing outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances</li></ul>	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"><li>Goal 2: Advance Health Equity</li><li>Goal 4: Foster Engagement</li><li>Goal 5: Strengthen Resiliency</li><li>Goal 7: Incentivize Innovation and Technology Adoption to Drive Care Improvements</li></ul>	<ul style="list-style-type: none"><li>Public health investment</li><li>Racial equity</li><li>Address food and nutrition, housing, and other SDOH</li><li>Improve the behavioral health service system for children and families</li><li>Improve maternal-infant health and reduce outcome disparities</li><li>Reduce lead exposure for children</li><li>Reduce child maltreatment and improve rate of permanency</li><li>Fully implement the FFPSA state plan</li><li>Expand and simplify safety net access</li><li>Reduce opioid and drug-related deaths</li><li>Ensure all administrations are managing outcomes, investing in evidence-based</li></ul>	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
	solutions, and ensuring program accuracy in benefit issuances	
<b>Goal #5: Improve quality outcomes through value-based initiatives and payment reform</b>		
<ul style="list-style-type: none"> <li>Goal 7: Incentivize Innovation and Technology Adoption to Drive Care Improvements</li> <li>Goal 8: Increasing Alignment</li> </ul>	<ul style="list-style-type: none"> <li>Ensure all administrations are managing outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances</li> </ul>	<b>Objective 5.1:</b> 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 ICOs and some PIHPs, are accredited by a national accrediting body such as the National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), Commission on Accreditation of Rehabilitation Facilities (CARF), and/or The Joint Commission.
- **Opioid Strategy**—MDHHS actively participates in and supports Michigan’s opioid efforts to combat the opioid epidemic by preventing opioid misuse, ensuring individuals using opioids can access high-quality recovery treatment, and reducing the harm caused by opioids to individuals and their communities.
- **Health Home Models**—Michigan established three Health Home models in accordance with Section 2703 of the Affordable Care Act including the Opioid Health Home, MI Care Team, and the Behavioral Health Home. These Health Homes focus on high-need/high-cost members with chronic conditions, provide flexibility to create innovative and integrated care management models, and offer sustainable reimbursement to affect 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 beneficiaries may opt out at any time.
- **Behavioral Health Integration**—All Medicaid managed care programs address the integration of behavioral health services by requiring the MHPs and ICOs to coordinate behavioral health services and services for persons with disabilities with the 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 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 use a performance bonus (quality withhold) with defined measures, thresholds, and criteria to incentivize quality improvement and improved outcomes.
- **Health Equity Reporting and Tracking**—MDHHS is committed to addressing health equity and reducing racial and ethnic disparities in the healthcare services provided to Medicaid members. Disparities assessment, identification, and reduction are priorities for the Medicaid managed care programs, as indicated by the CQS goal to reduce racial and ethnic disparities in healthcare and health outcomes.

### 3. Assessment of Integrated Care Organization Performance

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

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

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

### Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in SFY 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 6, 2024	November 15, 2024
PMV	April 15, 2024	October 24, 2024



Activity	EQR Activity Start Date	EQR Activity End Date
Compliance Review	March 15, 2024	August 22, 2024
NAV—Analysis	February 7, 2024	November 26, 2024
NAV—Survey	February 21, 2024	August 12, 2024
EDV	February 26, 2024	March 17, 2025
CAHPS	March 5, 2024	November 20, 2024

### Validation of Quality Improvement Projects

For the SFY 2024 QIP validation activity, the ICOs continued the QIP topics that focus on disparities within their populations and reported Remeasurement 2 data for each specified performance indicator. HSAG conducted validation on the QIP Design (Steps 1 through 6), Implementation (Steps 7 and 8), and Outcomes (Step 9) stages of the selected QIP topic for each ICO in accordance with CMS EQR Protocol 1. Table 3-2 outlines the selected QIP topics and performance indicators as defined by each ICO.

**Table 3-2— QIP Topics and Performance Indicators**

ICO	QIP Topic	Performance Indicators
<b>AET</b>	<i>Comprehensive Diabetes Care—HbA1c [Hemoglobin A1c] Test: Decreasing the Disparity Between White and African American Members</i>	<ol style="list-style-type: none"> <li>1. Comprehensive Diabetes Care—HbA1c Test: Black or African American (Non-Hispanic or Latino).</li> <li>2. Comprehensive Diabetes Care—HbA1c Test: White (Non-Hispanic or Latino).</li> </ol>
<b>AMI</b>	<i>Transitions of Care, Medication Reconciliation Post-Discharge</i>	<ol style="list-style-type: none"> <li>1. Medication Reconciliation Post-Discharge for Disparate Group: Members Identified as Black/African American.</li> <li>2. Medication Reconciliation Post-Discharge for Comparison Group: Members Identified as White</li> </ol>
<b>HAP</b>	<i>Reducing Controlling Blood Pressure (CBP) Disparity Between Black/African American and White/Caucasian Members</i>	<ol style="list-style-type: none"> <li>1. The percentage of African-American members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (&lt;140/90 mm Hg) during the measurement year.</li> <li>2. The percentage of Caucasian members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (&lt;140/90 mm Hg) during the measurement year.</li> </ol>
<b>MER</b>	<i>Addressing Race and Ethnic Health Disparities: Statin Therapy for Patients With Diabetes</i>	<ol style="list-style-type: none"> <li>1. HEDIS statin therapy for patients with diabetes (SPD) adherence performance—African-American/Black population—all regions.</li> </ol>



ICO	QIP Topic	Performance Indicators
		2. HEDIS SPD adherence performance—White population—all regions.
<b>MOL</b>	<i>Addressing Disparities in Controlling Blood Pressure</i>	1. Controlling high blood pressure—Black members. 2. Controlling high blood pressure—White members.
<b>UPP</b>	<i>Annual Dental Care</i>	1. Annual dental visit for UPP American Indian/Alaskan Native MI Health Link (MI Health Link) members. 2. Annual dental visit for UPP White MI Health Link members.

### Performance Measure Validation

The purpose of PMV was to assess the accuracy of performance measures reported by ICOs and to determine the extent to which performance measures reported by the ICOs followed the *Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements* (Medicare-Medicaid Plan [MMP] Core Reporting Requirements)<sup>12</sup> and *Medicare-Medicaid Capitated Financial Alignment Model Michigan-Specific Reporting Requirements* (Michigan-Specific Reporting Requirements).<sup>13</sup> For the SFY 2024 PMV, the ICOs were required to submit a completed Information Systems Capabilities Assessment Tool (ISCAT) that provided information on their information systems (IS); processes used for collecting, storing, and processing data; and processes used for performance measure reporting. HSAG subsequently validated the ICOs' data collection and reporting processes used to calculate and report performance measure results for performance measures MDHHS selected for validation.

Table 3-3 lists the performance measures calculated and reported by the ICOs for calendar year (CY) 2023 (i.e., January 1, 2023, through December 31, 2023), along with the performance measure number. The performance measures are numbered as they appear in the MMP Core Reporting Requirements and the Michigan-Specific Reporting Requirements technical specification manuals.

<sup>12</sup> The Centers for Medicare & Medicaid Services. *Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements*. Available at: <https://www.cms.gov/files/document/mmpcorereportingrequirements2023.pdf>. Accessed on: Feb 28, 2025.

<sup>13</sup> The Centers for Medicare & Medicaid Services. *Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Michigan-Specific Reporting Requirements*. Available at: <https://www.cms.gov/files/document/mireportingrequirements02292024.pdf>. Accessed on: Feb 28, 2025.

**Table 3-3—Performance Measures for Validation**

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

### Performance Measure Rates

MDHHS and CMS also required each ICO to contract with an NCQA-certified HEDIS vendor and undergo a full audit of its HEDIS reporting process. For this EQR technical report, HSAG reviewed HEDIS MY 2023 performance data for each ICO, as well as statewide comparison data, to assess performance in the areas of prevention and screening, respiratory conditions, cardiovascular conditions, diabetes, musculoskeletal conditions, behavioral health, medication management and care coordination, overuse/appropriateness, access/availability of care, and risk-adjusted utilization. These data were compiled by a CMS vendor and provided to MDHHS, and subsequently to HSAG, for inclusion into this EQR. The HEDIS measures and performance areas reviewed by HSAG are included in Table 3-4.

**Table 3-4—HEDIS Measures**

HEDIS Measure
<b>Prevention and Screening</b>
<i>BCS-E—Breast Cancer Screening</i>
<i>COL—Colorectal Cancer Screening<sup>1</sup></i>
<i>COA—Care for Older Adults—Medication Review</i>
<i>COA—Care for Older Adults—Functional Status Assessment</i>
<i>COA—Care for Older Adults—Pain Assessment</i>
<b>Respiratory Conditions</b>
<i>SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD [Chronic Obstructive Pulmonary Disease]</i>
<i>PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid</i>
<i>PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator</i>
<b>Cardiovascular Conditions</b>
<i>CBP—Controlling High Blood Pressure</i>
<i>PBH—Persistence of Beta-Blocker Treatment After a Heart Attack<sup>2</sup></i>
<i>SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy</i>
<i>SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%</i>

HEDIS Measure
<b>Diabetes</b>
<i>HBD—Hemoglobin A1c Control in Patients With Diabetes—HbA1c Poor Control (&gt;9.0%)*</i>
<i>HBD—Hemoglobin A1c in Patients With Diabetes—HbA1c Control (&lt;8.0%)</i>
<i>EED—Eye Exam for Patients With Diabetes<sup>1</sup></i>
<i>BPD—Blood Pressure Control for Patients With Diabetes</i>
<i>SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy</i>
<i>SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%</i>
<b>Musculoskeletal Conditions</b>
<i>OMW—Osteoporosis Management in Women Who Had a Fracture</i>
<b>Behavioral Health</b>
<i>AMM—Antidepressant Medication Management—Effective Acute Phase Treatment<sup>1</sup></i>
<i>AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment<sup>1</sup></i>
<i>FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up</i>
<i>FUH—Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up</i>
<i>FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up</i>
<i>FUM—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up</i>
<b>Medication Management and Care Coordination</b>
<i>TRC—Transitions of Care—Medication Reconciliation Post-Discharge</i>
<i>TRC—Transitions of Care—Notification of Inpatient Admission</i>
<i>TRC—Transitions of Care—Receipt of Discharge Information</i>
<i>TRC—Transitions of Care—Patient Engagement After Inpatient Discharge</i>
<b>Overuse/Appropriateness</b>
<i>PSA—Non-Recommended PSA [Prostate-Specific Antigen]-Based Screening in Older Men*</i>
<i>DDE—Potentially Harmful Drug-Disease Interactions in Older Adults*</i>
<i>DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid*</i>
<i>DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis*</i>
<i>DAE—Use of High-Risk Medications in Older Adults—Total*</i>
<b>Access/Availability of Care</b>
<i>AAP—Adults' Access to Preventive/Ambulatory Health Services—20–44 Years</i>
<i>AAP—Adults' Access to Preventive/Ambulatory Health Services—45–64 Years</i>
<i>AAP—Adults' Access to Preventive/Ambulatory Health Services—65 Years and Older</i>
<i>AAP—Adults' Access to Preventive/Ambulatory Health Services—Total</i>
<i>IET—Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total<sup>1</sup></i>
<i>IET—Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total<sup>1</sup></i>

HEDIS Measure
<b>Risk-Adjusted Utilization</b>
<i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)*</i>
<i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)*</i>

\* Measures for which lower rates indicate better performance.

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

<sup>2</sup> Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between MY 2023 and prior years; therefore, the HEDIS MY 2022 rate and comparison from HEDIS MY 2022 vs. MY 2023 will not be displayed for this measure.

## Compliance Review

The SFY 2024 compliance review is the third year of the three-year cycle of compliance reviews that commenced in SFY 2022. The review focuses on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance reviews for Michigan ICOs consist of 14 program areas referred to as standards. MDHHS requested that HSAG conduct a review of the first seven standards in Year One (SFY 2022) and a review of the remaining seven standards in Year Two (SFY 2023). This SFY 2024 (Year Three) review consisted of a review of the standards and elements that required a corrective action plan (CAP) during the Year One (SFY 2022) and Year Two (SFY 2023) compliance review activities. Table 3-5 outlines the standards reviewed over the three-year compliance review cycle. The compliance review activity was conducted in accordance with CMS EQR Protocol 3.

**Table 3-5—Current Three-Year Compliance Review Cycle (SFY 2022–SFY 2024)**

Standard	Associated Federal Citations <sup>1</sup>	Year One (SFY 2022)	Year Two (SFY 2023)	Year Three (SFY 2024)
Standard I—Disenrollment: Requirements and Limitations	§438.56	✓		Review of ICOs' implementation of Year One and Year Two CAPs
Standard II—Member Rights and Member Information	§438.10 §438.100	✓		
Standard III—Emergency and Poststabilization Services	§438.114	✓		
Standard IV—Availability of Services	§438.206	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	✓		
Standard VI—Coordination and Continuity of Care	§438.208	✓		
Standard VII—Coverage and Authorization of Services	§438.210	✓		
Standard VIII—Provider Selection	§438.214		✓	
Standard IX—Confidentiality	§438.224		✓	
Standard X—Grievance and Appeal Systems	§438.228		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230		✓	

Standard	Associated Federal Citations <sup>1</sup>	Year One (SFY 2022)	Year Two (SFY 2023)	Year Three (SFY 2024)
Standard XII—Practice Guidelines	§438.236		✓	
Standard XIII—Health Information Systems <sup>2</sup>	§438.242		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330		✓	

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

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

## Network Adequacy Validation

HSAG collaborated with MDHHS to design annual NAV tasks pertinent to Medicaid services and LTSS covered by the MI Health Link program and that complemented the annual CMS NAV without duplication. As such, HSAG conducted two SFY 2024 activities assessing different aspects of the ICOs' network adequacy:

1. A NAV analysis of the ICOs' alignment with minimum time/distance network requirements and minimum provider capacity network requirements applicable to 23 Medicaid and LTSS provider categories.
2. Development and implementation of a telephone survey among dental providers contracted with one or more ICOs to serve individuals enrolled in the MI Health Link program (i.e., the secret shopper survey).

## Network Adequacy Analysis

The SFY 2024 NAV study sought to validate the adequacy of each ICO's provider network according to MI Health Link's minimum network standards for 23 Medicaid and LTSS provider categories in SFY 2024. Additionally, HSAG assessed the accuracy of the state-defined network adequacy indicators that the ICOs reported. HSAG evaluated the ICOs' methodologies, systems, and processes as well as their provider and network adequacy data collection, reliability, and validity for calculating and reporting the network adequacy indicators. HSAG used a CMS-suggested methodology to determine an overall validation rating for each indicator which reflects HSAG's overall confidence that each ICO used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators set by MDHHS.

To initiate the NAV activity, each ICO submitted member and network provider data files and exception requests to HSAG in April 2024, followed by an initial data file review. Following the initial data file

review, HSAG requested that applicable ICOs submit updated data files and/or exception<sup>14</sup> requests during June 2024 to address potential data quality and validity concerns prior to completing the NAV analyses. The provider categories included in the validation are displayed in Table 3-6.

**Table 3-6—MI Health Link Provider Categories**

Provider Category
<b>Provider Categories With Travel Time and Distance Network Requirements</b>
Adult Day Program
Dental (preventive and restorative)
Eye Examinations (provided by optometrists)
Eye Wear (providers dispensing eyeglasses and contact lenses)
Hearing Examinations
Hearing Aids
<b>Provider Categories With Capacity-Based Network Requirements</b>
Adaptive Medical Equipment and Supplies
Assistive Technology—Devices
Assistive Technology—Van Lifts and Tie Downs
Chore Services
Environmental Modifications
Expanded Community Living Supports (ECLS)
Fiscal Intermediary
Home Delivered Meals
Medical Supplies
Non-Emergency Medical Transportation (NEMT)
Non-Medical Transportation (waiver service only)
Personal Care Services
Personal Emergency Response System
Preventive Nursing Services
Private Duty Nursing
Respite
Skilled Nursing Home

<sup>14</sup> MDHHS allowed ICOs to request exceptions to the minimum network requirements for any provider categories for which there are known network access gaps. Exception requests were allowed when the ICO had contracted to the fullest extent of the available providers but was unable to meet the minimum network requirements.

## Network Validation Survey

HSAG conducted a network validation survey (NVS) among dental care providers contracted with one or more ICO to serve individuals dually enrolled in Medicare and Medicaid under the MI Health Link program to ensure members have appropriate access to provider information. The NVS included a provider directory validation (PDV) and a secret shopper survey.

For the PDV, HSAG compared key indicators published in each online provider directory with the data in the ICO's provider file to confirm whether each ICO's website meets the federal requirements in 42 CFR §§422.111(h), 423.128(d), 438.10(h)(3) and in the Marketing Guidance for Michigan Medicare-Medicaid Plans. HSAG then validated the accuracy of components of the online provider directories by completing a secret shopper survey to evaluate the accuracy of the provider information located in the directories. The secret shopper survey also provided information on appointment availability and wait times with the sampled providers for routine dental 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 survey allows for objective data collection from healthcare providers, without potential bias being introduced by knowing the identity of the survey caller. Specific survey objectives included the following:

- Determine whether dental service locations accept patients enrolled with the requested ICO and the degree to which ICO acceptance aligns with the ICOs' provider data.
- Determine whether dental service locations accepting the requested ICO accept new patients and the degree to which new patient acceptance aligns with the ICOs' provider data.
- Determine appointment availability with the sampled dental service locations for routine dental care visits.

To address the survey objectives, HSAG used an MDHHS-approved methodology and script to conduct a secret shopper survey of dental offices contracted with one or more ICO to serve MI Health Link members. Using region-specific provider data supplied to HSAG by each ICO, secret shopper callers contacted sampled dental care locations between March and May 2024 to inquire about appointment availability for routine dental visits. Several limitations and analytic considerations must be noted when reviewing the results of the NVS. These limitations are located in Appendix A—External Quality Review Activity Methodologies.

## Encounter Data Validation

In SFY 2024, HSAG conducted and completed an EDV activity for all six MI Health Link ICOs. 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' service records and Individual Integrated Care and Supports Plan (IICSP) documentation for services rendered from October 1, 2022, through September 30, 2023. This activity aligns with the *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 encounter data by cross-referencing provider-documented information for services rendered. The review encompassed service records along with the IICSP documents, which validated the reported information within the encounter data. Throughout the EDV activity, evidence supporting the delivery of services was referred to as the “service record.”

### **Consumer Assessment of Healthcare Providers and Systems Analysis**

For SFY 2024, HSAG administered the HCBS CAHPS Survey for MI Health Link members enrolled in the HCBS C-waiver program and receiving at least one qualifying personal care service, respite care at home, chore services, or expanded community living supports. The primary objective of the HCBS CAHPS Survey was to obtain information effectively and efficiently on members’ experiences with the LTSS they receive. A sample of 2,103 adult members was selected across the ICOs.<sup>15</sup> Sampled adult members completed the survey from June to July 2024 over the telephone in either English or Spanish. All six ICOs participated in the 2024 survey.

Results presented in this report include three global ratings, seven composite measures, three recommendation measures, five unmet need measures, and one physical safety measure. For purposes of reporting members’ experience with care results, CMS requires a minimum of 11 respondents per measure (i.e., a minimum cell size of 11). Due to the low number of respondents for each ICO and CMS suppression rules, HSAG could not present individual ICO-level results for the HCBS CAHPS Survey measures; therefore, results are only presented for the MI Health Link program in Section 5: Integrated Care Organization Comparative Information. HSAG presented the results in top-box scores for each measure in accordance with CMS’ *Technical Assistance Guide for Analyzing Data from the HCBS CAHPS Survey*.<sup>16,17</sup> Top-box scores represent the percentage of eligible respondents who answered with the most positive response. For more detailed information regarding top-box scores, please refer to Appendix A.

<sup>15</sup> The sample was drawn from the four regions where the demonstration is present (i.e., all counties in Upper Peninsula; Macomb county; Wayne county; and Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren counties in Southwest Michigan).

<sup>16</sup> HSAG recalculated the 2022 mean scores to top-box scores for HCBS CAHPS Database benchmark comparability; therefore, the 2022 results in this report will not match previous reports.

<sup>17</sup> Centers for Medicare & Medicaid Services. CAHPS Home and Community-Based Services Survey. *Technical Assistance Guide for Analyzing Data from the HCBS CAHPS Survey*. July 2021. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/hcbcahps-appk-data-analysis-guide.pdf>. Accessed on: January 6, 2025.

## External Quality Review Activity Results

### Aetna Better Health Premier Plan

#### Validation of Quality Improvement Projects

##### Performance Results

HSAG's validation evaluated the technical methods of **AET**'s QIP, including an evaluation of statistically significant improvement based on reported results and statistical testing (i.e., the QIP 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 QIP and Validation Rating 2 (i.e., *High Confidence*, *Moderate Confidence*, *Low Confidence*, *No Confidence*) based on overall confidence that the QIP 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**

QIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
Comprehensive Diabetes Care—HbA1c Test: Decreasing the Disparity Between White (Non-Hispanic) and African American (Non-Hispanic) Members	High Confidence	Low Confidence	Comprehensive Diabetes Care—HbA1c Test: Black or African-American (Non-Hispanic or Latino).	73.6%	76.6% ⇔	81.7% ↑	Yes
			Comprehensive Diabetes Care—HbA1c Test: White (Non-Hispanic or Latino).	87.8%	89.6% ⇔	87.9% ⇔	

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  $\geq 0.05$ ).

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

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

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

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

### ***Strengths, Weaknesses, and Recommendations***

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

**Strength #2: AET** demonstrated statistically significant improvement over the baseline performance for the disparate population during the second remeasurement period.

## Weaknesses and Recommendations

**Weakness #1: AET** did not achieve the state-specific goal of eliminating the existing disparity between the two subgroups during the second remeasurement period. [Quality and Access]

**Why the weakness exists:** While it is unclear why the goal was not achieved during the second remeasurement period, **AET** made significant progress in improving performance for the disparate subgroup, demonstrating a statistically significant increase in performance as compared to the baseline.

**Recommendation:** HSAG recommends **AET** revisit its causal/barrier analysis to determine whether any new barriers exist for the disparate subgroup that require the development of targeted strategies to improve performance. **AET** should continue testing or implement intervention strategies that have proven effective on the performance indicators.

## Performance Measure Validation

### Performance Results

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

**AET** received a measure designation of *Reportable (R)* for all measures, signifying that **AET** had reported the measures in compliance with the MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements and that rates could be reported. Table 3-9 includes the validation designation for each performance measure as well as the validated SFY 2024 performance measure rates.

**Table 3-9—Measure-Specific Validation Designation and Rates for AET**

Performance Measure	Validation Designation	SFY 2024 Rate
<b>Core Measure 9.3:</b> <i>Minimizing Facility Length of Stay</i>	<b>REPORTABLE (R)</b> The ICO reported this measure in alignment with the MMP Core Reporting Requirements.	1.04*
<b>MI2.6:</b> <i>Timely Transmission of Care Transition Record to Health Care Professional</i>	<b>REPORTABLE (R)</b> The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.	35.04%
<b>MI5.6:</b> <i>Care for Adults—Medication Review</i>	<b>REPORTABLE (R)</b> The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.	100%
<b>MI7.3:</b> <i>Annual Dental Visit</i>	<b>REPORTABLE (R)</b> The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.	26.87%

\*Please note for Core Measure 9.3 that the SFY 2024 rate is reflective of the ICO's calculated ratio of observed to expected discharges (O/E ratio) rather than a calculated percentage rate, as is reflected for MI2.6, MI5.6, and MI7.3.

### Performance Measure Rates

Table 3-10 shows each of **AET**'s audited HEDIS measures, rates for HEDIS MY 2022 and HEDIS MY 2023 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2023 with HEDIS MY 2022, and the HEDIS MY 2022 and HEDIS MY 2023 MI Health Link statewide average performance rates. HEDIS MY 2022 and HEDIS MY 2023 measure rates performing better than the MY 2022 and MY 2023 statewide averages are notated by green font.

Table 3-10—Measure-Specific Percentage Rates for AET

HEDIS Measure	HEDIS MY 2022 (%)	HEDIS MY 2023 (%)	HEDIS MY 2022 vs. MY 2023	MY 2022 Statewide Average (%)	MY 2023 Statewide Average (%)
<b>Prevention and Screening</b>					
BCS-E—Breast Cancer Screening	50.40	53.08	+2.68	56.70	58.82
COL—Colorectal Cancer Screening <sup>1</sup>	50.26	54.59	+4.33	57.59	60.82
COA—Care for Older Adults—Medication Review	93.67	100	+6.33	80.41	90.90
COA—Care for Older Adults—Functional Status Assessment	71.53	66.42	-5.11	62.71	70.13
COA—Care for Older Adults—Pain Assessment	79.32	78.10	-1.22	78.04	83.50
<b>Respiratory Conditions</b>					
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	19.88	19.23	-0.65	22.01	23.00
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	82.02	85.52	+3.50	74.10	74.05
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	93.26	90.50	-2.76	88.82	86.81
<b>Cardiovascular Conditions</b>					
CBP—Controlling High Blood Pressure	61.56	64.48	+2.92	66.14	68.85
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack <sup>2</sup>	—	66.67	—	—	56.36
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy	76.71	83.81	+7.10	80.90	85.02
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%	78.13	77.68	-0.45	79.55	81.48
<b>Diabetes</b>					
HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)*	32.36	32.60	+0.24	34.07	29.00
HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)	58.64	58.64	+/-0.00	58.51	63.61
EED—Eye Exam for Patients With Diabetes <sup>1</sup>	59.37	64.72	+5.35	62.89	65.27
BPD—Blood Pressure Control for Patients With Diabetes	64.96	68.86	+3.90	68.13	70.83
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy	73.88	77.05	+3.17	76.44	76.91
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%	74.48	78.13	+3.65	78.95	80.60
<b>Musculoskeletal Conditions</b>					
OMW—Osteoporosis Management in Women Who Had a Fracture	12.50	7.69	-4.81	11.18	20.27

HEDIS Measure	HEDIS MY 2022 (%)	HEDIS MY 2023 (%)	HEDIS MY 2022 vs. MY 2023	MY 2022 Statewide Average (%)	MY 2023 Statewide Average (%)
<b>Behavioral Health</b>					
AMM—Antidepressant Medication Management—Effective Acute Phase Treatment <sup>1</sup>	71.18	67.05	-4.13	73.66	70.76
AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment <sup>1</sup>	54.15	51.70	-2.45	57.94	54.20
FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	29.61	21.94	-7.67	32.79	31.03
FUH—Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up	53.95	53.55	-0.40	58.91	58.83
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up	48.60	41.80	-6.80	32.06	29.44
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up	68.16	59.02	-9.14	54.39	48.27
<b>Medication Management and Care Coordination</b>					
TRC—Transitions of Care—Medication Reconciliation Post-Discharge	67.88	79.08	+11.20	47.59	56.17
TRC—Transitions of Care—Notification of Inpatient Admission	1.22	17.27	+16.05	16.53	24.53
TRC—Transitions of Care—Receipt of Discharge Information	2.19	15.09	+12.90	15.38	19.48
TRC—Transitions of Care—Patient Engagement After Inpatient Discharge	71.53	77.86	+6.33	77.74	79.78
<b>Overuse/Appropriateness</b>					
PSA—Non-Recommended PSA-Based Screening in Older Men*	22.95	24.71	+1.76	26.71	27.99
DDE—Potentially Harmful Drug-Disease Interactions in Older Adults*	36.83	37.91	+1.08	33.45	33.54
DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid*	17.64	17.43	-0.21	18.16	17.57
DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis*	5.36	4.49	-0.87	5.23	4.99
DAE—Use of High-Risk Medications in Older Adults—Total*	21.53	20.86	-0.67	21.78	21.07
<b>Access/Availability of Care</b>					
AAP—Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	81.31	83.41	+2.10	84.90	85.69
AAP—Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	92.66	92.61	-0.05	93.83	93.71
AAP—Adults' Access to Preventive/Ambulatory Health Services—65 Years and Older	90.16	90.52	+0.36	91.69	91.79



HEDIS Measure	HEDIS MY 2022 (%)	HEDIS MY 2023 (%)	HEDIS MY 2022 vs. MY 2023	MY 2022 Statewide Average (%)	MY 2023 Statewide Average (%)
<i>AAP—Adults' Access to Preventive/Ambulatory Health Services—Total</i>	89.08	89.72	+0.64	91.08	91.24
<i>IET—Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total<sup>1</sup></i>	31.56	37.32	+5.76	34.10	35.83
<i>IET—Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total<sup>1</sup></i>	4.38	5.83	+1.45	3.84	4.43
<b>Risk-Adjusted Utilization</b>					
<i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)*</i>	1.40	1.53	+0.13	1.07	1.11
<i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)*</i>	1.51	1.47	-0.04	1.21	1.21

\* Measures for which lower rates indicate better performance.

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

<sup>2</sup> Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between MY 2023 and prior years; therefore, the HEDIS MY 2022 rate and comparison from HEDIS MY 2022 vs. MY 2023 will not be displayed for this measure.

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

### 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:** For MI5.6, AET's supplemental data process to perform clinical pharmacist medication reviews to close care gaps, maintained in the CaseTrakker system, resulted in a 100 percent performance measure rate, which was an increase over the prior year. The supplemental data project eliminated the need for AET to perform MRRs. [Quality]

**Strength #2:** For MI2.6, AET improved its performance over the prior year in having a documented timely transmission of care transition record to a healthcare professional. The improvement was attributed to multiple factors including revisions to its chart chase logic to ensure pursuit of documentation from the appropriate practitioner, and increased access to remote electronic health records (EHRs). [Quality, Timeliness, and Access]

**Strength #3:** For MI2.6, AET worked with its PIHP delegate to improve data accuracy in identifying hospital discharges to allow for these data to be included in performance measure

reporting. HSAG identified this as an opportunity for improvement from the prior year, as the inclusion of these data provides a more accurate performance measure rate. [Quality]

**Strength #4:** In the Prevention and Screening domain, **AET**'s rate for the *COA—Care for Older Adults—Medication Review* measure indicator increased by more than 6 percentage points from MY 2022 to MY 2023 and exceeded the HEDIS MY 2023 MI Health Link statewide average, suggesting strength and improvement in adult members ages 66 years and older having medication reviews conducted during the measurement year. Older adults may have more complex medication regimens. This measure ensures that older adults receive the care they need to optimize quality of life.<sup>18</sup> [Quality]

**Strength #5:** In the Cardiovascular Conditions domain, **AET**'s rate for the *SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy* measure indicator increased by more than 7 percentage points from MY 2022 to MY 2023, suggesting strength and improvement in cardiovascular treatment and prevention for members. Research indicates that statins are the primary treatment choice for cardiovascular diseases, which stand as the leading global cause of mortality. In general, statins are considered safe and well-tolerated medications, and are the most commonly prescribed drugs worldwide. They play a role in preventing stroke, improving outcomes in acute coronary syndrome, reducing the risk of atrial fibrillation after heart surgery, and benefiting patients with heart failure.<sup>19</sup> [Quality and Access]

**Strength #6:** In the Diabetes domain, **AET**'s rate for the *EED—Eye Exam for Patients With Diabetes* measure indicator increased by more than 5 percentage points from MY 2022 to MY 2023, suggesting strength and improvement in adult members ages 18 to 75 years with diabetes having a retinal eye exam performed. Diabetes is the leading cause of new cases of blindness among adults 18–64 years of age. 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.<sup>20</sup> [Quality]

**Strength #7:** In the Medication Management and Care Coordination domain, **AET**'s rate for the *TRC—Transitions of Care—Patient Engagement After Inpatient Discharge* measure indicator increased by more than 5 percentage points, and the rates for the *TRC—Transitions of Care—Medication Reconciliation Post-Discharge, Notification of Inpatient Admission, and Receipt of Discharge Information* measure indicators increased by more than 10 percentage points from MY

<sup>18</sup> National Committee for Quality Assurance. Care for Older Adults (COA). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/care-for-older-adults-coa/>. Accessed on: Feb 28, 2025.

<sup>19</sup> National Institutes of Health-National Library of Medicine. Khatiwada N, Hong Z. Potential Benefits and Risks Associated with the Use of Statins. *Pharmaceutics*. 2024 Feb 1;16(2):214. doi: 10.3390/pharmaceutics16020214. PMID: 38399268; PMCID: PMC10892755. Potential Benefits and Risks Associated with the Use of Statins. Available at: <https://pmc.ncbi.nlm.nih.gov/articles/PMC10892755/>. Accessed on: Mar 7, 2025.

<sup>20</sup> 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: Mar 3, 2025.

2022 to MY 2023, with the *TRC—Transitions of Care—Medication Reconciliation Post-Discharge* measure indicator exceeding the HEDIS MY 2023 MI Health Link statewide average. These results suggest strength and improvement for adult members in timely medication reconciliation being performed following discharge from an inpatient facility, timely notification of inpatient admissions and documentation of discharge information, as well as in patient engagement within 30 days after discharge. Research shows that when patients are engaged in their healthcare, it can lead to measurable improvements in safety and quality. Discharge from hospital to home requires the successful transfer of information from clinicians to the patient and family to reduce adverse events and prevent readmissions. Engaging patients and families in the discharge planning process helps make this transition in care safe and effective.<sup>21</sup> [Quality and Timeliness]

**Strength #8:** In the Access/Availability of Care domain, **AET**'s rate for the *IET—Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total* measure indicator increased by more than 5 percentage points from MY 2022 to MY 2023 and exceeded the HEDIS MY 2023 MI Health Link statewide average, suggesting strength and improvement in timely initiation of treatment for new SUD episodes. Substance use is one of the most expensive health issues. It is crucial that more effort is exerted to address unmet needs, facilitate progress, and prevent relapse in individuals with SUDs.<sup>22,23</sup> [Quality and Timeliness]

## Weaknesses and Recommendations

**Weakness #1:** For MI7.3, while **AET** incorporated race and ethnicity data to meet requirements for performance measure reporting by stratification, **AET** did not incorporate any race and ethnicity data other than the data submitted by the State in the 834 file. [Quality]

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

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

- 
- <sup>21</sup> Agency for Healthcare Research and Quality (AHRQ). Strategy 4: Care Transitions From Hospital to Home: IDEAL Discharge Planning. Available at: <https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/strategy4/index.html>. Accessed on Mar 7, 2025.
- <sup>22</sup> National Institutes of Health-National Library of Medicine. Farhoudian A, Razaghi E, Hooshyari Z, Noroozi A, Pilevari A, Mokri A, Mohammadi MR, Malekinejad M. Barriers and Facilitators to Substance Use Disorder Treatment: An Overview of Systematic Reviews. *Subst Abuse*. 2022 Aug 29;16:11782218221118462. doi: 10.1177/11782218221118462. PMID: 36062252; PMCID: PMC9434658. Available at: <https://pmc.ncbi.nlm.nih.gov/articles/PMC9434658/>. Accessed on: Mar 10, 2025.
- <sup>23</sup> National Institutes of Health-National Library of Medicine. Gressler LE, Natafagi NM, DeForge BR, Shaneman-Robinson B, Welsh C, Shaya FT. What motivates people with substance use disorders to pursue treatment? A patient-centered approach to understanding patient experiences and patient-provider interactions. *J Subst Use*. 2019;24(6):587-599. doi: 10.1080/14659891.2019.1620891. Epub 2019 Jul 9. PMID: 31582894; PMCID: PMC6776437. Available at: <https://pmc.ncbi.nlm.nih.gov/articles/PMC6776437/>. Accessed on: Mar 7, 2025.
-

**Weakness #2:** While **AET** demonstrated an efficient, internal process to conduct medication reviews for the MI5.6 measure, the audit found that **AET** lacked documentation in the CaseTrakker system of the medication list that was reviewed. [Quality]

**Why the weakness exists:** **AET** used a process to access pharmacy claims data for a given date range, which was determined to be sufficient given its external auditor approved the data source.

**Recommendation:** While **AET** was able to demonstrate its process to access pharmacy claims data for a given date range, HSAG recommended that in the future **AET** include a copy of the medication list that was reviewed in CaseTrackker so that this supplemental data source meets the hybrid specifications requirement that a documented medication list be included in the medical record.

**Weakness #3:** For 28 of the 42 reported HEDIS measures (67 percent), **AET**'s rates indicated worse performance than the statewide average, demonstrating an opportunity for improvement across multiple domains including Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Musculoskeletal Conditions, Behavioral Health, Medication Management and Care Coordination, Overuse/Appropriateness, Access/Availability of Care, and Risk-Adjusted Utilization. [Quality]

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

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

**Weakness #4:** In the Prevention and Screening domain, **AET**'s rate for the *COA—Care for Older Adults—Functional Status Assessment* measure indicator decreased by more than 5 percentage points from MY 2022 to MY 2023 and fell below the HEDIS MY 2023 MI Health Link statewide average, indicating that adult members ages 66 years and older were not always having functional status assessments conducted during the measurement year. As people age, their physical and cognitive function can decline and pain becomes more prevalent. This measure ensures that older adults receive the care they need to optimize quality of life.<sup>24</sup> [Quality]

**Why the weakness exists:** The rate for the *COA—Care for Older Adults—Functional Status Assessment* measure indicator decreasing by more than 5 percentage points from MY 2022 to MY 2023 and falling below the HEDIS MY 2023 MI Health Link statewide average suggests that barriers exist for some adults ages 66 years and older to have a functional status assessment completed.

**Recommendation:** HSAG recommends that **AET** conduct a root cause analysis or focused study to determine the decline in performance and why some adults ages 66 years and older are not having

<sup>24</sup> National Committee for Quality Assurance. Care for Older Adults (COA). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/care-for-older-adults-coa/>. Accessed on: Mar 4, 2025.

functional assessments completed. **AET** should consider the nature and scope of the issue (e.g., whether the issues are related to barriers such as provider education or the lack of implementing functional status assessments into routine patient care).

**Weakness #5:** In the Behavioral Health domain, **AET**'s rate for the *FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* measure indicator decreased by more than 7 percentage points from MY 2022 to MY 2023 and fell below the HEDIS MY 2023 MI Health Link statewide average, indicating that some members were not receiving timely follow-up care for mental illness after a hospitalization. Research suggests that patients with mental disorders are among the highest users of emergency department (ED) services, with visits characterized by long lengths of stay, intensive treatment, and elevated rates of hospitalizations. After discharge, fewer than half of these patients successfully transition to outpatient care, with high rates of readmission to the ED. Programs that allow patients with mental disorders to successfully engage with outpatient care hold the potential not only to improve quality and outcomes of care for people with mental disorders, but also to free capacity within EDs to provide care for other urgent needs.<sup>25</sup> [**Quality, Timeliness, and Access**]

**Why the weakness exists:** The rate for the *FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* measure indicator decreasing by more than 7 percentage points from MY 2022 to MY 2023 and falling below the HEDIS MY 2023 MI Health Link statewide average suggests that barriers exist for some members to receive timely follow-up care for mental illness after a hospitalization.

**Recommendation:** HSAG recommends that **AET** conduct a root cause analysis or focused study to determine why some members were not receiving follow-up care for mental illness after hospitalization. Upon identification of a root cause, **AET** should implement appropriate interventions to improve the performance related to the *FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* measure indicator. **AET** should consider the nature and scope of the issue (e.g., whether the issue is related to barriers such as a lack of patient and provider education or staffing shortages).

<sup>25</sup> National Institutes of Health-National Library of Medicine. Druss B, Lally CA, Li J, et al. Comparing Two Ways to Help Patients Get Follow-up Care after a Mental Health Visit to the Emergency Room—The EPIC Study [Internet]. Washington (DC): Patient-Centered Outcomes Research Institute (PCORI); 2021 May. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK601636/> doi: 10.25302/05.2021.IHS.151032431. Accessed on: Mar 7, 2025.

## Compliance Review

### Performance Results

Table 3-11 presents an overview of the results of the SFY 2022 and SFY 2023 compliance reviews for **AET**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. If a requirement was not applicable to **AET** during the period covered by the review, HSAG used a *Not Applicable (NA)* designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 14 standards.

**Table 3-11—Summary of Standard Compliance Scores**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			<i>M</i>	<i>NM</i>	<i>NA</i>	
Standard I—Disenrollment: Requirements and Limitations	9	6	6	0	3	<b>100%</b>
Standard II—Member Rights and Member Information	23	23	15	8	0	<b>65%</b>
Standard III—Emergency and Poststabilization Services	13	13	13	0	0	<b>100%</b>
Standard IV—Availability of Services	13	13	12	1	0	<b>92%</b>
Standard V—Assurances of Adequate Capacity and Services	4	4	4	0	0	<b>100%</b>
Standard VI—Coordination and Continuity of Care	31	30	22	8	1	<b>73%</b>
Standard VII—Coverage and Authorization of Services	28	28	25	3	0	<b>89%</b>
Standard VIII—Provider Selection	23	23	21	2	0	<b>91%</b>
Standard IX—Confidentiality	11	11	11	0	0	<b>100%</b>
Standard X—Grievance and Appeal Systems	45	45	35	10	0	<b>78%</b>
Standard XI—Subcontractual Relationships and Delegation	6	5	4	1	1	<b>80%</b>
Standard XII—Practice Guidelines	6	6	6	0	0	<b>100%</b>
Standard XIII—Health Information Systems <sup>1</sup>	9	9	8	1	0	<b>89%</b>
Standard XIV—Quality Assessment and Performance Improvement Program	21	21	19	2	0	<b>90%</b>
<b>Total</b>	<b>242</b>	<b>237</b>	<b>201</b>	<b>36</b>	<b>5</b>	<b>85%</b>

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

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

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

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

<sup>1</sup> This standard includes a comprehensive assessment of the ICO's IS capabilities.



## Corrective Action Plan Implementation

Based on the findings of the SFY 2022 and SFY 2023 compliance review activities, **AET** was required to develop and submit a CAP for each element assigned a score of *Not Met*. MDHHS and HSAG reviewed the CAP for sufficiency, and **AET** was responsible for implementing each action plan in a timely manner. Table 3-12 presents an overview of the results of the SFY 2024 compliance review for **AET**, which consisted of a comprehensive review of the ICO's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Section 2.

**Table 3-12—Summary of CAP Implementation**

Standard	Total CAP Elements	# of CAP Elements Complete	# of CAP Elements Not Complete
Standard II—Member Rights and Member Information	8	8	0
Standard IV—Availability of Services	1	1	0
Standard VI—Coordination and Continuity of Care	8	8	0
Standard VII—Coverage and Authorization of Services	3	3	0
Standard VIII—Provider Selection	2	2	0
Standard X—Grievance and Appeal Systems	10	10	0
Standard XI—Subcontractual Relationships and Delegation	1	1	0
Standard XIII—Health Information Systems <sup>1</sup>	1	1	0
Standard XIV—Quality Assessment and Performance Improvement Program	2	2	0
<b>Total</b>	<b>36</b>	<b>36</b>	<b>0</b>

**Total CAP Elements:** The total number of elements within each standard that required a CAP during the SFY 2022 and SFY 2023 compliance review activities.

**# of CAP Elements Complete:** The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirements under review.

**# of CAP Elements Not Complete:** The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirements under review.

<sup>1</sup>This standard includes a comprehensive assessment of the ICO's IS capabilities.

## 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 demonstrated that it successfully remediated all 36 elements, indicating that the necessary policies, procedures, and interventions were implemented to ensure compliance with the Member Rights and Member Information, Availability of Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Grievance and Appeal Systems, Subcontractual Relationships and Delegation, Health Information Systems requirements, and Quality Assessment and Performance Improvement Program. [Quality, Timeliness, and Access]

## Weaknesses and Recommendations

**Weakness #1:** HSAG did not identify any substantial weaknesses for AET as all CAPs had been fully implemented and all requirements deemed compliant.

**Why the weakness exists:** NA

**Recommendation:** NA

## Network Adequacy Validation

### Network Adequacy Analysis

### Performance Results

### ISCA Findings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if AET's interpretation of data was accurate. Table 3-13 summarizes HSAG's validation ratings for AET, by indicator type.

**Table 3-13—Summary of AET's Validation Ratings**

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Time and Distance	100%	0%	0%	0%
Provider Capacity	100%	0%	0%	0%

Of the network adequacy indicators assessed, AET received *High Confidence* for both time and distance and provider capacity indicator types.

### Analytic Findings

AET submitted its SFY 2024 region-specific member and Medicaid provider data files, and exception requests to HSAG on April 29, 2024. Based on HSAG's detailed file review findings communicated to AET on June 18, 2024, HSAG asked AET to resubmit its network data files for all regions to address

identified data issues. **AET** resubmitted its region-specific network data files to HSAG on June 26, 2024, and HSAG's NAV results indicated that **AET** met all Medicaid and LTSS minimum network standards for Region 7 and Region 9.

MDHHS did not approve **AET**'s requested exceptions for the Eye Examinations and Eye Wear network standards in Region 4, but MDHHS approved **AET**'s requested exception for the Adult Day Program network standard in Region 4.

Table 3-14 presents **AET**'s region-specific NAV results by Medicaid and LTSS provider category following all data resubmissions and MDHHS' exception determinations.

**Table 3-14—SFY 2024 NAV Results for AET by Region and Provider Category**

Provider Category	Region 4 Validation Result	Region 7 Validation Result	Region 9 Validation Result
<b>Provider Categories With Travel Time and Distance Standards</b>			
Adult Day Program	Exception Granted	Met	Met
Dental	Met	Met	Met
Eye Examinations	Not Met	Met	Met
Eye Wear	Not Met	Met	Met
Hearing Aids	Met	Met	Met
Hearing Examinations	Met	Met	Met
<b>Provider Categories Rendering Home-Based Services</b>			
Adaptive Medical Equipment and Supplies	Met	Met	Met
Assistive Technology—Devices	Met	Met	Met
Assistive Technology—Van Lifts and Tie Downs	Met	Met	Met
Chore Services	Met	Met	Met
ECLS	Met	Met	Met
Environmental Modifications	Met	Met	Met
Fiscal Intermediary	Met	Met	Met
Home-Delivered Meals	Met	Met	Met
Medical Supplies	Met	Met	Met
NEMT	Met	Met	Met
Non-Medical Transportation	Met	Met	Met
Personal Care Services	Met	Met	Met
Personal Emergency Response System	Met	Met	Met

Provider Category	Region 4 Validation Result	Region 7 Validation Result	Region 9 Validation Result
Preventive Nursing Services	Met	Met	Met
Private Duty Nursing	Met	Met	Met
Respite	Met	Met	Met
Skilled Nursing Home	Met	Met	Met
<b>Percentage of Total Standards Met*</b>	<b>87.0%</b>	<b>100%</b>	<b>100%</b>
<b>Percentage of Total Standards Met Inclusive of Granted Exceptions*</b>	<b>91.3%</b>	<b>100%</b>	<b>100%</b>

\*The denominators for Percentage of Total Standards Met and Percentage of Total Standards Met Inclusive of Granted Exceptions include all 23 provider categories.

### ***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 described a robust process to ensure network adequacy by conducting additional monthly network monitoring to better assess ongoing compliance. [Access]

**Strength #2:** AET demonstrated great ability in ensuring accuracy and oversight of delegated entities by establishing monthly reporting requirements, annual audits, and monthly meetings with each subcontractor. [Access]

**Strength #3:** AET met all Medicaid and LTSS minimum network standards for Region 7, indicating that AET maintained an adequate network for MI Health Link members in this region. [Access]

**Strength #4:** AET met all Medicaid and LTSS minimum network standards for Region 9, indicating that AET maintained an adequate network for MI Health Link members in this region. [Access]

#### **Weaknesses and Recommendations**

**Weakness #1:** HSAG identified opportunities in Adult Day Program, Eye Examinations, and Eye Wear provider categories for AET in Region 4 based on the SFY 2024 NAV. [Access]

**Why the weakness exists:** AET did not meet the minimum network requirements for Adult Day Program, Eye Examinations, and Eye Wear in Region 4. MDHHS did not approve AET's exception request for the Eye Examinations and Eye Wear network standards in Region 4.

**Recommendation:** AET should make ongoing efforts to identify and contract with additional Adult Day Program, Eye Examinations, and Eye Wear providers, with particular attention to portions of Region 4 that were not well-served by these providers, to assure member access and meet standards. Updated compliance for these provider categories in Region 4 will be evaluated during the SFY 2025 NAV.

### Network Validation Survey

#### Performance Results

HSAG performed a comparison of the provider data submitted to HSAG by AET against AET's online directory. The sample included 215 providers (Table 3-15). Among this sample, 96.3 percent were located in the online directory at the sampled location, while 1.9 percent of providers were found in the directory but not at the sampled location. Additionally, 1.9 percent of the providers could not be located in AET's online directory.

Table 3-15 summarizes findings by region, regarding the number of sampled providers and provider locations (i.e., "cases") that HSAG's reviewers were able to locate in the ICO's online provider directory.

**Table 3-15—Summary of Sampled Dental Providers Located in Online Provider Directory**

Region	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 (%)	Count	Rate (%)	Count	Rate (%)
Region 4	16	2	12.5%	1	6.3%	13	81.3%
Region 7	133	1	0.8%	3	2.3%	129	97.0%
Region 9	66	1	1.5%	0	0.0%	65	98.5%
<b>AET Total</b>	<b>215</b>	<b>4</b>	<b>1.9%</b>	<b>4</b>	<b>1.9%</b>	<b>207</b>	<b>96.3%</b>
<b>All ICOs Total</b>	<b>1,179</b>	<b>73</b>	<b>6.2%</b>	<b>18</b>	<b>1.5%</b>	<b>1,088</b>	<b>92.3%</b>

Table 3-16 displays the total number and percent of cases, by region, with matched data values for indicators that were reviewed in the comparison for all ICOs and between AET's submitted provider data and AET's online directory.

**Table 3-16—PDV Study Indicator Match Rates\***

Indicator	Region 4		Region 7		Region 9		AET Total		All ICOs Total	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Provider's Name	14	100%	132	100%	65	100%	211	100%	1,106	100%

Indicator	Region 4		Region 7		Region 9		AET Total		All ICOs Total	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Provider Street Address	12	85.7%	106	80.3%	56	86.2%	174	82.5%	1,052	95.1%
Provider Suite Number	13	92.9%	109	82.6%	56	86.2%	178	84.4%	1,069	96.7%
Provider City	13	92.9%	129	97.7%	65	100%	207	98.1%	1,089	98.5%
Provider State	14	100%	132	100%	65	100%	211	100%	1,106	100%
Provider ZIP Code	13	92.9%	130	98.5%	65	100%	208	98.6%	1,090	98.6%
Provider Telephone Number	13	92.9%	126	95.5%	65	100%	204	96.7%	1,077	97.4%
Provider Type/Specialty	14	100%	132	100%	65	100%	211	100%	1,106	100%
Provider Accepting New Patients**	14	100%	129	97.7%	65	100%	208	98.6%	1,068	99.4%
Provider Gender	14	100%	132	100%	65	100%	211	100%	1,077	97.4%

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

\*\* New patient information was not listed in the online directory for specific ICOs and could only be confirmed by contacting the provider's office. New patient acceptance match rates include an exact match or not listed in the online directory. Caution should be exercised when interpreting the new patient acceptance match rates.

HSAG attempted to contact 199 sampled provider locations for **AET**, with an overall response rate of 87.4 percent. Table 3-17 summarizes the survey response rates for all ICOs and for **AET**, by region.

**Table 3-17—Survey Response Rates, by Region**

Region	Total Survey Cases <sup>1</sup>	Cases Reached <sup>2</sup>	Response Rate (%)
Region 4	13	10	76.9%
Region 7	121	107	88.4%
Region 9	65	57	87.7%
<b>AET Total</b>	<b>199</b>	<b>174</b>	<b>87.4%</b>
<b>All ICOs Total</b>	<b>1,068</b>	<b>945</b>	<b>88.5%</b>

<sup>1</sup> Total survey 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).

<sup>2</sup> Cases reached includes cases that responded to the survey, confirmed the location, and offered the requested service.

Table 3-18 summarizes the acceptance rates for the requested insurance and new patients for all ICOs and for **AET**, by region.

**Table 3-18—Requested Insurance and New Patient Acceptance Rates, by Region**

Region	Cases Accepting Insurance <sup>1,2</sup>		Accepting New Patients <sup>1</sup>	
	Count	Rate (%)	Count	Rate (%)
Region 4	4	40.0%	4	40.0%
Region 7	90	84.1%	89	83.2%
Region 9	43	75.4%	42	73.7%
<b>AET Total</b>	<b>137</b>	<b>78.7%</b>	<b>135</b>	<b>77.6%</b>
<b>All ICOs Total</b>	<b>660</b>	<b>69.8%</b>	<b>645</b>	<b>68.3%</b>

<sup>1</sup> The denominator includes cases reached.

<sup>2</sup> Insurance acceptance includes offices that accepted the requested ICO, affiliated Dental Benefits Administrator (DBA), or MI Health Link program.

Table 3-19 displays the number of survey respondents who offered appointments to new patients for routine dental care (i.e., dental cleaning) for all ICOs and **AET**, by region.

**Table 3-19—New Patient Appointment Availability Results, by Region**

Region	Cases Reached	Cases Offered an Appointment	
		Count	Rate (%)
Region 4	10	2	20.0%
Region 7	107	86	80.4%
Region 9	57	40	70.2%
<b>AET Total</b>	<b>174</b>	<b>128</b>	<b>73.6%</b>
<b>All ICOs Total</b>	<b>945</b>	<b>589</b>	<b>62.3%</b>

Table 3-20 displays the new patient wait time statistics for all ICOs and **AET**, by region.

**Table 3-20—New Patient Appointment Wait Time Results, by Region**

Region	Appointment Wait Time (Calendar Days)				Percent of Cases Within Standard <sup>1</sup>
	Min	Max	Average	Median	
Region 4	74	230	152	152	0.0%
Region 7	1	196	20	9	90.7%
Region 9	1	162	36	20	75.0%
<b>AET Total</b>	<b>1</b>	<b>230</b>	<b>27</b>	<b>12</b>	<b>84.4%</b>
<b>All ICOs Total</b>	<b>0</b>	<b>321</b>	<b>32</b>	<b>13</b>	<b>83.5%</b>

<sup>1</sup> The denominator includes cases that offered an appointment.

<sup>2</sup> Percent of Cases Within Standard represents cases that offered an appointment that is compliant with MDHHS' standard for an initial dental appointment (i.e., appointments offered within eight weeks or 56 calendar days).

## 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 98.1 percent of the sampled providers in **AET**'s online provider directory. Of the providers located in **AET**'s online provider directory, all indicators had a match rate above 95.0 percent. [**Quality** and **Access**]

### Weaknesses and Recommendations

**Weakness #1:** Overall, 87.4 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 shown when reviewers attempted to contact 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., inaccurate and/or missing provider information) to address the provider data deficiencies. Since MDHHS required **AET** to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.

**Weakness #2:** Of the cases reached, 78.7 percent of provider locations accepted the insurance, and 77.6 percent accepted new patients. Of the regions surveyed, Region 4 had the lowest rates of providers accepting the insurance and accepting new patients at 40.0 percent each, although the total survey cases for this region was only 13 providers. [**Quality** and **Access**]

**Why the weakness exists:** **AET**'s provider data included inaccurate information regarding the provider location's acceptance of the insurance and new patients.

**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 insurance acceptance and new patient acceptance) to address the provider data deficiencies and educate provider offices on the MI Health Link program.

**Weakness #3:** Overall, 73.6 percent of the responsive cases offered an appointment, with 84.4 percent of the offered appointments meeting the wait time compliance standard for routine dental visits (i.e., within eight weeks or 56 calendar days). [**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 being required to



complete pre-registration or provide additional personal information to schedule an appointment and being required to verify eligibility by providing a member Medicaid identification (ID) number.

**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 service records and IICSP documentation for sampled members from their contracted providers, based on the final sample list provided by HSAG. These documents covered services that occurred during the review period. HSAG reviewed **AET**'s procured service records to evaluate the completeness and accuracy of encounter data by examining key data elements, such as *Date of Service*, *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Units*, as applicable. For personal care services, HSAG also reviewed the associated IICSP documents submitted by **AET** to ensure that the services reported in the encounters were supported by the members' service plans. This review confirmed alignment with authorization dates, scheduled services, units of service, and service providers.

Table 3-21 outlines the key findings for **AET** based on the assessment of encounter data completeness and accuracy, conducted through a review of members' service records and the IICSP documents for services rendered from October 1, 2022, through September 30, 2023.

**Table 3-21—EDV Results for AET**

Analysis	Key Findings
<b>Record Procurement Status</b>	
Service Record Procurement Rate	<ul style="list-style-type: none"> <li>The overall service record procurement rate was notably low at <b>77.4 percent</b>, indicating that more than 20 percent of the requested records were not procured and submitted.</li> <li>Of the service records not submitted, <b>77.4 percent</b> were not submitted due to non-responsive providers or provider did not respond in a timely manner.</li> <li>Submission rates varied across different service categories within <b>AET</b>, ranging from <b>64.9 percent</b> (i.e., Dental) to <b>100 percent</b> (i.e., Hearing).</li> </ul>
Second Date of Service Submission Rate	<ul style="list-style-type: none"> <li>Among the procured service records, <b>32.7 percent</b> included a corresponding second date of service. The submission rates for a second date of service varied across different service categories within <b>AET</b>, ranging from <b>0 percent</b> (i.e., NEMT) to <b>68.7 percent</b> (i.e., Dental).</li> </ul>

Analysis	Key Findings
IICSP Document Procurement Rate	<ul style="list-style-type: none"> <li>All requested IICSP documents (<b>100 percent</b>) were submitted for review.</li> </ul>
<b>Encounter Data Completeness</b>	
Service Record Omission Rate	<ul style="list-style-type: none"> <li>The overall service record omission rate for the <i>Date of Service</i> data element was high at <b>20.3 percent</b>. Rates varied by service category, ranging from <b>0 percent</b> (i.e., Hearing) to <b>28.2 percent</b> (i.e., Dental).</li> <li>The overall service record omission rate for the <i>Diagnosis Code</i> data element was moderately high at <b>11.9 percent</b>, with variations across service categories, ranging from <b>0 percent</b> (i.e., Hearing) to <b>14.3 percent</b> (i.e., Personal Care Service).</li> <li>The overall service record omission rate for the <i>Procedure Code</i> data element was high at <b>19.7 percent</b>. Rate varied by service category, ranging from <b>5.3 percent</b> (i.e., Vision) to <b>33.3 percent</b> (i.e., NEMT).</li> <li>The overall service record omission rate for the <i>Procedure Code Modifier</i> data element was <b>7.7 percent</b>. Rate varied by service category, ranging from <b>4.3 percent</b> (i.e., Vision) to <b>33.3 percent</b> (i.e., NEMT).</li> <li>The service record omission rate for the <i>Units</i> data element was high at <b>33.3 percent</b> for NEMT; however, the denominator for this data element was small, indicating limited data points that may affect interpretation.</li> <li>Higher rates of service record omission suggest that the data elements in the encounter data were not adequately supported by the members' service records.</li> </ul>
Encounter Data Omission Rate	<ul style="list-style-type: none"> <li>Across all key data elements, encounter data omission rates were generally low, with the <i>Date of Service</i> data element having the highest encounter data omission rate at <b>6.2 percent</b>.</li> </ul>
<b>Encounter Data Accuracy</b>	
Diagnosis Code Rate	<ul style="list-style-type: none"> <li>The <i>Diagnosis Code</i> data element was accurate in <b>100 percent</b> of instances where diagnosis codes were present in both the service records and encounter data.</li> </ul>
Procedure Code Rate	<ul style="list-style-type: none"> <li>The <i>Procedure Code</i> data element was accurate in <b>99.2 percent</b> of instances where procedure codes were present in both the service records and encounter data.</li> <li>The accuracy rate for Dental was at <b>98.1 percent</b>, while all other service categories reached <b>100 percent</b> accuracy for the <i>Procedure Code</i> data element.</li> </ul>
Procedure Code Modifier Rate	<ul style="list-style-type: none"> <li>The <i>Procedure Code Modifier</i> data element was accurate in <b>100 percent</b> of instances where procedure code modifiers were present in both the service records and encounter data.</li> </ul>

Analysis	Key Findings
Units Rate	<ul style="list-style-type: none"> <li>The <i>Units</i> data element was accurate in <b>100 percent</b> of instances where units were present in both the service records and encounter data.</li> </ul>
All-Element Rate	<ul style="list-style-type: none"> <li>Dates of service with accurate values for all key data elements relevant to their respective service categories (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, <i>Procedure Code Modifier</i>, and <i>Units</i>) were observed in <b>89.2 percent</b> of the dates of service present in both data sources (i.e., encounter data and service records).</li> </ul>
<b>IICSP Review</b>	
Document Review	<ul style="list-style-type: none"> <li>The percentage of valid IICSP documents with proper signatures was very low at <b>14.3 percent</b>, which largely prevented the assessment of subsequent items requiring signature verification.</li> </ul>

### 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:** When the *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Units* data elements were present in both the encounter data and the members' service records and were evaluated independently across all service categories, the data element values demonstrated high accuracy, with rates of at least 99.2 percent. [Quality]

**Strength #2:** The diagnosis codes, procedure codes, procedure code modifiers, and units documented in the service records were mostly reflected in the encounter data, as evidenced by the relatively low encounter data omission rates. [Quality]

#### Weaknesses and Recommendations

**Weakness #1:** AET was unable to procure all the requested service records from its contracted providers primarily due to the 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:** AET should ensure that its contracted providers are held accountable for responding to service record requests in a timely manner to support auditing, inspection, and oversight activities. HSAG recommends that AET strengthen and/or enforce its contractual requirements with its providers to promote timely submission of requested documentation. This may

include implementing clear expectations, regular communication about submission requirements and deadlines, and consequences for non-compliance.

**Weakness #2:** Approximately 20.3 percent of the dates of service in the encounter data were not supported by the members' service records. Furthermore, around 11.9 percent and 19.7 percent of the *Diagnosis Code* and *Procedure Code* data elements, respectively, in the encounter data were not supported by the members' service records (i.e., service record omission). [Quality]

**Why the weakness exists:** The findings where encounter data are not supported by the members' service records can stem from several potential reasons, which can involve provider documentation practices (e.g., incomplete or inaccurate documentation, coding errors, insufficient detail in the service records), data submission (e.g., incorrect coding during data submission, data entry errors, or inconsistencies in submitted claims), or processing issues (e.g., data mapping, translation issues, or transmission that result in discrepancies between encounter data and service records).

**Recommendation:** AET should investigate the root causes of these omissions and consider performing periodic service record reviews of submitted claims to verify appropriate coding and data completeness, where appropriate. Findings from these reviews should be used to inform targeted education and training initiatives for providers. These initiatives should focus on encounter data submission practices, comprehensive and accurate documentation of members' service record, and adherence to accurate coding practices to reduce future discrepancies.

**Weakness #3:** The submitted documentation for the members' IICSP were incomplete, with required signatures missing for approximately 85.7 percent of the requested cases. Signatures are essential to validate that the IICSP has been reviewed, approved, and agreed upon by the appropriate parties, in accordance with regulatory and contractual requirements. [Quality]

**Why the weakness exists:** The absence of signatures highlights potential gaps in compliance with documentation standards and raises concerns about validating care coordination efforts. It may also impact the ability to demonstrate member or provider agreement with the outlined care plan, which is essential for ensuring accountability and alignment with care objectives.

**Recommendation:** AET should take proactive steps to ensure that all IICSP documentation includes the required signatures prior to providing or sharing the members' documentation with the relevant stakeholders. To achieve this, AET should implement robust internal quality assurance processes to review and verify that all documentation is complete and compliant with applicable guidelines prior to submission. Additionally, AET should provide targeted education and training for providers to emphasize the importance of obtaining signatures and maintaining accurate, complete documentation. These efforts will enhance compliance with regulatory and contractual requirements while improving the overall integrity and accountability of care coordination documentation.

## Consumer Assessment of Healthcare Providers and Systems Analysis

### Performance Results

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

### Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the HCBS 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 finding did not determine significant impact to the quality, timeliness, and/or accessibility of care.

### Strengths

**Strength #1:** As **AET**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, program level results indicated that the 2024 top-box score for *Rating of Personal Assistance and Behavioral Health Staff* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. **[Quality]**

**Strength #2:** As **AET**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, program level results indicated that the 2024 top-box score for *Rating of Case Manager* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. **[Quality]**

**Strength #3:** As **AET**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, program level results indicated that the 2024 top-box score for *Helpful Case Manager* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. **[Quality]**

**Strength #4:** As **AET**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, program level results indicated that the 2024 top-box score for *Personal Safety and Respect* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. **[Quality]**

**Strength #5:** As **AET**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, program level results indicated that the 2024 top-box score for *Planning Your Time and Activities* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. **[Access]**

## Weaknesses and Recommendations

**Weakness #1:** As **AET**-specific results were not available due to low response rates, no substantial weaknesses could be presented at the individual ICO level. However, program level results identified that while the 2024 top-box score for *Planning Your Time and Activities* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark, it was the lowest performing measure with a 2024 top-box score of 64.14 percent. This composite measure indicates there are opportunities to promote community inclusion and empowerment, as some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day. **[Access]**

**Why the weakness exists:** The program level results indicate there are opportunities for the MI Health Link program to help members with community inclusion and empowerment.

**Recommendation:** **AET** has reported utilizing case management interventions to target performance of *Planning Your Time and Activities*. HSAG recommends that **AET** continue utilizing case management interventions and add measures of effectiveness of the interventions as appropriate. Further, HSAG recommends that **AET** focus on member barriers such as transportation or other social determinants of health. In addition, HSAG recommends that **AET** collect regular feedback throughout the year to identify member input and feedback through town halls, focus groups, and short surveys. HSAG also recommends that **AET** ensure member demographic information is correct to improve response rates.

## 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 MI Health Link program's progress in achieving the CQS goals and objectives. Table 3-22 displays each MDHHS CQS goal and the EQR activity results that indicate whether the ICO positively (✓), negatively (✗), or minimally (m) impacted the MI Health Link program'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 3-22—Overall Performance Impact to CQS and Quality, Timeliness, and Access**

Objective	Quality Measure	Overall Performance Impact	Performance Domain
<b>Goal #1: Ensure high quality and high levels of access to care</b>			
1.1	<i>MI7.3 Annual Dental Visit</i>	✗	☑ Quality
	<i>FUH—Follow-Up After Hospitalization for Mental Illness (30 Days)</i>	✗	☑ Timeliness

Objective	Quality Measure	Overall Performance Impact	Performance Domain
	<i>COL—Colorectal Cancer Screening</i>	<b>m</b>	<input checked="" type="checkbox"/> Access
1.2	<i>CBP—Controlling High Blood Pressure</i>	<b>m</b>	
	<i>PCR—Plan All-Cause Readmission</i>	<b>m<sup>1</sup></b>	
	<i>COL—Colorectal Cancer Screening</i>	<b>m</b>	
1.3	<i>Annual Flu Vaccine</i>	<b>NA</b>	
	<i>MI5.6 Medication Review—All Populations</i>	✓	
	<i>TRC—Transitions of Care—Medication Reconciliation Post-Discharge</i>	✓	
	<i>PM13 Number and percent of enrollees whose IICSP addressed their assessed health and safety risks (HCBS C-Waiver population)</i>	<b>NA</b>	
	<i>PM15 Number &amp; percent of enrollees with an individualized contingency/back-up plan addressing caregiver absences, severe weather, fire/other emergencies (HCBS C-Waiver population)</i>	<b>NA</b>	
	<i>PM24 Number and percent of files that show enrollee/family/legal guardians (as appropriate) received information and education on how to report abuse, neglect, exploitation, and other critical incidents within 60 days of waiver enrollment.</i>	<b>NA</b>	
<b>Goal #2: Strengthen person and family-centered approaches</b>			
2.1	<i>MI2.3 Members with documented discussions of care goals</i>	<b>NA</b>	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	<i>Core 9.3 Minimizing Facility Length of Stay—Ratio of Observed to Expected Discharge Rates</i>	<b>x</b>	
	<i>PM17 Number and percent of enrollee IICSPs that are updated as the enrollee's needs change</i>	<b>NA</b>	
2.2	<i>SNS-E Social Needs Screening &amp; Intervention</i>	<b>NA</b>	
<b>Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)</b>			
3.1	<i>FUH—Follow-Up After Hospitalization for Mental Illness (30 Days)</i>	<b>x</b>	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
3.2	<i>MI2.6 Timely transmission of care transition record to health care professional</i>	<b>x</b>	



Objective	Quality Measure	Overall Performance Impact	Performance Domain
<b>Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes</b>			
4.1	<i>Aetna—Comprehensive Diabetes Care—HbA1cTest: Decreasing the Disparity Between White and African American Members</i>	✓ <sup>2</sup>	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
<b>Goal #5: Improve quality outcomes through value-based initiatives and payment reform</b>			
5.1	The CQS does not include quality measures for the MI Health Link Program under Goal #5.	NA	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access

✓ = The ICO's rate met the 2026 statewide performance target

m = The ICO's rate did not meet the 2026 statewide performance target, or the ICO's HEDIS rate did not meet the 2026 statewide performance target but the ICO's HEDIS rate increased in performance from the prior year

✗ = The ICO's rate did not meet the 2026 statewide performance target and/or the ICO's HEDIS 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 or the CQS did not include any quality measures for the MI Health Link program.

<sup>1</sup> The CQS did not identify the age stratification associated with the quality measure; therefore, HSAG used the 65+ stratification rate for the assessment.

<sup>2</sup> Evaluation of this quality measure used the results of the QIP activity and not the HEDIS rate reported under the PMV activity. While the disparity was not eliminated, the ICO demonstrated statistically significant improvement over the baseline performance for the disparate population during second remeasurement period.

## AmeriHealth Caritas VIP Care Plus

### Validation of Quality Improvement Projects

#### Performance Results

HSAG's validation evaluated the technical methods of **AMI**'s QIP, including an evaluation of statistically significant improvement based on reported results and statistical testing (i.e., the QIP 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 QIP and Validation Rating 2 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence that the QIP achieved significant improvement. Table 3-23 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 3-23—Overall Validation Rating for AMI**

QIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
Transitions of Care, Medication Reconciliation Post-Discharge	High Confidence	No Confidence	Medication Reconciliation Post-Discharge for Disparate Group: Members Identified as Black/African American.	66.2%	61.4% ⇔	56.8% ↓	Yes
			Medication Reconciliation Post-Discharge for Comparison Group: Members Identified as White.	80.0%	59.1% ↓	66.7% ↓	

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  $\geq 0.05$ ).

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

The goals for **AMI**'s QIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black or African American) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White). Table 3-24 displays the barriers identified through quality improvement and causal/barrier analysis processes and the interventions initiated by the ICO to support achievement of the QIP goals and address the barriers.

**Table 3-24—Remeasurement 2 Barriers and Interventions for AMI**

Barriers	Interventions
Not leveraging ability of nurse care coordinators to complete medication reconciliation post-discharge (MRP) on every member who experiences a transition of care (TOC).	Revised internal processes to include MRP as a required step. Nurse care coordinators to complete the process with every TOC, utilizing functionality within the ICO's medical record system, forwarding MRP to primary care providers, and including it in HEDIS data abstraction.
Providers may not submit applicable Current Procedural Terminology II (CPT II) codes after completing MRP.	Notified providers that they will receive a \$25 payment for submission of CPT II codes after reconfiguration of the claims system to support it.
Providers may not be aware that TOC has occurred and MRP is needed.	Developed and implemented automated fax notifications to providers of admission and discharge dates based on a daily report.
Members may not complete timely follow-up care with providers after TOC has occurred.	Requested new text campaign to remind members who have experienced TOC to follow up with the provider within 30 days.
Verify that all race, ethnicity, and language (REL) data available to the ICO are included in HEDIS reporting.	Requested evaluation of systems where REL data are stored and development of a process to ensure all REL data are being included in HEDIS reporting.
Members do not have an assigned primary care provider (PCP) that they can visit with to complete timely follow-up care after TOC has occurred.	Member Services, Care Management and Member Concierge teams engage in focused TOC member outreach.
Existing and newly enrolled members not having an assigned PCP that will meet their REL needs. A PCP they can visit after a TOC has occurred to complete a timely follow-up visit during which a MRP can be completed	Member letter: offers assistance to members for selecting a PCP who will meet the member's REL needs. Member Flyer: Include in Member Welcome Packet for newly enrolled members. Informs members on the importance of selecting a PCP that will meet the member's REL needs.
Unknown additional barriers for MRP completion with the Black or African American member population. Increase provider engagement to help identify additional barriers to develop targeted interventions.	Engage provider groups with the most Black or African American MRP non-compliant members by sending them a survey (SurveyMonkey) to learn what barriers the providers are aware of specific to their Black or African American patients.
Identified that Black or African American members with multiple chronic conditions (behavioral health, hypertension, diabetes) have a higher MRP non-compliance rate than White members.	Evaluate year-end 2023 data to develop process for Quality to provide a monthly report to Care Management of MRP non-compliant Black/African American members who have multiple chronic conditions to support prioritization of these members for TOC follow-up.
MRP forms not being completed consistently by some Registered Nurse (RN) Care Coordinators for members who they were UTR; some RN Care Coordinators not understanding MRP HEDIS specifications where member contact is not required for MRP form completion.	Additional education provided about the MRP HEDIS specifications and review of the process for the RN Care Coordinators to follow.

### ***Strengths, Weaknesses, and Recommendations***

Through the EQR, HSAG assessed the QIP 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:** AMI used appropriate quality improvement tools to conduct a causal/barrier analysis and to prioritize the identified barriers, and interventions were implemented in a timely manner. [Quality and Timeliness]

#### **Weaknesses and Recommendations**

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

**Why the weakness exists:** While it is unclear what led to the decline in performance for both subgroups, the data suggest that there are barriers to care for both populations that require the development of targeted improvement strategies.

**Recommendation:** HSAG recommends that AMI consider evidence-based intervention efforts and risk factors in quality of care for the Black/African-American population for the selected performance indicator and put interventions in place that would support improvement in the White population.

## Performance Measure Validation

### Performance Results

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

**AMI** received a measure designation of *Reportable (R)* for all measures, signifying that **AMI** had reported the measures in compliance with the MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements and that rates could be reported. Table 3-25 includes the validation designation for each performance measure as well as the validated SFY 2024 performance measure rates.

**Table 3-25—Measure-Specific Validation Designation for AMI**

Performance Measure	Validation Designation	SFY 2024 Rate
<b>Core Measure 9.3:</b> <i>Minimizing Facility Length of Stay</i>	<b>REPORTABLE (R)</b> The ICO reported this measure in alignment with the MMP Core Reporting Requirements.	0.62*
<b>MI2.6:</b> <i>Timely Transmission of Care Transition Record to Health Care Professional</i>	<b>REPORTABLE (R)</b> The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.	30.90%
<b>MI5.6:</b> <i>Care for Adults—Medication Review</i>	<b>REPORTABLE (R)</b> The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.	95.38%
<b>MI7.3:</b> <i>Annual Dental Visit</i>	<b>REPORTABLE (R)</b> The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.	18.89%

\*Please note for Core Measure 9.3 that the SFY 2024 rate is reflective of the ICO's calculated ratio of observed to expected discharges (O/E ratio) rather than a calculated percentage rate, as is reflected for MI2.6, MI5.6, and MI7.3.

### Performance Measure Rates

Table 3-26 shows each of **AMI**'s audited HEDIS measures, rates for HEDIS MY 2022 and HEDIS MY 2023 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2023 with HEDIS MY 2022, and the HEDIS MY 2022 and HEDIS MY 2023 MI Health Link statewide average performance rates. HEDIS MY 2022 and HEDIS MY 2023 measure rates performing better than the MY 2022 and MY 2023 statewide averages are notated by green font.

Table 3-26—Measure-Specific Percentage Rates for AMI

HEDIS Measure	HEDIS MY 2022 (%)	HEDIS MY 2023 (%)	HEDIS MY 2022 vs. MY 2023	MY 2022 Statewide Average (%)	MY 2023 Statewide Average (%)
<b>Prevention and Screening</b>					
BCS-E—Breast Cancer Screening	50.11	58.39	+8.28	56.70	58.82
COL—Colorectal Cancer Screening <sup>1</sup>	45.45	52.92	+7.47	57.59	60.82
COA—Care for Older Adults—Medication Review	95.13	97.27	+2.14	80.41	90.90
COA—Care for Older Adults—Functional Status Assessment	64.48	76.67	+12.19	62.71	70.13
COA—Care for Older Adults—Pain Assessment	72.51	78.06	+5.55	78.04	83.50
<b>Respiratory Conditions</b>					
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	20.31	22.22	+1.91	22.01	23.00
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	60.00	77.14	+17.14	74.10	74.05
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	86.67	88.57	+1.90	88.82	86.81
<b>Cardiovascular Conditions</b>					
CBP—Controlling High Blood Pressure	62.03	61.86	-0.17	66.14	68.85
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack <sup>2</sup>	—	50.00	—	—	56.36
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy	84.87	87.60	+2.73	80.90	85.02
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%	81.19	84.91	+3.72	79.55	81.48
<b>Diabetes</b>					
HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)*	37.32	40.00	+2.68	34.07	29.00
HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)	53.66	53.41	-0.25	58.51	63.61
EED—Eye Exam for Patients With Diabetes <sup>1</sup>	56.83	55.85	-0.98	62.89	65.27
BPD—Blood Pressure Control for Patients With Diabetes	59.51	57.07	-2.44	68.13	70.83
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy	77.82	79.58	+1.76	76.44	76.91
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%	77.50	79.58	+2.08	78.95	80.60
<b>Musculoskeletal Conditions</b>					
OMW—Osteoporosis Management in Women Who Had a Fracture	0.00	28.57	+28.57	11.18	20.27

HEDIS Measure	HEDIS MY 2022 (%)	HEDIS MY 2023 (%)	HEDIS MY 2022 vs. MY 2023	MY 2022 Statewide Average (%)	MY 2023 Statewide Average (%)
<b>Behavioral Health</b>					
AMM—Antidepressant Medication Management—Effective Acute Phase Treatment <sup>1</sup>	78.13	67.31	-10.82	73.66	70.76
AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment <sup>1</sup>	59.38	53.85	-5.53	57.94	54.20
FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	24.56	14.04	-10.52	32.79	31.03
FUH—Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up	49.12	35.09	-14.03	58.91	58.83
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up	11.43	33.33	+21.90	32.06	29.44
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up	34.29	46.67	+12.38	54.39	48.27
<b>Medication Management and Care Coordination</b>					
TRC—Transitions of Care—Medication Reconciliation Post-Discharge	58.15	60.10	+1.95	47.59	56.17
TRC—Transitions of Care—Notification of Inpatient Admission	25.30	26.03	+0.73	16.53	24.53
TRC—Transitions of Care—Receipt of Discharge Information	16.79	13.38	-3.41	15.38	19.48
TRC—Transitions of Care—Patient Engagement After Inpatient Discharge	71.68	74.21	+2.53	77.74	79.78
<b>Overuse/Appropriateness</b>					
PSA—Non-Recommended PSA-Based Screening in Older Men*	22.18	22.30	+0.12	26.71	27.99
DDE—Potentially Harmful Drug-Disease Interactions in Older Adults*	26.23	30.05	+3.82	33.45	33.54
DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid*	10.69	10.11	-0.58	18.16	17.57
DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis*	4.21	4.66	+0.45	5.23	4.99
DAE—Use of High-Risk Medications in Older Adults—Total*	14.18	13.75	-0.43	21.78	21.07
<b>Access/Availability of Care</b>					
AAP—Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	82.30	78.47	-3.83	84.90	85.69
AAP—Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	90.13	90.84	+0.71	93.83	93.71
AAP—Adults' Access to Preventive/Ambulatory Health Services—65 Years and Older	86.31	87.83	+1.52	91.69	91.79



HEDIS Measure	HEDIS MY 2022 (%)	HEDIS MY 2023 (%)	HEDIS MY 2022 vs. MY 2023	MY 2022 Statewide Average (%)	MY 2023 Statewide Average (%)
<i>AAP—Adults’ Access to Preventive/Ambulatory Health Services—Total</i>	86.71	87.01	+0.30	91.08	91.24
<i>IET— Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total<sup>1</sup></i>	41.55	42.59	+1.04	34.10	35.83
<i>IET— Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total<sup>1</sup></i>	3.52	2.78	-0.74	3.84	4.43
<b>Risk-Adjusted Utilization</b>					
<i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)*</i>	0.95	1.25	+0.30	1.07	1.11
<i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)*</i>	1.66	1.33	-0.33	1.21	1.21

\* Measures for which lower rates indicate better performance.

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

<sup>2</sup> Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between MY 2023 and prior years; therefore, the HEDIS MY 2022 rate and comparison from HEDIS MY 2022 vs. MY 2023 will not be displayed for this measure.

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

### 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:** AMI continued to demonstrate high performance for MI5.6, as its rate was one of the highest reported among the ICOs. AMI continued to leverage its director of Medicare pharmacy to complete medication reviews, which may have helped influence the timely completion of medication reviews, a practice that can support timely quality care for members and the overall monitoring of members with complex medication regimens. [Quality and Timeliness]

**Strength #2:** In the Prevention and Screening domain, AMI’s rate for the BCS-E—Breast Cancer Screening measure indicator increased by more than 8 percentage points from MY 2022 to MY 2023, suggesting strength and improvement in women 50–74 years of age having at least one mammogram to screen for breast cancer during the measurement year. Finding breast cancer early and getting state-of-the-art cancer treatment are two of the most important ways to prevent deaths from breast cancer. If breast cancer is found early, when it’s small and has not spread, it is easier to

treat successfully. Getting regular screening tests is the most reliable way to find breast cancer early.<sup>26</sup> [Quality, Timeliness, and Access]

**Strength #3:** In the Prevention and Screening domain, **AMI**'s rate for the *COL—Colorectal Cancer Screening* measure indicator increased by more than more than 7 percentage points from MY 2022 to MY 2023, suggesting strength and improvement in the percentage of members 45–75 years of age who had appropriate screening for colorectal cancer conducted during the measurement year. Colorectal cancer is a leading cause of cancer death in the United States. Regular colorectal cancer screening is one of the most powerful tools against colorectal cancer. Screening can often find colorectal cancer early, when it's small, hasn't spread, and might be easier to treat. Regular screening can even prevent colorectal cancer. A polyp can take as many as 10 to 15 years to develop into cancer. With screening, doctors can find and remove polyps before they have the chance to turn into cancer.<sup>27</sup> [Quality and Access]

**Strength #4:** In the Prevention and Screening domain, **AMI**'s rates for the *COA—Care for Older Adults—Functional Status Assessment* and *Pain Assessment* measure indicators increased by more than 12 percentage points and 5 percentage points, respectively, from MY 2022 to MY 2023, with the *COA—Care for Older Adults—Functional Status Assessment* measure indicator exceeding the HEDIS MY 2023 MI Health Link statewide average, suggesting strength and improvement in adult members 66 years and older having functional status and pain assessments conducted during the measurement year. As people age, their physical and cognitive function can decline, and pain becomes more prevalent. Screening of elderly patients is effective in identifying functional decline.<sup>28</sup> [Quality and Access]

**Strength #5:** In the Respiratory Conditions domain, **AMI**'s rate for the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicator increased by more than 17 percentage points from MY 2022 to MY 2023 and exceeded the HEDIS MY 2023 MI Health Link statewide average, suggesting strength and improvement in adult members 40 years of age and older receiving appropriate medication therapy to manage COPD exacerbations. Exacerbations of COPD are episodes of worsening symptoms, leading to substantial morbidity and mortality. Patients with a history of frequent exacerbations have worse quality of life than patients with a history of less frequent exacerbations, and have consistent exacerbation frequencies when studied from year to year. The success of oral corticosteroids in the treatment of COPD

<sup>26</sup> American Cancer Society. American Cancer Society Recommendations for the Early Detection of Breast Cancer. Available at: <https://www.cancer.org/cancer/types/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations-for-the-early-detection-of-breast-cancer.html>. Accessed on: Mar 1, 2025.

<sup>27</sup> American Cancer Society. Can Colorectal Polyps and Cancer Be Found Early? Available at: <https://www.cancer.org/cancer/types/colon-rectal-cancer/detection-diagnosis-staging/detection.html>. Accessed on: Mar 1, 2025.

<sup>28</sup> National Committee for Quality Assurance. Care for Older Adults (COA). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/care-for-older-adults-coa/>. Accessed on: Mar 1, 2025.

exacerbations with reduction of hospital length of stay has prompted much interest in the use of inhaled steroids to reduce exacerbation frequency in COPD.<sup>29</sup> [Quality and Access]

**Strength #6:** In the Musculoskeletal Conditions domain, **AMI**'s rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator increased by more than 28 percentage points from MY 2022 to MY 2023 and exceeded the HEDIS MY 2023 MI Health Link statewide average, suggesting strength and improvement in timely screening and treatment of women who suffered a fracture, with either a bone mineral density test or a prescription for a drug to treat osteoporosis. Osteoporosis is a bone disease that develops when bone mineral density and bone mass decrease, or when the quality or structure of bone changes. This can lead to a decrease in bone strength that can increase the risk of fractures. For older adults, the risk of breaking another bone is highest in the year or two after breakage of the first bone. The risk of another fracture can be reduced, so it is important to take steps as soon as possible after a fracture to prevent another one.<sup>30</sup> [Quality, Timeliness, and Access]

**Strength #7:** In the Behavioral Health domain, **AMI**'s rates for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* measure indicators increased by more than 21 percentage points and 12 percentage points, respectively, from MY 2022 to MY 2023, with the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* measure indicator exceeding the HEDIS MY 2023 MI Health Link statewide average, suggesting strength and improvement in timely follow-up care with a mental health provider for members with a diagnosis of mental illness following inpatient discharge. Research suggests that patients with mental disorders are among the highest users of ED services, with visits characterized by long lengths of stay, intensive treatment, and elevated rates of hospitalizations. After discharge, fewer than half of these patients successfully transition to outpatient care, with high rates of readmission to the ED. Programs that allow patients with mental disorders to successfully engage with outpatient care hold the potential not only to improve quality and outcomes of care for people with mental disorders, but also to free capacity within EDs to provide care for other urgent needs.<sup>3-31</sup> [Quality, Timeliness, and Access]

<sup>29</sup> National Institutes of Health-National Library of Medicine. COPD exacerbations: defining their cause and prevention. Wedzicha JA, Seemungal TA. COPD exacerbations: defining their cause and prevention. *Lancet*. 2007 Sep 1;370(9589):786-96. doi: 10.1016/S0140-6736(07)61382-8. PMID: 17765528; PMCID: PMC7134993. Available at: <https://pmc.ncbi.nlm.nih.gov/articles/PMC7134993/>. Accessed on Mar 7, 2025.

<sup>30</sup> National Institutes of Health-National Institute of Arthritis and Musculoskeletal and Skin Diseases. Preventing Another Broken Bone. Available at: <https://www.niams.nih.gov/health-topics/preventing-another-broken-bone>. Accessed on: Mar 7, 2025.

<sup>31</sup> National Institutes of Health-National Library of Medicine. Druss B, Lally CA, Li J, et al. Comparing Two Ways to Help Patients Get Follow-up Care after a Mental Health Visit to the Emergency Room—The EPIC Study [Internet]. Washington (DC): Patient-Centered Outcomes Research Institute (PCORI); 2021 May. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK601636/> doi: 10.25302/05.2021.IHS.151032431. Accessed on: Mar 7, 2025.

## Weaknesses and Recommendations

**Weakness #1:** During medical record review validation (MRRV), six confirmed critical errors were identified in the first sample for MI2.6, and one critical error was identified in a second sample for MI2.6, which resulted in resubmission of MI2.6 to the FAI Data Collection System (DCS).

**[Quality]**

**Why the weakness exists:** Reasons for the confirmed critical errors included transition records not being sent within the required two-day time frame from the day of discharge; faxing of unreadable discharge summary paperwork; no documentation of a transition record transmission; and no submission of a discharge or summary of care record (i.e., only progress notes, discharge notes, and history and physical notes were submitted). **AMI** indicated that staff had been reeducated on the process for discharge from a nursing facility and transfer to the hospital; that is, reviewing documentation to confirm that the discharge summary is in a readable format and faxing the discharge paperwork within the required 48 hours.

**Recommendation:** Although **AMI** proactively implemented process enhancements and reeducated staff members as a result of the findings, HSAG recommends that **AMI** incorporate additional quality checks and overreads into its MRR processes to ensure timely transition record transmissions and accurate reporting of numerator-compliant data. HSAG also recommends that **AMI** review a statistically significant sample of numerator-compliant cases to ensure that the cases meet reporting requirements.

**Weakness #2:** HSAG identified multiple cases that were incorrectly reported in data elements A and B for Core Measure 9.3, which resulted in resubmission of Core Measure 9.3 to the CMS Health Plan Management System (HPMS). **[Quality]**

**Why the weakness exists:** Primary source verification (PSV) results for Core Measure 9.3 indicated that multiple cases were incorrectly reported in data element B, as the members were hospitalized within 60 days of the day of discharge and therefore should have been excluded from data element B. **AMI** noted that the errors were due to validation checks missing that the members were hospitalized within 60 days of discharge. In addition, **AMI** identified three members with admissions to a facility that originated from another facility, and therefore were required to be removed from data elements A and B. **AMI** indicated that source code review would be done, and appropriate source code updates would be made to account for data element B exclusions. In addition, a validation matrix document would be developed and used to reeducate staff on effective ways to validate the output, review claims within Facets, and perform other requirement verifications such as validating and auditing the output on a quarterly basis.

**Recommendation:** HSAG recommends that **AMI** execute its outlined mitigation steps to address the findings, including implementing more stringent quality assurance checks and increasing the frequency of validation checks prior to submission of data to MDHHS and HSAG. HSAG also recommends that **AMI** review the annual release of the MMP Core reporting requirements and current source code for Core Measure 9.3 to further ensure that the programming logic is in alignment with the reporting requirements.

**Weakness #3:** For 25 of the 42 reported HEDIS measures (60 percent), **AMI**'s rates indicated worse performance than the statewide average, demonstrating an opportunity for improvement across multiple domains including Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Behavioral Health, Medication Management and Care Coordination, Access/Availability of Care, and Risk-Adjusted Utilization. [Quality]

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

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

**Weakness #4:** In the Behavioral Health domain, **AMI**'s rates for the *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators decreased by more than 10 percentage points and 5 percentage points, respectively, from MY 2022 to MY 2023 and fell below the HEDIS MY 2023 MI Health Link statewide average, indicating that some adults with a diagnosis of major depression, who were newly treated with antidepressant medication, did not remain on antidepressant medication for at least 84 days and 180 days. Depression can cause severe symptoms that affect how a person feels, thinks, and handles daily activities, such as sleeping, eating, or working. Antidepressants are medications commonly used to treat depression. They work by changing how the brain produces or uses certain chemicals involved in mood or stress. Antidepressants take time to work—usually 4–8 weeks—and problems with sleep, appetite, and concentration often improve before mood lifts. Giving a medication a chance to work is important.<sup>32</sup> [Quality, Timeliness, and Access]

**Why the weakness exists:** The rates for the *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators decreasing by more than 10 percentage points and 5 percentage points, respectively, from MY 2022 to MY 2023 and falling below the HEDIS MY 2023 MI Health Link statewide average suggests that barriers exist for some adult members with a diagnosis of major depression to remain on antidepressant medication.

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

<sup>32</sup> National Institutes of Health-National Institute of Mental Health. Transforming the understanding and treatment of mental illnesses. Available at: [https://www.nimh.nih.gov/health/publications/depression#part\\_6159](https://www.nimh.nih.gov/health/publications/depression#part_6159). Accessed on: Mar 7, 2025.

**Weakness #5:** In the Behavioral Health domain, **AMI**'s rates for the *FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* measure indicators decreased by more than 10 percentage points and 14 percentage points, respectively, from MY 2022 to MY 2023, and fell below the HEDIS MY 2023 MI Health Link statewide average, indicating that some members were not receiving timely follow-up care for mental illness after a hospitalization. Research suggests that patients with mental disorders are among the highest users of ED services, with visits characterized by long lengths of stay, intensive treatment, and elevated rates of hospitalizations. After discharge, fewer than half of these patients successfully transition to outpatient care, with high rates of readmission to the ED. Programs that allow patients with mental disorders to successfully engage with outpatient care hold the potential not only to improve quality and outcomes of care for people with mental disorders, but also to free capacity within EDs to provide care for other urgent needs.<sup>33</sup> [Quality, Timeliness, and Access]

**Why the weakness exists:** The rates for the *FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* measure indicators decreasing by more than 10 percentage points and 14 percentage points, respectively, from MY 2022 to MY 2023 and falling below the HEDIS MY 2023 MI Health Link statewide average suggests that barriers exist for some members to receive follow-up care for mental illness after a hospitalization.

**Recommendation:** HSAG recommends that **AMI** conduct a root cause analysis or focused study to determine why some members were not receiving follow-up care for mental illness after a hospitalization. Upon identification of a root cause, **AMI** should implement appropriate interventions to improve the performance related to the *FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* measure indicators. **AMI** should consider the nature and scope of the issue (e.g., whether the issue is related to barriers such as a lack of patient and provider education or staffing shortages).

<sup>33</sup> National Institutes of Health-National Library of Medicine. Druss B, Lally CA, Li J, et al. Comparing Two Ways to Help Patients Get Follow-up Care after a Mental Health Visit to the Emergency Room—The EPIC Study [Internet]. Washington (DC): Patient-Centered Outcomes Research Institute (PCORI); 2021 May. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK601636/> doi: 10.25302/05.2021.IHS.151032431. Accessed on: Mar 7, 2025.



## Compliance Review

### Performance Results

Table 3-27 presents an overview of the results of the SFY 2022 and SFY 2023 compliance reviews for **AMI**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. If a requirement was not applicable to **AMI** during the period covered by the review, HSAG used a *Not Applicable (NA)* designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 14 standards.

**Table 3-27—Summary of Standard Compliance Scores**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			<i>M</i>	<i>NM</i>	<i>NA</i>	
Standard I—Disenrollment: Requirements and Limitations	9	6	6	0	3	<b>100%</b>
Standard II—Member Rights and Member Information	23	22	13	9	1	<b>59%</b>
Standard III—Emergency and Poststabilization Services	13	13	13	0	0	<b>100%</b>
Standard IV—Availability of Services	13	13	11	2	0	<b>85%</b>
Standard V—Assurances of Adequate Capacity and Services	4	4	4	0	0	<b>100%</b>
Standard VI—Coordination and Continuity of Care	31	30	23	7	1	<b>77%</b>
Standard VII—Coverage and Authorization of Services	28	27	24	3	1	<b>89%</b>
Standard VIII—Provider Selection	23	23	21	2	0	<b>91%</b>
Standard IX—Confidentiality	11	11	8	3	0	<b>73%</b>
Standard X—Grievance and Appeal Systems	45	45	32	13	0	<b>71%</b>
Standard XI—Subcontractual Relationships and Delegation	6	5	4	1	1	<b>80%</b>
Standard XII—Practice Guidelines	6	6	6	0	0	<b>100%</b>
Standard XIII—Health Information Systems <sup>1</sup>	9	9	9	0	0	<b>100%</b>
Standard XIV—Quality Assessment and Performance Improvement Program	21	21	19	2	0	<b>90%</b>
<b>Total</b>	<b>242</b>	<b>235</b>	<b>193</b>	<b>42</b>	<b>7</b>	<b>82%</b>

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

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

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

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

<sup>1</sup> This standard includes a comprehensive assessment of the ICO's IS capabilities.



## Review of Corrective Action Plan Implementation

Based on the findings of the SFY 2022 and SFY 2023 compliance review activities, **AMI** was required to develop and submit a CAP for each element assigned a score of *Not Met*. MDHHS and HSAG reviewed the CAP for sufficiency, and **AMI** was responsible for implementing each action plan in a timely manner. Table 3-28 presents an overview of the results of the SFY 2024 compliance review for **AMI**, which consisted of a comprehensive review of the ICO's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Section 2.

**Table 3-28—Summary of CAP Implementation**

Standard	Total CAP Elements	# of CAP Elements Complete	# of CAP Elements Not Complete
Standard II—Member Rights and Member Information	9	9	0
Standard IV—Availability of Services	2	2	0
Standard VI—Coordination and Continuity of Care	7	7	0
Standard VII—Coverage and Authorization of Services	3	3	0
Standard VIII—Provider Selection	2	1	1
Standard IX—Confidentiality	3	3	0
Standard X—Grievance and Appeal Systems	13	12	1
Standard XI—Subcontractual Relationships and Delegation	1	1	0
Standard XIV—Quality Assessment and Performance Improvement Program	2	2	0
<b>Total</b>	<b>42</b>	<b>40</b>	<b>2</b>

**Total CAP Elements:** The total number of elements within each standard that required a CAP during the SFY 2022 and SFY 2023 compliance review activities.

**# of CAP Elements Complete:** The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirements under review.

**# of CAP Elements Not Complete:** The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirements under review.

<sup>1</sup>This standard includes a comprehensive assessment of the ICO's IS capabilities.

## 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:** AMI demonstrated that it successfully remediated 40 of 42 elements, indicating the necessary policies, procedures, and initiatives were implemented to ensure compliance with the Member Rights and Member Information, Availability of Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Confidentiality, Subcontractual Relationships and Delegation, and Quality Assessment and Performance Improvement Program. [Quality, Timeliness, and Access]

## Weaknesses and Recommendations

**Weakness #1:** AMI did not remediate one element for the Provider Selection standard and one element for the Grievance and Appeal Systems standard, indicating continued gaps in the ICO's processes within these program areas. [Quality, Timeliness, and Access]

**Why the weakness exists:** AMI did not provide evidence that it collected information on ownership and control from its providers through enrollment forms, credentialing and recredentialing packages, and anytime there was a change in ownership. The ICO explained that in lieu of collecting the ownership and disclosure form at credentialing/rec credentialing, it checks the provider's active status in MDHHS' Community Health Automated Medicaid Processing System (CHAMPS). However, HSAG confirmed with MDHHS that CHAMPS is not an acceptable substitute for the required ownership and control disclosure form. Additionally, the ICO explained that if an appeal was untimely, the ICO would notify the member but would continue the appeal and make an approval or denial decision. However, for Medicaid-based appeals, once the time frame expires, the appeal process is deemed exhausted, and the ICO must send the member the appeal resolution notice as well as provide the member with State fair hearing rights information.

**Recommendation:** HSAG required AMI to participate in a mandatory technical assistance meeting with MDHHS and HSAG to further discuss the requirements, expectations, and appropriate action plans to bring the elements into compliance. AMI was also required to update its existing CAPs and applicable action plans to align with the expectations addressed during the technical assistance meeting, and subsequently follow MDHHS' and HSAG's direction and implement timely interventions to fully remediate the remaining action plans. As AMI's updated action plans were approved by MDHHS and HSAG, HSAG recommends that the ICO conduct an internal audit to verify its action plans were successful in remediating the deficiencies.

## Network Adequacy Validation

### Network Adequacy Analysis

#### Performance Results

#### ISCA Findings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if **AMI**'s interpretation of data was accurate. Table 3-29 summarizes HSAG's validation ratings for **AMI**, by indicator type.

**Table 3-29—Summary of AMI's Validation Ratings**

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Time and Distance	100%	0%	0%	0%
Provider Capacity	100%	0%	0%	0%

Of the network adequacy indicators assessed, **AMI** received *High Confidence* for both time and distance and provider capacity indicator types.

#### Analytic Findings

**AMI** submitted its SFY 2024 region-specific member and Medicaid provider data files, and exception requests to HSAG on April 29, 2024. Based on HSAG's detailed file review findings communicated to **AMI** on June 18, 2024, HSAG asked **AMI** to resubmit its network data files for all regions to address identified data issues. **AMI** resubmitted its region-specific network data files to HSAG on June 26, 2024, and HSAG's NAV results indicated that **AMI** met all Medicaid and LTSS minimum network standards for Region 7 and Region 9.

Table 3-30 presents **AMI**'s region-specific NAV results by Medicaid and LTSS provider category following all data resubmissions and MDHHS' exception determinations.

**Table 3-30—SFY 2024 NAV Results for AMI by Region and Provider Category**

Provider Category	Region 7 Validation Result	Region 9 Validation Result
<b>Provider Categories With Travel Time and Distance Standards</b>		
Adult Day Program	Met	Met
Dental	Met	Met
Eye Examinations	Met	Met

Provider Category	Region 7 Validation Result	Region 9 Validation Result
Eye Wear	Met	Met
Hearing Aids	Met	Met
Hearing Examinations	Met	Met
<b>Provider Categories Rendering Home-Based Services</b>		
Adaptive Medical Equipment and Supplies	Met	Met
Assistive Technology—Devices	Met	Met
Assistive Technology—Van Lifts and Tie Downs	Met	Met
Chore Services	Met	Met
ECLS	Met	Met
Environmental Modifications	Met	Met
Fiscal Intermediary	Met	Met
Home-Delivered Meals	Met	Met
Medical Supplies	Met	Met
NEMT	Met	Met
Non-Medical Transportation	Met	Met
Personal Care Services	Met	Met
Personal Emergency Response System	Met	Met
Preventive Nursing Services	Met	Met
Private Duty Nursing	Met	Met
Respite	Met	Met
Skilled Nursing Home	Met	Met
<b>Percent of Total Standards Met</b>	<b>100%</b>	<b>100%</b>

### ***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: AMI** maintained a detailed process to generate the network adequacy report, ensuring business continuity of the network adequacy reporting process. [Access]

**Strength #2: AMI** established a robust process to maintain data accuracy for its reporting by verifying code, testing sampled results, and working with other team members to review the code and output to ensure unique members were counted and reported. [Access]

**Strength #3: AMI** met all Medicaid and LTSS minimum network standards for Region 7, indicating that **AMI** maintained an adequate network for MI Health Link members in this region. [Access]

**Strength #4: AMI** met all Medicaid and LTSS minimum network standards for Region 9, indicating that **AMI** maintained an adequate network for MI Health Link members in this region. [Access]

## Weaknesses and Recommendations

**Weakness #1:** HSAG identified no specific opportunities related to the time and distance or provider capacity network standards for **AMI** based on the SFY 2024 NAV results. [Access]

**Why the weakness exists:** NA

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

## Network Validation Survey

### Performance Results

HSAG performed a comparison of the provider data submitted to HSAG by **AMI** against **AMI**'s online provider directory. The sample included 38 providers (Table 3-31). Among this sample, 71.1 percent were located in the online directory at the sampled location, while 13.2 percent of providers were found in the directory but not at the sampled location. Additionally, 15.8 percent of the providers could not be located in **AMI**'s online directory.

Table 3-31 summarizes findings by region, regarding the number of sampled providers and provider locations (i.e., "cases") that HSAG's reviewers were able to locate in the ICO's online provider directory.

**Table 3-31—Summary of Sampled Dental Providers Located in Online Provider Directory**

Region	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 (%)	Count	Rate (%)	Count	Rate (%)
Region 7	24	3	12.5%	3	12.5%	18	75.0%
Region 9	14	3	21.4%	2	14.3%	9	64.3%
<b>AMI Total</b>	<b>38</b>	<b>6</b>	<b>15.8%</b>	<b>5</b>	<b>13.2%</b>	<b>27</b>	<b>71.1%</b>
<b>All ICOs Total</b>	<b>1,179</b>	<b>73</b>	<b>6.2%</b>	<b>18</b>	<b>1.5%</b>	<b>1,088</b>	<b>92.3%</b>

Table 3-32 displays the total number and percentage of cases, by region, with matched data values for indicators that were reviewed in the comparison between all ICOs and **AMI**'s submitted provider data and **AMI**'s online provider directory.

**Table 3-32—PDV Study Indicator Match Rates\***

Indicator	Region 7		Region 9		AMI Total		All ICOs Total	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Provider's Name	21	100%	11	100%	32	100%	1,106	100%
Provider Street Address	18	85.7%	9	81.8%	27	84.4%	1,052	95.1%
Provider Suite Number	21	100%	11	100%	32	100%	1,069	96.7%
Provider City	19	90.5%	9	81.8%	28	87.5%	1,089	98.5%
Provider State	21	100%	11	100%	32	100%	1,106	100%
Provider ZIP Code	18	85.7%	9	81.8%	27	84.4%	1,090	98.6%
Provider Telephone Number	15	71.4%	9	81.8%	24	75.0%	1,077	97.4%
Provider Type/Specialty	21	100%	11	100%	32	100%	1,106	100%
Provider Accepting New Patients**	NA	NA	NA	NA	NA	NA	1,068	99.4%
Provider Gender	20	95.2%	11	100%	31	96.9%	1,077	97.4%

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

\*\* New patient information was not listed in the online directory for **AMI** and could only be confirmed by contacting the provider's office. Therefore, **AMI** was excluded from the new patient acceptance match rate. Caution should be exercised when interpreting the new patient acceptance match rates. NA indicates "Not Applicable" as this survey indicator was not evaluated.

HSAG attempted to contact 24 sampled provider locations for **AMI**, with an overall response rate of 87.5 percent. Table 3-33 summarizes the survey response rates for all ICOs and for **AMI**, by region.

**Table 3-33—Secret Shopper Survey Response Rates, by Region**

Region	Total Survey Cases <sup>1</sup>	Cases Reached <sup>2</sup>	Response Rate (%)
Region 7	15	14	93.3%
Region 9	9	7	77.8%
<b>AMI Total</b>	<b>24</b>	<b>21</b>	<b>87.5%</b>
<b>All ICOs Total</b>	<b>1,068</b>	<b>945</b>	<b>88.5%</b>

<sup>1</sup> Total survey cases includes cases that were found in the online directory and matched on seven key indicators (i.e., name, address, city, state, ZIP Code, telephone number, and provider type/specialty).

<sup>2</sup> Cases reached includes cases that responded to the survey, confirmed the location, and offered the requested service.

Table 3-34 summarizes the acceptance rates for the requested insurance and new patients for all ICOs and for **AMI**, by region.

**Table 3-34—Requested Insurance and New Patient Acceptance Rates, by Region**

Region	Cases Accepting Insurance <sup>1,2</sup>		Accepting New Patients <sup>1</sup>	
	Count	Rate (%)	Count	Rate (%)
Region 7	11	78.6%	11	78.6%
Region 9	5	71.4%	5	71.4%
<b>AMI Total</b>	<b>16</b>	<b>76.2%</b>	<b>16</b>	<b>76.2%</b>
<b>All ICOs Total</b>	<b>660</b>	<b>69.8%</b>	<b>645</b>	<b>68.3%</b>

<sup>1</sup> The denominator includes cases reached.

<sup>2</sup> Insurance acceptance includes offices that accepted the requested ICO, affiliated DBA, or MI Health Link program.

Table 3-35 displays the number of survey respondents who offered appointments to new patients for routine dental care (i.e., dental cleaning) for all ICOs and **AMI**, by region.

**Table 3-35—New Patient Appointment Availability Results, by Region**

Region	Cases Reached	Cases Offered an Appointment	
		Count	Rate (%)
Region 7	14	9	64.3%
Region 9	7	3	42.9%
<b>AMI Total</b>	<b>21</b>	<b>12</b>	<b>57.1%</b>
<b>All ICOs Total</b>	<b>945</b>	<b>589</b>	<b>62.3%</b>



Table 3-36 displays the new patient wait time statistics for all ICOs and **AMI**, by region.

**Table 3-36—New Patient Appointment Wait Time Results, by Region**

Region	Appointment Wait Time (Calendar Days)				Percentage of Cases Within Standard <sup>1,2</sup>
	Min	Max	Average	Median	
Region 7	1	169	30	7	88.9%
Region 9	7	80	38	28	66.7%
<b>AMI Total</b>	<b>1</b>	<b>169</b>	<b>32</b>	<b>10</b>	<b>83.3%</b>
<b>All ICOs Total</b>	<b>0</b>	<b>321</b>	<b>32</b>	<b>13</b>	<b>83.5%</b>

<sup>1</sup> The denominator includes cases that offered an appointment.

<sup>2</sup> Percentage of Cases Within Standard represents cases that offered an appointment that is compliant with MDHHS' standard for an initial dental appointment (i.e., appointments offered within eight weeks or 56 calendar days).

### ***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 **AMI**'s online provider directory, all indicators had a match rate above 95.0 percent. [**Quality**]

#### **Weaknesses and Recommendations**

**Weakness #1:** Reviewers located 84.2 percent of the sampled providers in **AMI**'s online provider directory. [**Access**]

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

**Recommendation:** HSAG recommends that **AMI** 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. In addition, as MDHHS required **AMI** to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.

**Weakness #2:** Overall, 87.5 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, AMI's provider data included invalid telephone or address information shown when reviewers attempted to contact the office staff members.

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

**Weakness #3:** Among the responsive cases, 76.2 percent of provider locations accepted the insurance, and new patients. [Quality and Access]

**Why the weakness exists:** AMI's provider data included incorrect MI Health Link acceptance and new patient acceptance.

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

**Weakness #4:** Among the responsive cases, 57.1 percent of locations offered an appointment date, including an appointment rate of 64.3 percent in Region 7, and 42.9 percent in Region 9. Of the cases that offered an appointment, 83.3 percent of the offered appointments met the wait time compliance standard for routine dental visits (i.e., within eight weeks or 56 calendar days). The wait time compliance rate was 88.9 percent in Region 7, compared to 66.7 percent in Region 9. [Timeliness and Access]

**Why the weakness exists:** For new AMI members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included being required to complete pre-registration or provide additional personal information to schedule an appointment and being required to verify eligibility by providing a member Medicaid ID number. Regional differences in appointment availability were present, with Region 9 having a lower appointment rate and lower rate of cases meeting the wait time compliance standard.

**Recommendation:** HSAG recommends that AMI work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that AMI 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 **AMI** procured service records and IICSP documentation for sampled members from their contracted providers, based on the final sample list provided by HSAG. These documents covered services that occurred during the review period. HSAG reviewed **AMI**'s procured service records to evaluate the completeness and accuracy of encounter data by examining key data elements, such as *Date of Service*, *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier* and *Units*, as applicable. For personal care services, HSAG also reviewed the associated IICSP documents submitted by **AMI** to ensure that the services reported in the encounters were supported by the members' service plans. This review confirmed alignment with authorization dates, scheduled services, units of service, and service providers.

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

**Table 3-37—EDV Results for AMI**

Analysis	Key Findings
<b>Record Procurement Status</b>	
Service Record Procurement Rate	<ul style="list-style-type: none"> <li>The overall service record procurement rate was at <b>95.4 percent</b>, indicating that most of the requested records were procured and submitted.</li> <li>Of the service records not submitted, <b>57.9 percent</b> were not submitted due to documentation not available for the requested date of service, despite member was a patient at the practice.</li> <li>Submission rates varied across different service categories within <b>AMI</b>, ranging from <b>88.9 percent</b> (i.e., NEMT) to <b>100 percent</b> (i.e., Hearing).</li> </ul>
Second Date of Service Submission Rate	<ul style="list-style-type: none"> <li>Among the procured service records, <b>34.0 percent</b> included a corresponding second date of service. The submission rates for a second date of service varied across different service categories within <b>AMI</b>, ranging from <b>0 percent</b> (i.e., Hearing) to <b>62.5 percent</b> (i.e., NEMT).</li> </ul>
IICSP Document Procurement Rate	<ul style="list-style-type: none"> <li>A total of <b>99.4 percent</b> of the requested IICSP documents were successfully submitted for review.</li> </ul>
<b>Encounter Data Completeness</b>	
Service Record Omission Rate	<ul style="list-style-type: none"> <li>The overall service record omission rate for the <i>Date of Service</i> data element was at <b>9.8 percent</b>. Rates varied by service category, ranging from <b>0 percent</b> (i.e., Hearing) to <b>14.7 percent</b> (i.e., Vision).</li> </ul>

Analysis	Key Findings
	<ul style="list-style-type: none"> <li>The overall service record omission rate for the <i>Diagnosis Code</i> data element was high at <b>16.9 percent</b>, with variations across service categories, ranging from <b>0 percent</b> (i.e., Hearing) to <b>19.3 percent</b> (i.e., Vision).</li> <li>The overall service record omission rate for the <i>Procedure Code</i> data element was at <b>9.8 percent</b>. Rates varied by service category, ranging from <b>0 percent</b> (i.e., Hearing) to <b>46.2 percent</b> (i.e., NEMT).</li> <li>The overall service record omission rate for the <i>Procedure Code Modifier</i> data element was high at <b>16.2 percent</b>. Rates varied by service category, ranging from <b>14.2 percent</b> (i.e., Vision) to <b>100 percent</b> (i.e., NEMT).</li> <li>The service record omission rate for the <i>Units</i> data element was high at <b>46.2 percent</b> for NEMT; however, the denominator for this data element was small, indicating limited data points that may affect interpretation.</li> <li>Higher rates of service record omission suggest that the data elements in the encounter data were not adequately supported by the members' service records.</li> </ul>
Encounter Data Omission Rate	<ul style="list-style-type: none"> <li>Across all key data elements, encounter data omission rates were relatively low, with the <i>Date of Service</i> data element having the highest encounter data omission rate at <b>9.3 percent</b>.</li> </ul>
<b>Encounter Data Accuracy</b>	
Diagnosis Code Rate	<ul style="list-style-type: none"> <li>The <i>Diagnosis Code</i> data element was accurate in <b>99.1 percent</b> of instances where diagnosis codes were present in both the service records and encounter data, with all errors attributed to inaccurate coding.</li> <li>The accuracy rate for Vision was at <b>98.5 percent</b>, while Hearing and Personal Care Service reached 100 percent accuracy for diagnosis codes.</li> </ul>
Procedure Code Rate	<ul style="list-style-type: none"> <li>The <i>Procedure Code</i> data element was accurate in <b>99.6 percent</b> of instances where procedure codes were present in both the service records and encounter data.</li> <li>The accuracy rate for Dental was at <b>99.1 percent</b>, while all other service categories reached 100 percent accuracy for procedure codes.</li> </ul>
Procedure Code Modifier Rate	<ul style="list-style-type: none"> <li>The <i>Procedure Code Modifier</i> data element was accurate in <b>100 percent</b> of instances where procedure code modifiers were present in both the service records and encounter data.</li> </ul>
Units Rate	<ul style="list-style-type: none"> <li>The <i>Units</i> data element was accurate in <b>85.7 percent</b> of instances where units were present in both the service records and encounter data.</li> </ul>

Analysis	Key Findings
All-Element Rate	<ul style="list-style-type: none"> <li>Dates of service with accurate values for all key data elements relevant to their respective service categories (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, <i>Procedure Code Modifier</i>, and <i>Units</i>) were observed in <b>93.1 percent</b> of the dates of service present in both data sources (i.e., encounter data and service records).</li> </ul>
<b>IICSP Review</b>	
Document Review	<ul style="list-style-type: none"> <li>The percentage of valid IICSP documents with proper signatures was very low at <b>1.9 percent</b>, which largely prevented the assessment of subsequent items requiring signature verification.</li> </ul>

### 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:** When the *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data elements were present in both the encounter data and the members' service records and were evaluated independently across all service categories, the data element values demonstrated high accuracy with rates of at least 99.1 percent. [Quality]

**Strength #2:** The diagnosis codes, procedure codes, procedure code modifiers, and units documented in the service records were mostly reflected in the encounter data, as evidenced by the relatively low encounter data omission rates. [Quality]

#### Weaknesses and Recommendations

**Weakness #1:** Approximately 16.9 percent and 16.2 percent of the *Diagnosis Code* and *Procedure Code Modifier* data elements, respectively, in the encounter data were not supported by the members' service records (i.e., service record omission). [Quality]

**Why the weakness exists:** The findings where encounter data are not supported by the members' service records can stem from several potential reasons, which can involve provider documentation practices (e.g., incomplete or inaccurate documentation, coding errors, insufficient detail in the service records), data submission (e.g., incorrect coding during data submission, data entry errors, or inconsistencies in submitted claims), or processing issues (e.g., data mapping, translation issues, or transmission that result in discrepancies between encounter data and service records).

**Recommendation:** **AMI** should investigate the root causes of these omissions and consider performing periodic service record reviews of submitted claims to verify appropriate coding and data completeness, where appropriate. Findings from these reviews should be used to inform targeted education and training initiatives for providers. These initiatives should focus on encounter data

submission practices, comprehensive and accurate documentation of members' service records, and adherence to accurate coding practices to reduce future discrepancies.

**Weakness #2:** The submitted documentation for the members' IICSP was incomplete, with required signatures missing for approximately 98.1 percent of the requested cases. Signatures are essential to validate that the IICSP has been reviewed, approved, and agreed upon by the appropriate parties, in accordance with regulatory and contractual requirements. [Quality]

**Why the weakness exists:** The absence of signatures highlights potential gaps in compliance with documentation standards and raises concerns about validating care coordination efforts. It may also impact the ability to demonstrate member or provider agreement with the outlined care plan, which is essential in ensuring accountability and alignment with care objectives.

**Recommendation:** AMI should take proactive steps to ensure that all IICSP documentation includes the required signatures prior to providing or sharing the members' documentation with the relevant stakeholders. To achieve this, AMI should implement robust internal quality assurance processes to review and verify that all documentation is complete and compliant with applicable guidelines prior to submission. Additionally, AMI should provide targeted education and training for providers to emphasize the importance of obtaining signatures and maintaining accurate, complete documentation. These efforts will enhance compliance with regulatory and contractual requirements while improving the overall integrity and accountability of care coordination documentation.

## Consumer Assessment of Healthcare Providers and Systems Analysis

### Performance Results

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

### Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the HCBS 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 finding did not determine significant impact to the quality, timeliness, and/or accessibility of care.

## Strengths

**Strength #1:** As AMI-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis indicated that the 2024 top-box score for *Rating of Personal Assistance and Behavioral Health Staff* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. [Quality]

**Strength #2:** As AMI-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis

indicated that the 2024 top-box score for *Rating of Case Manager* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. [Quality]

**Strength #3:** As **AMI**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis indicated that the 2024 top-box score for *Helpful Case Manager* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. [Quality]

**Strength #4:** As **AMI**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis indicated that the 2024 top-box score for *Personal Safety and Respect* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. [Quality]

**Strength #5:** As **AMI**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis indicated that the 2024 top-box score for *Planning Your Time and Activities* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. [Access]

## Weaknesses and Recommendations

**Weakness #1:** As **AMI**-specific results were not available due to low response rates, no substantial weaknesses could be presented at the individual ICO level. However, program level results identified that while the 2024 top-box score for *Planning Your Time and Activities* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark, it was the lowest performing measure with a 2024 top-box score of 64.14 percent. This composite measure indicates there are opportunities to promote community inclusion and empowerment, as some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day. [Access]

**Why the weakness exists:** The program level results indicate there are opportunities for the MI Health Link program to help members with community inclusion and empowerment opportunities.

**Recommendation:** **AMI** has reported utilizing case management and non-medical transportation to target performance of *Planning Your Time and Activities*. HSAG recommends that **AMI** continue these interventions and add measures of effectiveness of the interventions as appropriate. Further, HSAG recommends that **AMI** focus on barriers such as transportation or other SDOH. In addition, HSAG recommends that **AMI** collect regular feedback throughout the year to identify member input and feedback through town halls, focus groups, and short surveys. HSAG further recommends that **AMI** ensure member demographic information is correct to improve response rates.



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

HSAG performed a comprehensive assessment of **AMI**'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 **AMI**'s overall performance contributed to the MI Health Link program's progress in achieving the CQS goals and objectives. Table 3-38 displays each MDHHS CQS goal and the EQR activity results that indicate whether the ICO positively (✓), negatively (✗), or minimally (m) impacted the MI Health Link program'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 **AMI**'s Medicaid members. Not applicable (NA) was used if a CQS goal did not include any quality measures for the MI Health Link program or the EQR activities do not produce data to assess the impact of a quality measure(s) under an objective.

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

Objective	Quality Measure	Overall Performance Impact	Performance Domain
<b>Goal #1: Ensure high quality and high levels of access to care</b>			
1.1	<i>MI7.3 Annual Dental Visit</i>	✗	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	<i>FUH—Follow-Up After Hospitalization for Mental Illness (30 Days)</i>	✗	
	<i>COL—Colorectal Cancer Screening</i>	m	
1.2	<i>CBP—Controlling High Blood Pressure</i>	✗	
	<i>PCR—Plan All-Cause Readmission</i>	m <sup>1</sup>	
	<i>COL—Colorectal Cancer Screening</i>	m	
1.3	<i>Annual Flu Vaccine</i>	NA	
	<i>MI5.6 Medication Review—All Populations</i>	✓	
	<i>TRC—Transitions of Care—Medication Reconciliation Post-Discharge</i>	m	
	<i>PM13 Number and percent of enrollees whose IICSP addressed their assessed health and safety risks (HCBS C-Waiver population)</i>	NA	
	<i>PM15 Number &amp; percent of enrollees with an individualized contingency/back-up plan addressing caregiver absences, severe weather, fire/other emergencies (HCBS C-Waiver population)</i>	NA	
	<i>PM24 Number and percent of files that show enrollee/family/legal guardians (as appropriate) received information and education on how to report abuse, neglect, exploitation, and other critical incidents within 60 days of waiver enrollment.</i>	NA	

Objective	Quality Measure	Overall Performance Impact	Performance Domain
<b>Goal #2: Strengthen person and family-centered approaches</b>			
2.1	MI2.3 Members with documented discussions of care goals	NA	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness
	Core 9.3 Minimizing Facility Length of Stay—Ratio of Observed to Expected Discharge Rates	✗	<input checked="" type="checkbox"/> Access
	PM17 Number and percent of enrollee IICSPs that are updated as the enrollee's needs change	NA	
2.2	SNS-E Social Needs Screening & Intervention	NA	
<b>Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)</b>			
3.1	FUH—Follow-Up After Hospitalization for Mental Illness (30 Days)	✗	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness
3.2	MI2.6 Timely transmission of care transition record to health care professional	✗	<input checked="" type="checkbox"/> Access
<b>Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes</b>			
4.1	AmeriHealth—Transitions of Care, Medication Reconciliation Post-Discharge: Black/African American vs White	✗ <sup>2</sup>	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
<b>Goal #5: Improve quality outcomes through value-based initiatives and payment reform</b>			
5.1	The CQS does not include quality measures for the MI Health Link Program under Goal #5.	NA	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access

✓ = The ICO's rate met the 2026 statewide performance target

m = The ICO's rate did not meet the 2026 statewide performance target, or the ICO's HEDIS rate did not meet the 2026 statewide performance target but the ICO's HEDIS rate increased in performance from the prior year

✗ = The ICO's rate did not meet the 2026 statewide performance target and/or the ICO's HEDIS 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 or the CQS did not include any quality measures for the MI Health Link program.

<sup>1</sup> The CQS did not identify the age stratification associated with the quality measure; therefore, HSAG used the 65+ stratification rate for the assessment.

<sup>2</sup> Evaluation of this quality measure used the results of the QIP activity and not the HEDIS rate reported under the PMV activity. While the disparity was not eliminated, the ICO demonstrated statistically significant improvement over the baseline performance for the disparate population during second remeasurement period.

## HAP CareSource

### Validation of Quality Improvement Projects

#### Performance Results

HSAG's validation evaluated the technical methods of **HCS'** QIP, including an evaluation of statistically significant improvement based on reported results and statistical testing (i.e., the QIP 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 QIP and Validation Rating 2 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence that the QIP achieved significant improvement. Table 3-39 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 3-39—Overall Validation Rating for HCS**

QIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
Reducing Controlling High Blood Pressure Disparity Between Black/African American and White/Caucasian Members	High Confidence	High Confidence	The percentage of African-American members 18–85 years of age who had a diagnosis of HTN and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.	51.5%	63.8% ↑	70.8% ↑	No
			The percentage of Caucasian members 18–85 years of age who had a diagnosis of HTN and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.	74.2%	67.4% ⇔	78.3% ⇔	

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 **HCS'** QIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black or African American) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (Caucasian). Table 3-40 displays the barriers identified through quality improvement and causal/barrier

analysis processes and the interventions initiated by the ICO to support achievement of the QIP goals and address the barriers.

**Table 3-40—Remeasurement 2 Barriers and Interventions for HCS**

Barriers	Interventions
The coronavirus disease 2019 (COVID-19) pandemic exacerbated pre-existing health inequities, such as access to healthcare services.	The ICO pharmacy benefit manager (PBM), Express Scripts, Inc. (ESI) has a medication adherence program and targets members for outreach. Continued to distribute a new report for providers that focused on gaps in care for their members.
Racial disparities between Caucasian and African-American populations in hypertension control are well-documented in the United States.	Created an adherence report to ensure providers are monitoring members who have uncontrolled blood pressure readings. Members were encouraged to have follow-up visits with the provider for regular monitoring.
Having multiple information technology (IT) systems makes pulling data difficult.	The ICO is modifying supplemental data HEDIS extracts to include at-home and telehealth visit blood pressure readings.
Contact information for members is incorrect.	Designed an incentive program to reward primary care providers for high-quality, cost-effective primary care services. This will encourage providers, who may have more updated contact information for members, to contact members and make appointments for a blood pressure check.
Black/African American members do not attend provider appointments to document their blood pressure.	The ICO has focused on an access to care campaign, with outreach conducted to members who need to schedule a physician visit.
The COVID-19 pandemic exacerbated pre-existing health inequities, such as access to healthcare services.	The ICO PBM, ESI has a medication adherence program and targets members for outreach.

### **Strengths, Weaknesses, and Recommendations**

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

**Strength #2:** The disparate subgroup sustained statistically significant improvement over the baseline performance for the second remeasurement period and the state-specific goal of eliminating the existing disparity was achieved. [Quality and Access]

## Weaknesses and Recommendations

**Weakness #1:** No substantial weaknesses were identified.

**Why the weakness exists:** NA

**Recommendation:** Although there were no substantial weaknesses, HSAG recommends that HCS implement intervention strategies that have demonstrated improvement on the performance indicators and continue to evaluate the success of each intervention.

## Performance Measure Validation

### Performance Results

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

HCS received a measure designation of *Reportable (R)* for all measures, signifying that HCS had reported the measures in compliance with the MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements and that rates could be reported. Table 3-41 includes the validation designation for each performance measure as well as the validated SFY 2024 performance measure rates.

**Table 3-41—Measure-Specific Validation Designation for HCS**

Performance Measure	Validation Designation	SFY 2024 Rate
<b>Core Measure 9.3:</b> <i>Minimizing Facility Length of Stay</i>	<b>REPORTABLE (R)</b> The ICO reported this measure in alignment with the MMP Core Reporting Requirements.	1.50*
<b>MI2.6:</b> <i>Timely Transmission of Care Transition Record to Health Care Professional</i>	<b>REPORTABLE (R)</b> The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.	25.79%
<b>MI5.6:</b> <i>Care for Adults—Medication Review</i>	<b>REPORTABLE (R)</b> The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.	71.29%
<b>MI7.3:</b> <i>Annual Dental Visit</i>	<b>REPORTABLE (R)</b> The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.	31.47%

\*Please note for Core Measure 9.3 that the SFY 2024 rate is reflective of the ICO's calculated ratio of observed to expected discharges (O/E ratio) rather than a calculated percentage rate, as is reflected for MI2.6, MI5.6, and MI7.3.

### Performance Measure Rates

Table 3-42 shows each of **HCS**' audited HEDIS measures, rates for HEDIS MY 2022 and HEDIS MY 2023 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2023 with HEDIS MY 2022, and the HEDIS MY 2022 and HEDIS MY 2023 MI Health Link statewide average performance rates. HEDIS MY 2022 and HEDIS MY 2023 measure rates performing better than the MY 2022 and MY 2023 statewide averages are notated by green font.

**Table 3-42—Measure-Specific Percentage Rates for HCS**

HEDIS Measure	HEDIS MY 2022 (%)	HEDIS MY 2023 (%)	HEDIS MY 2022 vs. MY 2023	MY 2022 Statewide Average (%)	MY 2023 Statewide Average (%)
<b>Prevention and Screening</b>					
<i>BCS-E—Breast Cancer Screening</i>	59.61	59.24	-0.37	56.70	58.82
<i>COL—Colorectal Cancer Screening<sup>1</sup></i>	57.63	60.48	+2.85	57.59	60.82
<i>COA—Care for Older Adults—Medication Review</i>	61.67	73.47	+11.80	80.41	90.90
<i>COA—Care for Older Adults—Functional Status Assessment</i>	68.55	70.41	+1.86	62.71	70.13
<i>COA—Care for Older Adults—Pain Assessment</i>	78.62	82.40	+3.78	78.04	83.50
<b>Respiratory Conditions</b>					
<i>SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD</i>	29.81	26.15	-3.66	22.01	23.00
<i>PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid</i>	74.42	72.92	-1.50	74.10	74.05
<i>PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator</i>	94.19	89.58	-4.61	88.82	86.81
<b>Cardiovascular Conditions</b>					
<i>CBP—Controlling High Blood Pressure</i>	68.11	74.72	+6.61	66.14	68.85
<i>PBH—Persistence of Beta-Blocker Treatment After a Heart Attack<sup>2</sup></i>	—	60.00	—	—	56.36
<i>SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy</i>	82.86	84.26	+1.40	80.90	85.02
<i>SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%</i>	87.36	83.52	-3.84	79.55	81.48
<b>Diabetes</b>					
<i>HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (&gt;9.0%)*</i>	29.20	27.37	-1.83	34.07	29.00
<i>HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (&lt;8.0%)</i>	64.23	62.63	-1.60	58.51	63.61
<i>EED—Eye Exam for Patients With Diabetes<sup>1</sup></i>	66.67	63.95	-2.72	62.89	65.27
<i>BPD—Blood Pressure Control for Patients With Diabetes</i>	66.91	72.37	+5.46	68.13	70.83



HEDIS Measure	HEDIS MY 2022 (%)	HEDIS MY 2023 (%)	HEDIS MY 2022 vs. MY 2023	MY 2022 Statewide Average (%)	MY 2023 Statewide Average (%)
<i>SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy</i>	78.56	80.71	+2.15	76.44	76.91
<i>SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%</i>	80.00	82.26	+2.26	78.95	80.60
<b>Musculoskeletal Conditions</b>					
<i>OMW—Osteoporosis Management in Women Who Had a Fracture</i>	20.00	27.27	+7.27	11.18	20.27
<b>Behavioral Health</b>					
<i>AMM—Antidepressant Medication Management—Effective Acute Phase Treatment<sup>1</sup></i>	74.16	75.26	+1.10	73.66	70.76
<i>AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment<sup>1</sup></i>	60.67	61.11	+0.44	57.94	54.20
<i>FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up</i>	20.90	22.86	+1.96	32.79	31.03
<i>FUH—Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up</i>	52.24	58.57	+6.33	58.91	58.83
<i>FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up</i>	34.55	22.45	-12.10	32.06	29.44
<i>FUM—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up</i>	50.91	51.02	+0.11	54.39	48.27
<b>Medication Management and Care Coordination</b>					
<i>TRC—Transitions of Care—Medication Reconciliation Post-Discharge</i>	42.09	58.88	+16.79	47.59	56.17
<i>TRC—Transitions of Care—Notification of Inpatient Admission</i>	15.57	39.90	+24.33	16.53	24.53
<i>TRC—Transitions of Care—Receipt of Discharge Information</i>	16.55	27.01	+10.46	15.38	19.48
<i>TRC—Transitions of Care—Patient Engagement After Inpatient Discharge</i>	79.32	80.05	+0.73	77.74	79.78
<b>Overuse/Appropriateness</b>					
<i>PSA—Non-Recommended PSA-Based Screening in Older Men*</i>	28.02	32.58	+4.56	26.71	27.99
<i>DDE—Potentially Harmful Drug-Disease Interactions in Older Adults*</i>	35.26	32.14	-3.12	33.45	33.54
<i>DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid*</i>	23.18	20.65	-2.53	18.16	17.57
<i>DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis*</i>	4.62	4.93	+0.31	5.23	4.99
<i>DAE—Use of High-Risk Medications in Older Adults—Total*</i>	25.78	23.38	-2.40	21.78	21.07



HEDIS Measure	HEDIS MY 2022 (%)	HEDIS MY 2023 (%)	HEDIS MY 2022 vs. MY 2023	MY 2022 Statewide Average (%)	MY 2023 Statewide Average (%)
<b>Access/Availability of Care</b>					
<i>AAP—Adults' Access to Preventive/Ambulatory Health Services—20–44 Years</i>	84.08	84.60	+0.52	84.90	85.69
<i>AAP—Adults' Access to Preventive/Ambulatory Health Services—45–64 Years</i>	94.49	92.80	-1.69	93.83	93.71
<i>AAP—Adults' Access to Preventive/Ambulatory Health Services—65 Years and Older</i>	91.42	91.14	-0.28	91.69	91.79
<i>AAP—Adults' Access to Preventive/Ambulatory Health Services—Total</i>	91.13	90.57	-0.56	91.08	91.24
<i>IET—Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total<sup>1</sup></i>	45.14	37.07	-8.07	34.10	35.83
<i>IET—Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total<sup>1</sup></i>	5.14	2.93	-2.21	3.84	4.43
<b>Risk-Adjusted Utilization</b>					
<i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)*</i>	1.00	0.86	-0.14	1.07	1.11
<i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)*</i>	0.99	1.25	+0.26	1.21	1.21

\* Measures for which lower rates indicate better performance.

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

<sup>2</sup> Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between MY 2023 and prior years; therefore, the HEDIS MY 2022 rate and comparison from HEDIS MY 2022 vs. MY 2023 will not be displayed for this measure.

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

### 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** significantly improved the MI5.6 rate from the prior year. [Quality and Timeliness]

**Strength #2: HCS'** MI7.3 total rate is higher than several other Michigan ICOs. [Quality]

**Strength #3:** In the Prevention and Screening domain, **HCS'** rate for the *COA—Care for Older Adults—Medication Review* measure indicator increased by more than 11 percentage points from

MY 2022 to MY 2023, suggesting strength and improvement in adult members ages 66 years and older having medication reviews conducted during the measurement year. Older adults may have more complex medication regimens. This measure ensures that older adults receive the care they need to optimize quality of life.<sup>34</sup> [Quality]

**Strength #4:** In the Cardiovascular Conditions domain, **HCS'** rate for the *CBP—Controlling High Blood Pressure* measure indicator increased by more than 6 percentage points from MY 2022 to MY 2023 and exceeded the HEDIS MY 2023 MI Health Link statewide average, suggesting some members ages 18–85 years of age with a diagnosis of hypertension had their blood pressure adequately controlled during the measurement year. Known as the “silent killer,” high blood pressure, or hypertension, increases the risk of heart disease and stroke, which are the leading causes of death in the United States. 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. Healthcare providers and plans can help individuals manage their high blood pressure by prescribing medications and encouraging low-sodium diets, increased physical activity, and smoking cessation.<sup>35</sup> [Quality, Timeliness, and Access]

**Strength #5:** In the Diabetes domain, **HCS'** rate for the *BPD—Blood Pressure Control for Patients With Diabetes* measure indicator increased by more than 5 percentage points from MY 2022 to MY 2023 and exceeded the HEDIS MY 2023 MI Health Link statewide average, suggesting strength and improvement in members 18–75 years of age with a diagnosis of diabetes who had controlled blood pressure levels. People with diabetes are especially prone to high blood pressure because of the amount of insulin in their body. 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.<sup>36</sup> [Quality and Access]

**Strength #6:** In the Musculoskeletal Conditions domain, **HCS'** rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator increased by more than 7 percentage points from MY 2022 to MY 2023 and exceeded the HEDIS MY 2023 MI Health Link statewide average, suggesting strength and improvement in timely screening and treatment of women who suffered a fracture, with either a bone mineral density test or a prescription for a drug to treat osteoporosis. Osteoporosis is a bone disease that develops when bone mineral density and bone mass decrease, or when the quality or structure of bone changes. This can lead to a decrease in bone strength that can increase the risk of fractures. For older adults, the risk of breaking another bone is

<sup>34</sup> National Committee for Quality Assurance. Care for Older Adults (COA). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/care-for-older-adults-coa/>. Accessed on: Mar 3, 2025.

<sup>35</sup> 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: Mar 3, 2025.

<sup>36</sup> 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: Mar 3, 2025.

highest in the year or two after breakage of the first bone. The risk of another fracture can be reduced, so it is important to take steps as soon as possible after a fracture to prevent another one.<sup>37</sup> [Quality, Timeliness, and Access]

**Strength #7:** In the Behavioral Health domain, **HCS'** rate for the *FUH—Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up* measure indicator increased by more than 6 percentage points from MY 2022 to MY 2023, suggesting strength and improvement in timely follow-up care for mental illness after a hospitalization. Research suggests that patients with mental disorders are among the highest users of ED services, with visits characterized by long lengths of stay, intensive treatment, and elevated rates of hospitalizations. After discharge, fewer than half of these patients successfully transition to outpatient care, with high rates of readmission to the ED. Programs that allow patients with mental disorders to successfully engage with outpatient care hold the potential not only to improve quality and outcomes of care for people with mental disorders, but also to free capacity within EDs to provide care for other urgent needs.<sup>38</sup> [Quality, Timeliness, and Access]

**Strength #8:** In the Medication Management and Care Coordination domain, **HCS'** rates for the *TRC—Transitions of Care—Medication Reconciliation Post-Discharge, Notification of Inpatient Admission, and Receipt of Discharge Information* measure indicators increased by more than 16 percentage points, 24 percentage points, and 10 percentage points, respectively, from MY 2022 to MY 2023, and exceeded the HEDIS MY 2023 MI Health Link statewide average, suggesting strength and improvement for adult members in timely medication reconciliation being performed following discharge from an inpatient facility, and timely notification of inpatient admissions and documentation of discharge information. Research shows that when patients are engaged in their healthcare, it can lead to measurable improvements in safety and quality. Discharge from hospital to home requires the successful transfer of information from clinicians to the patient and family to reduce adverse events and prevent readmissions. Engaging patients and families in the discharge planning process helps make this transition in care safe and effective.<sup>39</sup> [Quality and Timeliness]

## Weaknesses and Recommendations

**Weakness #1:** **HCS'** MI2.6 rate decreased from the prior year and is significantly lower than the other ICOs' reported rates. [Quality and Timeliness]

- 
- <sup>37</sup> National Institutes of Health-National Institute of Arthritis and Musculoskeletal and Skin Diseases. Preventing Another Broken Bone. Available at: <https://www.niams.nih.gov/health-topics/preventing-another-broken-bone>. Accessed on: Mar 7, 2025.
- <sup>38</sup> National Institutes of Health-National Library of Medicine. Druss B, Lally CA, Li J, et al. Comparing Two Ways to Help Patients Get Follow-up Care after a Mental Health Visit to the Emergency Room—The EPIC Study [Internet]. Washington (DC): Patient-Centered Outcomes Research Institute (PCORI); 2021 May. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK601636/> doi: 10.25302/05.2021.IHS.151032431. Accessed on: Mar 7, 2025.
- <sup>39</sup> Agency for Healthcare Research and Quality (AHRQ). Strategy 4: Care Transitions From Hospital to Home: IDEAL Discharge Planning. Available at: <https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/strategy4/index.html>. Accessed on Mar 7, 2025.
-

**Why the weakness exists:** HCS reported that the main reason for noncompliance is that providers were not using a shared EHR system with HCS and were maintaining Continuity of Care Documents (CCDs) that were greater than 100 pages. These files were too large to transmit.

**Recommendation:** HSAG recommends that HCS continue its efforts to obtain access to additional EHR systems.

**Weakness #2:** PSV results identified that the dates used for the Core Measure 9.3 numerator did not necessarily represent the date that the member was discharged to the community. [Quality and Timeliness]

**Why the weakness exists:** HCS clarified that the date parameters were incorrect in the initial query that pulled all institutional claims. Claims with dates of service from January 1, 2022, through June 30, 2023, were pulled. There were many stays, however, that started within the measurement period and continued after the measurement period. To capture such claims, the second date parameter needed to be moved forward to December 31, 2023, or removed completely. The initial query was revised to include all institutional claims from January 1, 2022, forward. Once this query was rerun, the stays that originally showed June 30, 2023, as a discharge date were all updated to reflect the correct discharge dates. HSAG confirmed that the revised data provided were correct, and HCS was approved to resubmit its data to CMS.

**Recommendation:** Although HCS proactively addressed the findings and revised its programming logic, HSAG recommends that HCS incorporate more stringent quality assurance checks and increased frequency of data validation checks prior to submission of final rates to MDHHS and member-level data to HSAG. HSAG also recommends that HCS review the annual release of the Core reporting requirements for Core Measure 9.3 to further ensure that programming logic is in alignment with the reporting requirements.

**Weakness #3:** While only 19 of the 42 reported HEDIS measures rates (45 percent) indicated worse performance than the statewide average, opportunity exists for HCS to further improve performance across multiple domains including Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Behavioral Health, Overuse/Appropriateness, Access/Availability of Care, and Risk-Adjusted Utilization. [Quality]

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

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

**Weakness #4:** In the Behavioral Health domain, HCS' rate for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* measure indicator decreased by more than 12 percentage points and fell below the HEDIS MY 2023 MI Health Link statewide average, indicating that some members were not receiving timely follow-up care for mental illness after an ED visit. Research suggests that patients with mental disorders are among the highest users

of ED services, with visits characterized by long lengths of stay, intensive treatment, and elevated rates of hospitalizations. After discharge, fewer than half of these patients successfully transition to outpatient care, with high rates of readmission to the ED. Programs that allow patients with mental disorders to successfully engage with outpatient care hold the potential not only to improve quality and outcomes of care for people with mental disorders, but also to free capacity within EDs to provide care for other urgent needs.<sup>40</sup> [Quality, Timeliness, and Access]

**Why the weakness exists:** The rate for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* measure indicator decreasing by more than 12 percentage points and falling below the HEDIS MY 2023 MI Health Link statewide average suggests that barriers exist for some members to receive follow-up care for mental illness after an ED visit.

**Recommendation:** HSAG recommends that **HCS** conduct a root cause analysis or focused study to determine why some members were not receiving follow-up care for mental illness after an ED visit. Upon identification of a root cause, **HCS** should implement appropriate interventions to improve the performance related to the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* measure indicator. **HCS** should consider the nature and scope of the issue (e.g., whether the issue is related to barriers such as a lack of patient and provider education or staffing shortages).

## Compliance Review

### Performance Results

Table 3-43 presents an overview of the results of the SFY 2022 and SFY 2023 compliance reviews for **HCS**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. If a requirement was not applicable to **HCS** during the period covered by the review, HSAG used a *Not Applicable (NA)* designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 14 standards.

**Table 3-43—Summary of Standard Compliance Scores**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			<i>M</i>	<i>NM</i>	<i>NA</i>	
Standard I—Disenrollment: Requirements and Limitations	9	6	6	0	3	<b>100%</b>
Standard II—Member Rights and Member Information	23	23	14	9	0	<b>61%</b>
Standard III—Emergency and Poststabilization Services	13	13	13	0	0	<b>100%</b>

<sup>40</sup> National Institutes of Health-National Library of Medicine. Druss B, Lally CA, Li J, et al. Comparing Two Ways to Help Patients Get Follow-up Care after a Mental Health Visit to the Emergency Room—The EPIC Study [Internet]. Washington (DC): Patient-Centered Outcomes Research Institute (PCORI); 2021 May. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK601636/> doi: 10.25302/05.2021.IHS.151032431. Accessed on: Mar 7, 2025.

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			<i>M</i>	<i>NM</i>	<i>NA</i>	
Standard IV—Availability of Services	13	13	13	0	0	100%
Standard V—Assurances of Adequate Capacity and Services	4	4	3	1	0	75%
Standard VI—Coordination and Continuity of Care	31	30	24	6	1	80%
Standard VII—Coverage and Authorization of Services	28	28	24	4	0	86%
Standard VIII—Provider Selection	23	23	20	3	0	87%
Standard IX—Confidentiality	11	11	10	1	0	91%
Standard X—Grievance and Appeal Systems	45	45	35	10	0	78%
Standard XI—Subcontractual Relationships and Delegation	6	5	4	1	1	80%
Standard XII—Practice Guidelines	6	6	6	0	0	100%
Standard XIII—Health Information Systems <sup>1</sup>	9	9	9	0	0	100%
Standard XIV—Quality Assessment and Performance Improvement Program	21	21	19	2	0	90%
<b>Total</b>	<b>242</b>	<b>237</b>	<b>200</b>	<b>37</b>	<b>5</b>	<b>84%</b>

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

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

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

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

<sup>1</sup> This standard includes a comprehensive assessment of the ICO's IS capabilities.

## Review of Corrective Action Plan Implementation

Based on the findings of the SFY 2022 and SFY 2023 compliance review activities, **HCS** was required to develop and submit a CAP for each element assigned a score of *Not Met*. MDHHS and HSAG reviewed the CAP for sufficiency, and **HCS** was responsible for implementing each action plan in a timely manner. Table 3-44 presents an overview of the results of the SFY 2024 compliance review for **HCS** which consisted of a comprehensive review of the ICO's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Section 2.



**Table 3-44—Summary of CAP Implementation**

Standard	Total CAP Elements	# of CAP Elements Complete	# of CAP Elements Not Complete
Standard II—Member Rights and Member Information	9	8	1
Standard V—Assurances of Adequate Capacity and Services	1	1	0
Standard VI—Coordination and Continuity of Care	6	6	0
Standard VII—Coverage and Authorization of Services	4	4	0
Standard VIII—Provider Selection	3	2	1
Standard IX—Confidentiality	1	1	0
Standard X—Grievance and Appeal Systems	10	6	4
Standard XI—Subcontractual Relationships and Delegation	1	1	0
Standard XIV—Quality Assessment and Performance Improvement Program	2	2	0
<b>Total</b>	<b>37</b>	<b>31</b>	<b>6</b>

**Total CAP Elements:** The total number of elements within each standard that required a CAP during the SFY 2022 and SFY 2023 compliance review activities.

**# of CAP Elements Complete:** The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirements under review.

**# of CAP Elements Not Complete:** The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirements under review.

<sup>1</sup>This standard includes a comprehensive assessment of the ICO's IS capabilities.

### ***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** demonstrated that it successfully remediated 31 of 37 elements, indicating the necessary policies, procedures, and initiatives were implemented to ensure compliance with the Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Confidentiality, Subcontractual Relationships and Delegation, and Quality Assessment and Performance Improvement Program. [**Quality, Timeliness, and Access**]

#### **Weaknesses and Recommendations**

**Weakness #1: HCS** did not remediate one element for the Member Rights and Member Information, one element for the Provider Selection standard, and four elements for the Grievance



and Appeal Systems standard, indicating continued gaps in the ICO's processes within these program areas. [Quality, Timeliness, and Access]

**Why the weakness exists:** HCS' member handbook did not include the structure and operation of the ICO's physician incentive program. Additionally, the recredentialing case examples provided by the ICO did not contain evidence that the delegated entities performing credentialing functions on behalf of the ICO reviewed utilization management (UM) information, member satisfaction surveys, or performance indicators obtained through the QIP during the recredentialing process. Further, HCS demonstrated several opportunities for improvement in the processing of member grievances and appeals specific to the acknowledgement and resolution of grievances, obtaining written consent of the member for a provider to file an appeal on the member's behalf, and the acknowledgement of member appeals.

**Recommendation:** HSAG required HCS to participate in a mandatory technical assistance meeting with MDHHS and HSAG to further discuss the requirements, expectations, and appropriate action plans to bring the elements into compliance. HCS was also required to update its existing CAPs and applicable action plans to align with the expectations addressed during the technical assistance meeting, and subsequently follow MDHHS' and HSAG's direction and implement timely interventions to fully remediate the remaining action plans. As HCS' updated action plans were approved by MDHHS and HSAG, HSAG recommends that the ICO conduct an internal audit to verify its action plans were successful in remediating the deficiencies.

## Network Adequacy Validation

### Network Adequacy Analysis

#### Performance Results

#### ISCA Findings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if HCS' interpretation of data was accurate. Table 3-45 summarizes HSAG's validation ratings for HCS, by indicator type.

**Table 3-45—Summary of HCS' Validation Ratings**

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Time and Distance	100%	0%	0%	0%
Provider Capacity	100%	0%	0%	0%

Of the network adequacy indicators assessed, HCS received *High Confidence* for both time and distance and provider capacity indicator types.

### Analytic Findings

**HCS** submitted its SFY 2024 region-specific member and Medicaid provider data files, and exception requests to HSAG on April 29, 2024. Based on HSAG’s detailed file review findings communicated to **HCS** on June 18, 2024, HSAG asked **HCS** to resubmit its network data files for all regions to address identified data issues. **HCS** resubmitted its region-specific network data files to HSAG on June 26, 2024, and HSAG’s NAV results indicated that **HCS** met all Medicaid and LTSS minimum network standards for Region 7 and Region 9.

Table 3-46 presents **HCS**’ region-specific NAV results by Medicaid and LTSS provider category following all data resubmissions and MDHHS’ exception determinations.

**Table 3-46—SFY 2024 NAV Results for HCS by Region and Provider Category**

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

Provider Category	Region 7 Validation Result	Region 9 Validation Result
Personal Emergency Response System	Met	Met
Preventive Nursing Services	Met	Met
Private Duty Nursing	Met	Met
Respite	Met	Met
Skilled Nursing Home	Met	Met
<b>Percent of Total Standards Met</b>	<b>100%</b>	<b>100%</b>

### ***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 demonstrated the ability to maintain accurate and complete provider information through its quarterly directory validation process. [Access]

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

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

#### **Weaknesses and Recommendations**

**Weakness #1:** HSAG identified no specific opportunities related to the time and distance or provider capacity network standards for HCS based on the SFY 2024 NAV results. [Access]

**Why the weakness exists:** NA

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

## Network Validation Survey

### Performance Results

HSAG performed a comparison of the provider data submitted to HSAG by **HCS** against **HCS**' online directory. The sample included 332 providers (Table 3-47). Among this sample, 85.2 percent were located in the online directory at the sampled location, while 1.8 percent of providers were found in the directory but not at the sampled location. Additionally, 13.0 percent of the providers could not be located in **HCS**' online directory.

Table 3-47 summarizes findings by region, regarding the number of sampled providers and provider locations (i.e., "cases") that HSAG's reviewers were able to locate in the ICO's online provider directory.

**Table 3-47—Summary of Sampled Dental Providers Located in Online Provider Directory**

Region	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 (%)	Count	Rate (%)	Count	Rate (%)
Region 7	163	20	12.3%	2	1.2%	141	86.5%
Region 9	169	23	13.6%	4	2.4%	142	84.0%
<b>HCS Total</b>	<b>332</b>	<b>43</b>	<b>13.0%</b>	<b>6</b>	<b>1.8%</b>	<b>283</b>	<b>85.2%</b>
<b>All ICOs Total</b>	<b>1,179</b>	<b>73</b>	<b>6.2%</b>	<b>18</b>	<b>1.5%</b>	<b>1,088</b>	<b>92.3%</b>

Table 3-48 displays the total number and percent of cases, by region, with matched data values for indicators that were reviewed in the comparison between all ICOs and **HCS**' submitted provider data and **HCS**' online directory.

**Table 3-48—PDV Study Indicator Match Rates\***

Indicator	Region 7		Region 9		HCS Total		All ICOs Total	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Provider's Name	143	100%	146	100%	<b>289</b>	<b>100%</b>	<b>1,106</b>	<b>100%</b>
Provider Street Address	141	98.6%	140	95.9%	<b>281</b>	<b>97.2%</b>	<b>1,052</b>	<b>95.1%</b>
Provider Suite Number	143	100%	143	97.9%	<b>286</b>	<b>99.0%</b>	<b>1,069</b>	<b>96.7%</b>
Provider City	142	99.3%	142	97.3%	<b>284</b>	<b>98.3%</b>	<b>1,089</b>	<b>98.5%</b>
Provider State	143	100%	146	100%	<b>289</b>	<b>100%</b>	<b>1,106</b>	<b>100%</b>

Indicator	Region 7		Region 9		HCS Total		All ICOs Total	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Provider ZIP Code	142	99.3%	142	97.3%	284	98.3%	1,090	98.6%
Provider Telephone Number	140	97.9%	142	97.3%	282	97.6%	1,077	97.4%
Provider Type/Specialty	143	100%	146	100%	289	100%	1,106	100%
Provider Accepting New Patients**	142	99.3%	145	99.3%	287	99.3%	1,068	99.4%
Provider Gender	143	100%	146	100%	289	100%	1,077	97.4%

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

\*\* New patient information was not listed in the online directory for specific ICOs and could only be confirmed by contacting the provider's office. New patient acceptance match rates include an exact match or not listed in the online directory. Caution should be exercised when interpreting the new patient acceptance match rates.

HSAG attempted to contact 280 sampled provider locations for **HCS**, with an overall response rate of 88.6 percent. Table 3-49 summarizes the survey response rates for all ICOs and for **HCS**, by region.

**Table 3-49—Secret Shopper Survey Response Rates, by Region**

Region	Total Survey Cases <sup>1</sup>	Cases Reached <sup>2</sup>	Response Rate (%)
Region 7	139	126	90.6%
Region 9	141	122	86.5%
<b>HCS Total</b>	<b>280</b>	<b>248</b>	<b>88.6%</b>
<b>All ICOs Total</b>	<b>1,068</b>	<b>945</b>	<b>88.5%</b>

<sup>1</sup> Total survey 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).

<sup>2</sup> Cases reached includes cases that responded to the survey, confirmed the location, and offered the requested service.

Table 3-50 summarizes the acceptance rates for the requested insurance and new patients for all ICOs and for **HCS**, by region.

**Table 3-50—Requested Insurance and New Patient Acceptance Rates, by Region**

Region	Cases Accepting Insurance <sup>1,2</sup>		Accepting New Patients <sup>1</sup>	
	Count	Rate (%)	Count	Rate (%)
Region 7	99	78.6%	97	77.0%
Region 9	83	68.0%	83	68.0%

Region	Cases Accepting Insurance <sup>1,2</sup>		Accepting New Patients <sup>1</sup>	
	Count	Rate (%)	Count	Rate (%)
<b>HCS Total</b>	<b>182</b>	<b>73.4%</b>	<b>180</b>	<b>72.6%</b>
<b>All ICOs Total</b>	<b>660</b>	<b>69.8%</b>	<b>645</b>	<b>68.3%</b>

<sup>1</sup> The denominator includes cases reached.

<sup>2</sup> Insurance acceptance includes offices that accepted the requested ICO, affiliated DBA, or MI Health Link program.

Table 3-51 displays the number of survey respondents who offered appointments to new patients for routine dental care (i.e., dental cleaning) for all ICOs and **HCS**, by region.

**Table 3-51—New Patient Appointment Availability Results, by Region**

Region	Cases Reached	Cases Offered an Appointment	
		Count	Rate (%)
Region 7	126	96	76.2%
Region 9	122	83	68.0%
<b>HCS Total</b>	<b>248</b>	<b>179</b>	<b>72.2%</b>
<b>All ICOs Total</b>	<b>945</b>	<b>589</b>	<b>62.3%</b>

Table 3-52 displays the new patient wait time statistics for all ICOs and **HCS**, by region.

**Table 3-52—New Patient Appointment Wait Time Results, by Region**

Region	Appointment Wait Time (Calendar Days)				Percent of Cases Within Standard <sup>1,2</sup>
	Min	Max	Average	Median	
Region 7	1	180	28	14	86.5%
Region 9	0	180	24	7	86.7%
<b>HCS Total</b>	<b>0</b>	<b>180</b>	<b>26</b>	<b>11</b>	<b>86.6%</b>
<b>All ICOs Total</b>	<b>0</b>	<b>321</b>	<b>32</b>	<b>13</b>	<b>83.5%</b>

<sup>1</sup> The denominator includes cases that offered an appointment.

<sup>2</sup> Percent of Cases Within Standard represents cases that offered an appointment that is compliant with MDHHS' standard for an initial dental appointment (i.e., appointments offered within eight weeks or 56 calendar days).

### ***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 the online provider directory, all indicators had a match rate above 95.0 percent. [Access]

## Weaknesses and Recommendations

**Weakness #1:** Reviewers located 87.0 percent of the sampled providers in HCS' online provider directory.

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

**Recommendation:** HSAG recommends that HCS 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. In addition, as MDHHS required HCS to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.

**Weakness #2:** Overall, 88.6 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, HCS' data included inaccurate provider information.

**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 and educate provider offices on the MI Health Link program.

**Weakness #3:** Of the sampled provider locations reached, 73.4 percent accepted the insurance, and 72.6 percent accepted new patients. [Quality and Access]

**Why the weakness exists:** HCS' provider data included inaccurate information about acceptance of the insurance and new patients.

**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 #4:** Among the responsive cases, 72.2 percent of locations offered an appointment date. Of the cases that offered an appointment, 86.6 percent were compliant with the appointment wait time standard for routine dental visits (i.e., within eight weeks or 56 calendar days). [Timeliness and 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 service records and IICSP documentation for sampled members from their contracted providers, based on the final sample list provided by HSAG. These documents covered services that occurred during the review period. HSAG reviewed **HCS**' procured service records to evaluate the completeness and accuracy of encounter data by examining key data elements, such as *Date of Service*, *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Units*, as applicable. For personal care services, HSAG also reviewed the associated IICSP documents submitted by **HCS** to ensure that the services reported in the encounters were supported by the members' service plans. This review confirmed alignment with authorization dates, scheduled services, units of service, and service providers.

Table 3-53 outlines the key findings for **HCS** based on the assessment of encounter data completeness and accuracy conducted through a review of members' service records and the IICSP documents for services rendered from October 1, 2022, through September 30, 2023.

**Table 3-53—EDV Results for HCS**

Analysis	Key Findings
<b>Record Procurement Status</b>	
Service Record Procurement Rate	<ul style="list-style-type: none"> <li>The overall service record procurement rate was at <b>96.8 percent</b>, indicating that most of the requested records were procured and submitted.</li> <li>Of the service records not submitted, <b>92.3 percent</b> were not submitted due to non-responsive providers or provider did not respond in a timely manner.</li> <li>Submission rates varied across different service categories within <b>HCS</b>, ranging from <b>95.2 percent</b> (i.e., Vision) to <b>100 percent</b> (i.e., Hearing, NEMT, and Personal Care Service).</li> </ul>
Second Date of Service Submission Rate	<ul style="list-style-type: none"> <li>Among the procured service records, <b>35.8 percent</b> included a corresponding second date of service. The submission rates for a second date of service varied across different service categories within <b>HCS</b>, ranging from <b>2.5 percent</b> (i.e., Vision) to <b>100 percent</b> (i.e., Hearing).</li> </ul>

Analysis	Key Findings
IICSP Document Procurement Rate	<ul style="list-style-type: none"> <li>Only 86.6 percent of the requested IICSP documents were successfully submitted for review.</li> </ul>
<b>Encounter Data Completeness</b>	
Service Record Omission Rate	<ul style="list-style-type: none"> <li>The overall service record omission rate for the <i>Date of Service</i> data element was at <b>4.3 percent</b>. Rates varied by service category, ranging from <b>0 percent</b> (i.e., Hearing) to <b>8.3 percent</b> (i.e., Vision).</li> <li>The overall service record omission rate for the <i>Diagnosis Code</i> data element was high at <b>16.3 percent</b>, with variations across service categories, ranging from <b>0 percent</b> (i.e., Hearing) to <b>22.1 percent</b> (i.e., Vision).</li> <li>The overall service record omission rate for the <i>Procedure Code</i> data element was relatively high at <b>10.3 percent</b>. Rates varied by service category, ranging from <b>0.7 percent</b> (i.e., Personal Care Service) to <b>33.3 percent</b> (i.e., Hearing).</li> <li>There were no procedure code modifiers present in the encounter data; therefore, there were no service record omission rates to report for the <i>Procedure Code Modifier</i> data element.</li> <li>The service record omission rate for the <i>Units</i> data element was high at <b>32.6 percent</b> for NEMT.</li> <li>Higher rates of service record omission suggest that the data elements in the encounter data were not adequately supported by the members' service records.</li> </ul>
Encounter Data Omission Rate	<ul style="list-style-type: none"> <li>Across all key data elements, encounter data omission rates were low, with the <i>Date of Service</i> data element having the highest encounter data omission rate at <b>3.7 percent</b>.</li> </ul>
<b>Encounter Data Accuracy</b>	
Diagnosis Code Rate	<ul style="list-style-type: none"> <li>The <i>Diagnosis Code</i> data element was accurate in <b>98.8 percent</b> of instances where diagnosis codes were present in both the service records and encounter data, with all errors attributed to inaccurate coding.</li> <li>The accuracy rate for Vision was at <b>95.5 percent</b>, while Hearing and Personal Care Service reached 100 percent accuracy for diagnosis codes.</li> </ul>
Procedure Code Rate	<ul style="list-style-type: none"> <li>The <i>Procedure Code</i> data element was accurate in <b>99.2 percent</b> of instances where procedure codes were present in both the service records and encounter data.</li> <li>The accuracy rate for Dental was at <b>98.8 percent</b>, while all other service categories reached 100 percent accuracy for procedure codes.</li> </ul>
Procedure Code Modifier Rate	<ul style="list-style-type: none"> <li>There were no procedure code modifiers present in both the encounter data and the service record; therefore, there was no accuracy rate to report for the <i>Procedure Code Modifier</i> data element.</li> </ul>

Analysis	Key Findings
Units Rate	<ul style="list-style-type: none"> <li>The <i>Units</i> data element was accurate in <b>58.6 percent</b> of instances where units were present in both the service records and encounter data.</li> </ul>
All-Element Rate	<ul style="list-style-type: none"> <li>Dates of service with accurate values for all key data elements relevant to their respective service categories (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, <i>Procedure Code Modifier</i>, and <i>Units</i>) were observed in <b>80.5 percent</b> of the dates of service present in both data sources (i.e., encounter data and service records).</li> </ul>
<b>IICSP Review</b>	
Document Review	<ul style="list-style-type: none"> <li>The percentage of valid IICSP documents submission was low at <b>85.4 percent</b>.</li> <li>The percentage of valid IICSP documents with proper signatures was low at <b>44.3 percent</b>, which largely prevented the assessment of subsequent items requiring signature verification.</li> <li>IICSPs with proper signatures, consistently demonstrated strong alignment with the service records.</li> </ul>

### 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:** When the *Diagnosis Code* and *Procedure Code* data elements were present in both the encounter data and the members' service records and were evaluated independently across all service categories, the data element values demonstrated high accuracy with rates of at least 98.8 percent. [Quality]

**Strength #2:** The diagnosis codes, procedure codes, and units documented in the service records were mostly reflected in the encounter data, as evidenced by the relatively low encounter data omission rates. [Quality]

#### Weaknesses and Recommendations

**Weakness #1:** Approximately 16.3 percent, 10.3 percent, and 32.6 percent of the *Diagnosis Code*, *Procedure Code*, and *Units* data elements, respectively, in the encounter data were not supported by the members' service records (i.e., service record omission). For NEMT, the accuracy rate for the *Units* data element was particularly low, at 58.6 percent. [Quality]

**Why the weakness exists:** The findings where encounter data are not supported by the members' service records can stem from several potential reasons, which can involve provider documentation

practices (e.g., incomplete or inaccurate documentation, coding errors, insufficient detail in the service records), data submission (e.g., incorrect coding during data submission, data entry errors, or inconsistencies in submitted claims), or processing issues (e.g., data mapping, translation issues, or transmission that result in discrepancies between encounter data and service records).

**Recommendation:** HCS should investigate the root causes of these omissions and consider performing periodic service record reviews of submitted claims to verify appropriate coding and data completeness, where appropriate. Findings from these reviews should be used to inform targeted education and training initiatives for providers. These initiatives should focus on encounter data submission practices, comprehensive and accurate documentation of members' service records, and adherence to accurate coding practices to reduce future discrepancies.

**Weakness #2:** The submitted documentation for the members' IICSP was incomplete, with only 85.4 percent of valid IICSP document submissions. Furthermore, required signatures were missing from approximately 55.7 percent of those valid IICSP documents. Signatures are essential to validate that the IICSP has been reviewed, approved, and agreed upon by the appropriate parties, in accordance with regulatory and contractual requirements. [Quality]

**Why the weakness exists:** The low submission rate of valid IICSP documents and absence of signatures highlights potential gaps in compliance with documentation standards and raises concerns about validating care coordination efforts. It may also impact the ability to demonstrate member or provider agreement with the outlined care plan, which is essential for ensuring accountability and alignment with care objectives.

**Recommendation:** HCS should take proactive steps to enhance its oversight and management of the IICSP document submission process to improve both the validity and the completion rates of submitted documents. This involves clearly defining and communicating the criteria for valid IICSP documents to all providers and ensuring that these guidelines are easily accessible and understood. HCS should also ensure that all IICSP documentation includes the required signatures prior to providing or sharing the members' documentation with the relevant stakeholders. To achieve this, HCS should implement robust internal quality assurance processes to review and verify that all documentation is complete and compliant with applicable guidelines prior to submission. Additionally, HCS should provide targeted education and training for providers to emphasize the importance of obtaining signatures and maintaining accurate, complete documentation. These efforts will enhance compliance with regulatory and contractual requirements while improving the overall integrity and accountability of care coordination documentation.

## Consumer Assessment of Healthcare Providers and Systems Analysis

### Performance Results

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

### Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the HCBS 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 finding did not determine significant impact to the quality, timeliness, and/or accessibility of care.

### Strengths

**Strength #1:** As **HCS**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis indicated that the 2024 top-box score for *Rating of Personal Assistance and Behavioral Health Staff* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark **[Quality]**

**Strength #2:** As **HCS**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis indicated that the 2024 top-box score for *Rating of Case Manager* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. **[Quality]**

**Strength #3:** As **HCS**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis indicated that the 2024 top-box score for *Helpful Case Manager* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. **[Quality]**

**Strength #4:** As **HCS**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis indicated that the 2024 top-box score for *Personal Safety and Respect* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. **[Quality]**

**Strength #5:** As **HCS**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis indicated that the 2024 top-box score for *Planning Your Time and Activities* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. **[Access]**

## Weaknesses and Recommendations

**Weakness #1:** As **HCS**-specific results were not available due to low response rates, no substantial weaknesses could be presented at the individual ICO level. However, program level results identified that while the 2024 top-box score for *Planning Your Time and Activities* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark, it was the lowest performing measure with a 2024 top-box score of 64.14 percent. This composite measure indicates there are opportunities to promote community inclusion and empowerment, as some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day. [Access]

**Why the weakness exists:** The program level results indicate there are opportunities for the MI Health Link program to help members with community inclusion and empowerment opportunities.

**Recommendation:** **HCS** has reported partnering with community-based organizations to target performance of *Planning Your Time and Activities*. HSAG recommends that **HCS** continue add measures of effectiveness of the interventions as appropriate. Further, HSAG recommends that **HCS** focus on barriers such as transportation or other social determinants of health. In addition, HSAG recommends that **HCS** collect regular feedback throughout the year to identify member input and feedback through town halls, focus groups, and short surveys. HSAG further recommends that **HCS** ensure member demographic information is correct to improve response rates.

## 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 that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **HCS**' overall performance contributed to the MI Health Link program's progress in achieving the CQS goals and objectives. Table 3-54 displays each MDHHS CQS goal and the EQR activity results that indicate whether the ICO positively (✓), negatively (✗), or minimally (m) impacted the MI Health Link program'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 if a CQS goal did not include any quality measures for the MI Health Link program or the EQR activities do not produce data to assess the impact of a quality measure(s) under an objective.

**Table 3-54—Overall Performance Impact to CQS and Quality, Timeliness, and Access**

Objective	Quality Measure	Overall Performance Impact	Performance Domain
<b>Goal #1: Ensure high quality and high levels of access to care</b>			
1.1	<i>MI7.3 Annual Dental Visit</i>	✗	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	<i>FUH—Follow-Up After Hospitalization for Mental Illness (30 Days)</i>	✓	
	<i>COL—Colorectal Cancer Screening</i>	m	
1.2	<i>CBP—Controlling High Blood Pressure</i>	✓	
	<i>PCR—Plan All-Cause Readmission</i>	✗ <sup>1</sup>	
	<i>COL—Colorectal Cancer Screening</i>	m	
1.3	<i>Annual Flu Vaccine</i>	NA	
	<i>MI5.6 Medication Review—All Populations</i>	✗	
	<i>TRC—Transitions of Care—Medication Reconciliation Post-Discharge</i>	m	
	<i>PM13 Number and percent of enrollees whose IICSP addressed their assessed health and safety risks (HCBS C-Waiver population)</i>	NA	
	<i>PM15 Number &amp; percent of enrollees with an individualized contingency/back-up plan addressing caregiver absences, severe weather, fire/other emergencies (HCBS C-Waiver population)</i>	NA	
	<i>PM24 Number and percent of files that show enrollee/family/legal guardians (as appropriate) received information and education on how to report abuse, neglect, exploitation, and other critical incidents within 60 days of waiver enrollment.</i>	NA	



Objective	Quality Measure	Overall Performance Impact	Performance Domain
Goal #2: Strengthen person and family-centered approaches			
2.1	MI2.3 Members with documented discussions of care goals	NA	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	Core 9.3 Minimizing Facility Length of Stay—Ratio of Observed to Expected Discharge Rates	✓	
	PM17 Number and percent of enrollee IICSPs that are updated as the enrollee's needs change	NA	
2.2	SNS-E Social Needs Screening & Intervention	NA	
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)			
3.1	FUH—Follow-Up After Hospitalization for Mental Illness (30 Days)	✓	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
3.2	MI2.6 Timely transmission of care transition record to health care professional	✗	
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes			
4.1	HCS—Reducing Controlling Blood Pressure Disparity Between Black/African American and White/Caucasian Members	✓ <sup>2</sup>	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
Goal #5: Improve quality outcomes through value-based initiatives and payment reform			
5.1	The CQS not does include quality measures for the MI Health Link Program under Goal #5.	NA	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access

✓ = The ICO's rate met the 2026 statewide performance target

m = The ICO's rate did not meet the 2026 statewide performance target, or the ICO's HEDIS rate did not meet the 2026 statewide performance target but the ICO's HEDIS rate increased in performance from the prior year

✗ = The ICO's rate did not meet the 2026 statewide performance target and/or the ICO's HEDIS 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 or the CQS did not include any quality measures for the MI Health Link program.

<sup>1</sup> The CQS did not identify the age stratification associated with the quality measure; therefore, HSAG used the 65+ stratification rate for the assessment.

<sup>2</sup> Evaluation of this quality measure used the results of the QIP activity and not the HEDIS rate reported under the PMV activity. While the disparity was not eliminated, the ICO demonstrated statistically significant improvement over the baseline performance for the disparate population during second remeasurement period.

## MeridianComplete

### Validation of Quality Improvement Projects

#### Performance Results

HSAG's validation evaluated the technical methods of **MER's** QIP, including an evaluation of statistically significant improvement based on reported results and statistical testing (i.e., the QIP 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 QIP and Validation Rating 2 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence that the QIP achieved significant improvement. Table 3-55 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 3-55—Overall Validation Rating for MER**

QIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
Addressing Race and Ethnic Health Disparities: Statin Therapy for Patients With Diabetes	High Confidence	No Confidence	HEDIS SPD adherence performance—African-American/Black population—all regions.	74.2%	75.0% ⇔	75.8% ⇔	Yes
			HEDIS SPD adherence performance—White population—all regions.	85.8%	82.5% ⇔	83.2% ⇔	

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  $\geq 0.05$ ).

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

The goals for **MER's** QIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African American/Black) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White). Table 3-56 displays the barriers identified through quality improvement and causal/barrier analysis processes and the interventions initiated by the ICO to support achievement of the QIP goals and address the barriers.

**Table 3-56—Remeasurement 2 Barriers and Interventions for MER**

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

### ***Strengths, Weaknesses, and Recommendations***

Through the EQR, HSAG assessed the QIP 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 quality improvement tools to conduct a causal/barrier analysis and prioritize the identified barriers, and interventions were implemented in a timely manner. [Quality and Timeliness]

## Weaknesses and Recommendations

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

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

**Recommendation:** HSAG recommends **MER** revisit its causal/barrier analysis to determine whether any new barriers exist for both the disparate and comparison subgroups that require the development of targeted strategies to improve performance.

## Performance Measure Validation

### Performance Results

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

**MER** received a measure designation of *Reportable (R)* for all measures, signifying that **MER** had reported the measures in compliance with the MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements and that rates could be reported. Table 3-57 includes the validation designation for each performance measure as well as the validated SFY 2024 performance measure rates.

**Table 3-57—Measure-Specific Validation Designation for MER**

Performance Measure	Validation Designation	SFY 2024 Rate
<b>Core Measure 9.3:</b> <i>Minimizing Facility Length of Stay</i>	<b>REPORTABLE (R)</b> The ICO reported this measure in alignment with the MMP Core Reporting Requirements.	1.59*
<b>MI2.6:</b> <i>Timely Transmission of Care Transition Record to Health Care Professional</i>	<b>REPORTABLE (R)</b> The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.	49.15%

Performance Measure	Validation Designation	SFY 2024 Rate
<b>MI5.6: Care for Adults—Medication Review</b>	<b>REPORTABLE (R)</b> The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.	91.73%
<b>MI7.3: Annual Dental Visit</b>	<b>REPORTABLE (R)</b> The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.	23.37%

\*Please note for Core Measure 9.3 that the SFY 2024 rate is reflective of the ICO's calculated ratio of observed to expected discharges (O/E ratio) rather than a calculated percentage rate, as is reflected for MI2.6, MI5.6, and MI7.3.

### Performance Measure Rates

Table 3-58 shows each of **MER**'s audited HEDIS measures, rates for HEDIS MY 2022 and HEDIS MY 2023 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2023 with HEDIS MY 2022, and the HEDIS MY 2022 and HEDIS MY 2023 MI Health Link statewide average performance rates. HEDIS MY 2022 and HEDIS MY 2023 measure rates performing better than the MY 2022 and MY 2023 statewide averages are notated by green font.

**Table 3-58—Measure-Specific Percentage Rates for MER**

HEDIS Measure	HEDIS MY 2022 (%)	HEDIS MY 2023 (%)	HEDIS MY 2022 vs. MY 2023	MY 2022 Statewide Average (%)	MY 2023 Statewide Average (%)
<b>Prevention and Screening</b>					
<i>BCS-E—Breast Cancer Screening</i>	55.86	54.57	-1.29	56.70	58.82
<i>COL—Colorectal Cancer Screening<sup>1</sup></i>	58.05	60.05	+2.00	57.59	60.82
<i>COA—Care for Older Adults—Medication Review</i>	66.18	91.97	+25.79	80.41	90.90
<i>COA—Care for Older Adults—Functional Status Assessment</i>	35.04	58.64	+23.60	62.71	70.13
<i>COA—Care for Older Adults—Pain Assessment</i>	64.96	79.08	+14.12	78.04	83.50
<b>Respiratory Conditions</b>					
<i>SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD</i>	20.11	19.78	-0.33	22.01	23.00
<i>PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid</i>	77.51	78.54	+1.03	74.10	74.05
<i>PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator</i>	89.00	89.04	+0.04	88.82	86.81
<b>Cardiovascular Conditions</b>					
<i>CBP—Controlling High Blood Pressure</i>	66.42	66.42	+/-0.00	66.14	68.85
<i>PBH—Persistence of Beta-Blocker Treatment After a Heart Attack<sup>2</sup></i>	—	33.33	—	—	56.36

HEDIS Measure	HEDIS MY 2022 (%)	HEDIS MY 2023 (%)	HEDIS MY 2022 vs. MY 2023	MY 2022 Statewide Average (%)	MY 2023 Statewide Average (%)
<i>SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy</i>	79.01	86.85	+7.84	80.90	85.02
<i>SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%</i>	81.82	82.39	+0.57	79.55	81.48
<b>Diabetes</b>					
<i>HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (&gt;9.0%)*</i>	33.09	23.84	-9.25	34.07	29.00
<i>HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (&lt;8.0%)</i>	58.88	70.07	+11.19	58.51	63.61
<i>EED—Eye Exam for Patients With Diabetes<sup>1</sup></i>	62.04	67.40	+5.36	62.89	65.27
<i>BPD—Blood Pressure Control for Patients With Diabetes</i>	69.83	71.53	+1.70	68.13	70.83
<i>SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy</i>	78.10	75.10	-3.00	76.44	76.91
<i>SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%</i>	79.97	80.51	+0.54	78.95	80.60
<b>Musculoskeletal Conditions</b>					
<i>OMW—Osteoporosis Management in Women Who Had a Fracture</i>	6.25	23.53	+17.28	11.18	20.27
<b>Behavioral Health</b>					
<i>AMM—Antidepressant Medication Management—Effective Acute Phase Treatment<sup>1</sup></i>	72.89	66.98	-5.91	73.66	70.76
<i>AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment<sup>1</sup></i>	59.34	46.70	-12.64	57.94	54.20
<i>FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up</i>	34.00	39.62	+5.62	32.79	31.03
<i>FUH—Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up</i>	58.00	60.38	+2.38	58.91	58.83
<i>FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up</i>	35.71	32.62	-3.09	32.06	29.44
<i>FUM—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up</i>	56.25	45.99	-10.26	54.39	48.27
<b>Medication Management and Care Coordination</b>					
<i>TRC—Transitions of Care—Medication Reconciliation Post-Discharge</i>	38.69	43.31	+4.62	47.59	56.17
<i>TRC—Transitions of Care—Notification of Inpatient Admission</i>	25.79	25.55	-0.24	16.53	24.53
<i>TRC—Transitions of Care—Receipt of Discharge Information</i>	27.74	23.11	-4.63	15.38	19.48
<i>TRC—Transitions of Care—Patient Engagement After Inpatient Discharge</i>	77.62	78.59	+0.97	77.74	79.78

HEDIS Measure	HEDIS MY 2022 (%)	HEDIS MY 2023 (%)	HEDIS MY 2022 vs. MY 2023	MY 2022 Statewide Average (%)	MY 2023 Statewide Average (%)
<b>Overuse/Appropriateness</b>					
<i>PSA—Non-Recommended PSA-Based Screening in Older Men*</i>	21.84	24.73	+2.89	26.71	27.99
<i>DDE—Potentially Harmful Drug-Disease Interactions in Older Adults*</i>	30.61	27.18	-3.43	33.45	33.54
<i>DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid*</i>	15.23	13.41	-1.82	18.16	17.57
<i>DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis*</i>	4.97	5.19	+0.22	5.23	4.99
<i>DAE—Use of High-Risk Medications in Older Adults—Total*</i>	18.79	17.33	-1.46	21.78	21.07
<b>Access/Availability of Care</b>					
<i>AAP—Adults' Access to Preventive/Ambulatory Health Services—20–44 Years</i>	81.80	82.43	+0.63	84.90	85.69
<i>AAP—Adults' Access to Preventive/Ambulatory Health Services—45–64 Years</i>	91.87	92.08	+0.21	93.83	93.71
<i>AAP—Adults' Access to Preventive/Ambulatory Health Services—65 Years and Older</i>	90.42	89.72	-0.70	91.69	91.79
<i>AAP—Adults' Access to Preventive/Ambulatory Health Services—Total</i>	89.12	88.98	-0.14	91.08	91.24
<i>IET—Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total<sup>1</sup></i>	23.20	27.47	+4.27	34.10	35.83
<i>IET—Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total<sup>1</sup></i>	1.59	3.30	+1.71	3.84	4.43
<b>Risk-Adjusted Utilization</b>					
<i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)*</i>	1.03	1.10	+0.07	1.07	1.11
<i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)*</i>	1.02	0.97	-0.05	1.21	1.21

\* Measures for which lower rates indicate better performance.

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

<sup>2</sup> Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between MY 2023 and prior years; therefore, the HEDIS MY 2022 rate and comparison from HEDIS MY 2022 vs. MY 2023 will not be displayed for this measure.

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



## 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** implemented various internal PIPs to focus on root cause barriers, and improving performance and member outcomes for MI2.6, MI5.6, and MI7.3. For MI2.6, **MER** built a custom measure catalog within the QSI XL system for ease and accuracy of measure tracking, and its abstraction team increased abstraction efforts by utilizing QSI-XL to identify facilities discharging members. Admission, Discharge, and Transition (ADT) electronic data feeds were also implemented to improve notification timeliness. For MI5.6, **MER** built a custom measure catalog in QSI-XL and increased abstraction efforts by collecting supplemental data via EHRs, hybrid activities, and fax blasts. **MER**'s abstraction team worked with its corporate partners to implement year-round supplemental data entry in the Quality Companion Action Tool and receive and incorporate supplemental data from the electronic data interchange (EDI). Lastly, for MI7.3, **MER** partnered with its dental vendor to send geocoded letters to members and providers to increase their awareness of benefits, and offered a provider P4P program that included an annual dental visit incentive. **MER**'s various PIP efforts may have had a positive impact on performance for these measures. [Quality, Timeliness, and Access]

**Strength #2:** In the Prevention and Screening domain, **MER**'s rates for the *COA—Care for Older Adults—Medication Review, Functional Status Assessment, and Pain Assessment* measure indicators increased by more than 25 percentage points, 23 percentage points, and 14 percentage points, respectively, and exceeded the HEDIS MY 2023 MI Health Link statewide average for the *COA—Care for Older Adults—Medication Review* measure indicator, suggesting strength and improvement in adult members 66 years and older having medication reviews, functional status assessments, and pain assessments conducted during the measurement year. As people age, their physical and cognitive function can decline, and pain becomes more prevalent. Older adults may have more complex medication regimens. Screening of elderly patients is effective in identifying functional decline.<sup>41</sup> [Quality and Access]

**Strength #3:** In the Cardiovascular Conditions domain, **MER**'s rate for the *SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy* measure indicator increased by more than 7 percentage points from MY 2022 to MY 2023 and exceeded the HEDIS MY 2023 MI Health Link statewide average, suggesting strength and improvement in cardiovascular treatment and prevention for members. Research indicates that statins are the primary treatment choice for cardiovascular diseases, which stand as the leading global cause of mortality. In general, statins are

<sup>41</sup> National Committee for Quality Assurance. Care for Older Adults (COA). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/care-for-older-adults-coa/>. Accessed on: Mar 4, 2025.

considered safe and well-tolerated medications, and are the most commonly prescribed drugs worldwide. They play a role in preventing stroke, improving outcomes in acute coronary syndrome, reducing the risk of atrial fibrillation after heart surgery, and benefiting patients with heart failure.<sup>42</sup> [Quality, Timeliness, and Access]

**Strength #4:** In the Diabetes domain, **MER**'s rate for the *HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* measure indicator increased by more than 11 percentage points from MY 2022 to MY 2023 and exceeded the HEDIS MY 2023 MI Health Link statewide average, suggesting strength and improvement in adult members ages 18 to 75 years with diabetes having controlled HbA1c levels. Diabetes is the eighth leading cause of death in the U.S. and was responsible for approximately 103,294 deaths in 2021. 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.<sup>43</sup> [Quality]

**Strength #5:** In the Diabetes domain, **MER**'s rate for the *EED—Eye Exam for Patients With Diabetes* measure indicator increased by more than 5 percentage points from MY 2022 to MY 2023 and exceeded the HEDIS MY 2023 MI Health Link statewide average, suggesting strength and improvement in adult members ages 18 to 75 years with diabetes having a retinal eye exam performed. Diabetes is the leading cause of new cases of blindness among adults 18–64 years of age. 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.<sup>44</sup> [Quality]

**Strength #6:** In the Musculoskeletal Conditions domain, **MER**'s rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator increased by more than 17 percentage points from MY 2022 to MY 2023 and exceeded the HEDIS MY 2023 MI Health Link statewide average, suggesting strength and improvement in timely screening and treatment of women who suffered a fracture, with either a bone mineral density test or a prescription for a drug to treat osteoporosis. Osteoporosis is a bone disease that develops when bone mineral density and bone mass decrease, or when the quality or structure of bone changes. This can lead to a decrease in bone strength that can increase the risk of fractures. For older adults, the risk of breaking another bone is highest in the year or two after breakage of the first bone. The risk of another fracture can be

<sup>42</sup> National Institutes of Health-National Library of Medicine. Khatiwada N, Hong Z. Potential Benefits and Risks Associated with the Use of Statins. *Pharmaceutics*. 2024 Feb 1;16(2):214. doi: 10.3390/pharmaceutics16020214. PMID: 38399268; PMCID: PMC10892755. Potential Benefits and Risks Associated with the Use of Statins. Available at: <https://pmc.ncbi.nlm.nih.gov/articles/PMC10892755/>. Accessed on: Mar 7, 2025.

<sup>43</sup> 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: Mar 4, 2025.

<sup>44</sup> 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: Mar 3, 2025.

reduced, so it is important to take steps as soon as possible after a fracture to prevent another one.<sup>45</sup> [Quality, Timeliness, and Access]

**Strength #7:** In the Behavioral Health domain, **MER**'s rate for the *FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* measure indicator increased by more than 5 percentage points from MY 2022 to MY 2023 and exceeded the HEDIS MY 2023 MI Health Link statewide average, suggesting strength and improvement in timely follow-up care for mental illness after a hospitalization. Research suggests that patients with mental disorders are among the highest users of ED services, with visits characterized by long lengths of stay, intensive treatment, and elevated rates of hospitalizations. After discharge, fewer than half of these patients successfully transition to outpatient care, with high rates of readmission to the ED. Programs that allow patients with mental disorders to successfully engage with outpatient care hold the potential not only to improve quality and outcomes of care for people with mental disorders, but also to free capacity within EDs to provide care for other urgent needs.<sup>46</sup> [Quality, Timeliness, and Access]

## Weaknesses and Recommendations

**Weakness #1:** It was identified that **MER**'s member-level data submission to HSAG included 599 members for Core Measure 9.3, while the final reported count reported to MDHHS was 600, resulting in resubmission of Core Measure 9.3 data to HPMS. [Quality]

**Why the weakness exists:** During the virtual review, **MER** shared that this was due to retroactivity for one member and that the member's claim was voided due to an error.

**Recommendation:** HSAG recommends that **MER** implement more stringent quality checks and increased frequency of data validation checks prior to submission of its final rates to MDHHS and member-level data to HSAG.

**Weakness #2:** For 21 of the 42 reported HEDIS measures (50 percent), **MER**'s rates indicated worse performance than the statewide average, demonstrating an opportunity for improvement across multiple domains including Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Behavioral Health, Medication Management and Care Coordination, Overuse/Appropriateness, and Access/Availability of Care. [Quality]

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

<sup>45</sup> National Institutes of Health-National Institute of Arthritis and Musculoskeletal and Skin Diseases. Preventing Another Broken Bone. Available at: <https://www.niams.nih.gov/health-topics/preventing-another-broken-bone>. Accessed on: Mar 7, 2025.

<sup>46</sup> National Institutes of Health-National Library of Medicine. Druss B, Lally CA, Li J, et al. Comparing Two Ways to Help Patients Get Follow-up Care after a Mental Health Visit to the Emergency Room—The EPIC Study [Internet]. Washington (DC): Patient-Centered Outcomes Research Institute (PCORI); 2021 May. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK601636/> doi: 10.25302/05.2021.IHS.151032431. Accessed on: Mar 7, 2025.

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

**Weakness #3:** In the Behavioral Health domain, **MER**'s rates for the *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators decreased by more than 5 percentage points and 12 percentage points, respectively, from MY 2022 to MY 2023 and fell below the HEDIS MY 2023 MI Health Link statewide average, indicating that some adults with a diagnosis of major depression, who were newly treated with antidepressant medication, did not remain on antidepressant medication for at least 84 days and 180 days. Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy and self-esteem, and can lead to suicide, the 10th leading cause of death in the United States each year. Depression can cause severe symptoms that affect how a person feels, thinks, and handles daily activities, such as sleeping, eating, or working. Antidepressants are medications commonly used to treat depression. They work by changing how the brain produces or uses certain chemicals involved in mood or stress. Antidepressants take time to work—usually 4–8 weeks—and problems with sleep, appetite, and concentration often improve before mood lifts. Giving a medication a chance to work is important.<sup>47</sup>

[Quality, Timeliness, and Access]

**Why the weakness exists:** The rates for the *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators decreasing by more than 5 percentage points and 12 percentage points, respectively, from MY 2022 to MY 2023 and falling below the HEDIS MY 2023 MI Health Link statewide average suggests that barriers exist for some adult members with a diagnosis of major depression to remain on antidepressant medication.

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

**Weakness #4:** In the Behavioral Health domain, **MER**'s rate for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up* measure indicator decreased by more than 10 percentage points from MY 2022 to MY 2023 and fell below the HEDIS MY 2023 MI Health Link statewide average, indicating that some members were not receiving timely follow-up care for mental illness after an ED visit. Research suggests that patients with mental disorders are among the highest users of ED services, with visits characterized by long lengths of stay, intensive treatment, and elevated rates of hospitalizations. After discharge, fewer than half of these patients

<sup>47</sup> National Institutes of Health-National Institute of Mental Health. Transforming the understanding and treatment of mental illnesses. Available at: [https://www.nimh.nih.gov/health/publications/depression#part\\_6159](https://www.nimh.nih.gov/health/publications/depression#part_6159). Accessed on: Mar 7, 2025.

successfully transition to outpatient care, with high rates of readmission to the ED. Programs that allow patients with mental disorders to successfully engage with outpatient care hold the potential not only to improve quality and outcomes of care for people with mental disorders, but also to free capacity within EDs to provide care for other urgent needs.<sup>48</sup> [Quality, Timeliness, and Access]

**Why the weakness exists:** The rate for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up* measure indicator decreasing by more than 10 percentage points from MY 2022 to MY 2023 and falling below the HEDIS MY 2023 MI Health Link statewide average suggests that barriers exist for some members to receive follow-up care for mental illness after an ED visit.

**Recommendation:** HSAG recommends that **MER** conduct a root cause analysis or focused study to determine why some members were not receiving follow-up care for mental illness after an ED visit. Upon identification of a root cause, **MER** should implement appropriate interventions to improve the performance related to the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up* measure indicator. **MER** should consider the nature and scope of the issue (e.g., whether the issue is related to barriers such as a lack of patient and provider education or staffing shortages).

## Compliance Review

### Performance Results

Table 3-59 presents an overview of the results of the SFY 2022 and SFY 2023 compliance reviews for **MER**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. If a requirement was not applicable to **MER** during the period covered by the review, HSAG used a *Not Applicable (NA)* designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 14 standards.

**Table 3-59—Summary of Standard Compliance Scores**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	NM	NA	
Standard I—Disenrollment: Requirements and Limitations	9	6	6	0	3	100%
Standard II—Member Rights and Member Information	23	23	16	7	0	70%
Standard III—Emergency and Poststabilization Services	13	13	13	0	0	100%
Standard IV—Availability of Services	13	13	13	0	0	100%

<sup>48</sup> National Institutes of Health-National Library of Medicine. Druss B, Lally CA, Li J, et al. Comparing Two Ways to Help Patients Get Follow-up Care after a Mental Health Visit to the Emergency Room—The EPIC Study [Internet]. Washington (DC): Patient-Centered Outcomes Research Institute (PCORI); 2021 May. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK601636/> doi: 10.25302/05.2021.IHS.151032431. Accessed on: Mar 7, 2025.



Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	NM	NA	
Standard V—Assurances of Adequate Capacity and Services	4	4	3	1	0	75%
Standard VI—Coordination and Continuity of Care	31	30	22	8	1	73%
Standard VII—Coverage and Authorization of Services	28	27	21	6	1	78%
Standard VIII—Provider Selection	23	23	20	3	0	87%
Standard IX—Confidentiality	11	11	10	1	0	91%
Standard X—Grievance and Appeal Systems	45	45	35	10	0	78%
Standard XI—Subcontractual Relationships and Delegation	6	5	4	1	1	80%
Standard XII—Practice Guidelines	6	6	5	1	0	83%
Standard XIII—Health Information Systems <sup>1</sup>	9	9	9	0	0	100%
Standard XIV—Quality Assessment and Performance Improvement Program	21	21	20	1	0	95%
<b>Total</b>	<b>242</b>	<b>236</b>	<b>197</b>	<b>39</b>	<b>6</b>	<b>83%</b>

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

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

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

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

<sup>1</sup> This standard includes a comprehensive assessment of the ICO's IS capabilities.

## Review of Corrective Action Plan Implementation

Based on the findings of the SFY 2022 and SFY 2023 compliance review activities, **MER** was required to develop and submit a CAP for each element assigned a score of *Not Met*. MDHHS and HSAG reviewed the CAP for sufficiency, and **MER** was responsible for implementing each action plan in a timely manner. Table 3-60 presents an overview of the results of the SFY 2024 compliance review for **MER**, which consisted of a comprehensive review of the ICO's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Section 2.

**Table 3-60—Summary of CAP Implementation**

Standard	Total CAP Elements	# of CAP Elements Complete	# of CAP Elements Not Complete
Standard II—Member Rights and Member Information	7	7	0
Standard V—Assurances of Adequate Capacity and Services	1	1	0
Standard VI—Coordination and Continuity of Care	8	8	0

Standard	Total CAP Elements	# of CAP Elements Complete	# of CAP Elements Not Complete
Standard VII—Coverage and Authorization of Services	6	6	0
Standard VIII—Provider Selection	3	3	0
Standard IX—Confidentiality	1	1	0
Standard X—Grievance and Appeal Systems	10	8	2
Standard XI—Subcontractual Relationships and Delegation	1	1	0
Standard XII—Practice Guidelines	1	1	0
Standard XIV—Quality Assessment and Performance Improvement Program	1	1	0
<b>Total</b>	<b>39</b>	<b>37</b>	<b>2</b>

**Total CAP Elements:** The total number of elements within each standard that required a CAP during the SFY 2022 and SFY 2023 compliance review activities.

**# of CAP Elements Complete:** The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirements under review.

**# of CAP Elements Not Complete:** The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirements under review.

<sup>1</sup>This standard includes a comprehensive assessment of the ICO's IS capabilities.

### 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** demonstrated that it successfully remediated 37 of 39 elements, indicating the necessary policies, procedures, and initiatives were implemented to ensure compliance with the Member Rights and Member Information, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Confidentiality, Subcontractual Relationships and Delegation, Practice Guidelines, and Quality Assessment and Performance Improvement Program. [Quality, Timeliness, and Access]

#### Weaknesses and Recommendations

**Weakness #1: MER** did not remediate two elements for the Grievance and Appeal Systems standard, indicating continued gaps in the ICO's processes within this program area. [Quality, Timeliness, and Access]



**Why the weakness exists:** **MER** did not provide sufficient evidence to confirm that it conducted adequate staff training to ensure staff are obtaining the member’s written consent when a provider files an appeal on the member’s behalf. Additionally, for one acknowledgement notice, it only included the authorization number and did not specify the name of the service/drug decision being appealed, and for a second acknowledgement notice, **MER** did not use the required MDHHS model notice, and the appeal was not acknowledged until nine calendar days after receipt of the appeal, when the ICO’s policy requires acknowledgement within three calendar days.

**Recommendation:** HSAG required **MER** to participate in a mandatory technical assistance meeting with MDHHS and HSAG to further discuss the requirements, expectations, and appropriate action plans to bring the elements into compliance. **MER** was also required to update its existing CAPs and applicable action plans to align with the expectations addressed during the technical assistance meeting, and subsequently follow MDHHS’ and HSAG’s direction and implement timely interventions to fully remediate the remaining action plans. As **MER**’s updated action plans were approved by MDHHS and HSAG, HSAG recommends that the ICO conduct an internal audit to verify its action plans were successful in remediating the deficiencies.

## Network Adequacy Validation

### Network Adequacy Analysis

#### Performance Results

#### ISCA Findings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if **MER**’s interpretation of data was accurate. Table 3-61 summarizes HSAG’s validation ratings for **MER**, by indicator type.

**Table 3-61—Summary of MER’s Validation Ratings**

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Time and Distance	100%	0%	0%	0%
Provider Capacity	100%	0%	0%	0%

Of the network adequacy indicators assessed, **MER** received *High Confidence* for both time and distance and provider capacity indicator types.

#### Analytic Findings

**MER** submitted its SFY 2024 region-specific member and Medicaid provider data files, and exception requests to HSAG on April 29, 2024. Based on HSAG’s detailed file review findings communicated to **MER** on June 18, 2024, HSAG asked **MER** to resubmit its network data files for all regions to address

identified data issues. **MER** resubmitted its region-specific network data files to HSAG on June 26, 2024, and resubmitted its provider data files for NEMT and Non-Medical Transportation provider categories to HSAG on August 26, 2024. HSAG's NAV results indicated that **MER** met all Medicaid and LTSS minimum network standards for Region 7.

MDHHS did not approve **MER**'s requested exception for the Environmental Modifications network standard in Region 9.

Table 3-62 presents **MER**'s region-specific NAV results by Medicaid and LTSS provider category following all data resubmissions and MDHHS' exception determinations.

**Table 3-62—SFY 2024 NAV Results for MER by Region and Provider Category**

Provider Category	Region 4 Validation Result	Region 7 Validation Result	Region 9 Validation Result
<b>Provider Categories With Travel Time and Distance Standards</b>			
Adult Day Program	Not Met	Met	Met
Dental	Met	Met	Met
Eye Examinations	Met	Met	Met
Eye Wear	Met	Met	Met
Hearing Aids	Not Met	Met	Met
Hearing Examinations	Met	Met	Met
<b>Provider Categories Rendering Home-Based Services</b>			
Adaptive Medical Equipment and Supplies	Met	Met	Met
Assistive Technology—Devices	Met	Met	Met
Assistive Technology—Van Lifts and Tie Downs	Met	Met	Met
Chore Services	Met	Met	Met
ECLS	Met	Met	Met
Environmental Modifications	Met	Met	Not Met
Fiscal Intermediary	Met	Met	Met
Home-Delivered Meals	Met	Met	Met
Medical Supplies	Met	Met	Met
NEMT	Met	Met	Met
Non-Medical Transportation	Met	Met	Met
Personal Care Services	Met	Met	Met
Personal Emergency Response System	Met	Met	Met

Provider Category	Region 4 Validation Result	Region 7 Validation Result	Region 9 Validation Result
Preventive Nursing Services	Met	Met	Met
Private Duty Nursing	Met	Met	Met
Respite	Met	Met	Met
Skilled Nursing Home	Met	Met	Met
<b>Percent of Total Standards Met</b>	<b>91.3%</b>	<b>100%</b>	<b>95.7%</b>

### ***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 the ability to maintain accurate and complete delegated provider data through regular oversight activities. [Access]

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

#### **Weaknesses and Recommendations**

**Weakness #1:** HSAG identified a weakness in Adult Day Program and Hearing Aids provider categories for **MER** in Region 4 based on the SFY 2024 NAV. [Access]

**Why the weakness exists:** **MER** did not meet the minimum network requirements for Adult Day Program and Hearing Aids in Region 4.

**Recommendation:** **MER** should make ongoing efforts to identify and contract with additional Adult Day Program and Hearing Aids providers, with particular attention to portions of Region 4 that were not well-served by these providers, to assure member access and meet standards. Updated compliance for these provider categories in Region 4 will be evaluated during the SFY 2025 NAV.

**Weakness #2:** HSAG identified a weakness in the Environmental Modifications provider category for **MER** in Region 9 based on the SFY 2024 NAV. [Access]

**Why the weakness exists:** **MER** did not meet the minimum network requirement for Environmental Modifications in Region 9. MDHHS did not approve **MER**'s exception request for the Environmental Modifications network standard in Region 9.

**Recommendation:** **MER** should make ongoing efforts to identify and contract with additional Environmental Modifications providers to assure member access and meet standards. Updated compliance for this provider category in Region 9 will be evaluated during the SFY 2025 NAV.

### Network Validation Survey

#### Performance Results

HSAG performed a comparison of the provider data submitted to HSAG by **MER** against **MER**'s online directory. The sample included 386 providers (Table 3-63). Among this sample, 95.9 percent were located in the online directory at the sampled location. Additionally, 4.1 percent of the providers could not be located in **MER**'s online directory.

Table 3-63 summarizes findings by region, regarding the number of sampled providers and provider locations (i.e., "cases") that HSAG's reviewers were able to locate in the ICO's online provider directory.

**Table 3-63—Summary of Sampled Dental Providers Located in Online Provider Directories**

Region	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 (%)	Count	Rate (%)	Count	Rate (%)
Region 4	51	1	2.0%	0	0.0%	50	98.0%
Region 7	165	7	4.2%	0	0.0%	158	95.8%
Region 9	170	8	4.7%	0	0.0%	162	95.3%
<b>MER Total</b>	<b>386</b>	<b>16</b>	<b>4.1%</b>	<b>0</b>	<b>0.0%</b>	<b>370</b>	<b>95.9%</b>
<b>All ICOs Total</b>	<b>1,179</b>	<b>73</b>	<b>6.2%</b>	<b>18</b>	<b>1.5%</b>	<b>1,088</b>	<b>92.3%</b>

Table 3-64 displays the total number and percent of cases, by region, with matched data values for indicators that were reviewed in the comparison between all ICOs and **MER**'s submitted provider data and **MER**'s online provider directory.

**Table 3-64—PDV Study Indicator Match Rates\***

Indicator	Region 4		Region 7		Region 9		MER Total		All ICOs Total	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Provider's Name	50	100%	158	100%	162	100%	<b>370</b>	<b>100%</b>	<b>1,106</b>	<b>100%</b>
Provider Street Address	50	100%	157	99.4%	162	100%	<b>369</b>	<b>99.7%</b>	<b>1,052</b>	<b>95.1%</b>

Indicator	Region 4		Region 7		Region 9		MER Total		All ICOs Total	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Provider Suite Number	50	100%	157	99.4%	162	100%	369	99.7%	1,069	96.7%
Provider City	50	100%	158	100%	162	100%	370	100%	1,089	98.5%
Provider State	50	100%	158	100%	162	100%	370	100%	1,106	100%
Provider ZIP Code	50	100%	158	100%	162	100%	370	100%	1,090	98.6%
Provider Telephone Number	50	100%	157	99.4%	162	100%	369	99.7%	1,077	97.4%
Provider Type/Specialty	50	100%	158	100%	162	100%	370	100%	1,106	100%
Provider Accepting New Patients**	50	100%	158	100%	162	100%	370	100%	1,068	99.4%
Provider Gender	41	82.0%	143	90.5%	159	98.1%	343	92.7%	1,077	97.4%

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

\*\* New patient information was not listed in the online directory for specific ICOs and could only be confirmed by contacting the provider's office. New patient acceptance match rates include an exact match or not listed in the online directory. Caution should be exercised when interpreting the new patient acceptance match rates.

HSAG attempted to contact 369 sampled provider locations for **MER**, with an overall response rate of 90.5 percent. Table 3-65 summarizes the survey response rates for all ICOs and for **MER**, by region.

**Table 3-65—Secret Shopper Survey Response Rates, by Region**

Region	Total Survey Cases <sup>1</sup>	Cases Reached <sup>2</sup>	Response Rate (%)
Region 4	50	40	80.0%
Region 7	157	144	91.7%
Region 9	162	150	92.6%
<b>Meridian Total</b>	<b>369</b>	<b>334</b>	<b>90.5%</b>
<b>All ICOs Total</b>	<b>1,068</b>	<b>945</b>	<b>88.5%</b>

<sup>1</sup> Total survey 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).

<sup>2</sup> Cases reached includes cases that responded to the survey, confirmed the location, and offered the requested service.

Table 3-66 summarizes the acceptance rates for the requested insurance and new patients for all ICOs and for **MER**, by region.

**Table 3-66—Requested Insurance and New Patient Acceptance Rates, by Region**

Region	Cases Accepting Insurance <sup>1,2</sup>		Accepting New Patients <sup>1</sup>	
	Count	Rate (%)	Count	Rate (%)
Region 4	24	60.0%	22	55.0%
Region 7	98	68.1%	94	65.3%
Region 9	81	54.0%	79	52.7%
<b>Meridian Total</b>	<b>203</b>	<b>60.8%</b>	<b>195</b>	<b>58.4%</b>
<b>All ICOs Total</b>	<b>660</b>	<b>69.8%</b>	<b>645</b>	<b>68.3%</b>

<sup>1</sup> The denominator includes cases reached.<sup>2</sup> Insurance acceptance includes offices that accepted the requested ICO, affiliated DBA, or MI Health Link program.

Table 3-67 displays the number of survey respondents who offered appointments to new patients for routine dental care (i.e., dental cleaning) for all ICOs and **MER**, by region.

**Table 3-67—New Patient Appointment Availability Results, by Region**

Region	Cases Reached	Cases Offered an Appointment	
		Count	Rate (%)
Region 4	40	16	40.0%
Region 7	144	87	60.4%
Region 9	150	65	43.3%
<b>Meridian Total</b>	<b>334</b>	<b>168</b>	<b>50.3%</b>
<b>All ICOs Total</b>	<b>945</b>	<b>589</b>	<b>62.3%</b>

Table 3-68 displays the new patient wait time statistics for all ICOs and **MER**, by region.

**Table 3-68—New Patient Appointment Wait Time Results, by Region**

Region	Appointment Wait Time (Calendar Days)	Percent of Cases Within Standard <sup>1,2</sup>			
	Min	Max	Average	Median	
Region 4	22	278	145	175	25.0%
Region 7	0	161	27	13	81.6%
Region 9	1	308	24	7	89.2%
<b>Meridian Total</b>	<b>0</b>	<b>308</b>	<b>37</b>	<b>13</b>	<b>79.2%</b>
<b>All ICOs Total</b>	<b>0</b>	<b>321</b>	<b>32</b>	<b>13</b>	<b>83.5%</b>

<sup>1</sup> The denominator includes cases that offered an appointment.<sup>2</sup> Percent of Cases Within Standard represents cases that offered an appointment that is compliant with MDHHS' standard for an initial dental appointment (i.e., appointments offered within eight weeks or 56 calendar days).

## 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 95.9 percent of the sampled providers in **MER**'s online provider directory. Of the providers located in the online directory, all indicators had a match rate above 95.0 percent. [Access]

**Strength #2:** The response rate for the secret shopper telephone survey was 90.5 percent [Access].

### Weaknesses and Recommendations

**Weakness #1:** Of the cases reached, 60.8 percent of provider locations accepted the insurance, and 58.4 percent accepted new patients. [Quality and Access]

**Why the weakness exists:** **MER**'s data included inaccurate information regarding the provider acceptance of the insurance and new patients.

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

**Weakness #2:** Among the responsive cases, 50.3 percent of locations offered an appointment date, including 40.0 percent in Region 4, 60.4 percent in Region 7, and 43.3 percent in Region 9. Of the cases that offered an appointment, 79.2 percent were compliant with the appointment wait time standard for routine dental visits (i.e., within eight weeks or 56 calendar days), including 25.0 percent compliant in Region 4, 81.6 percent compliant in Region 7, and 89.2 percent compliant in Region 9. [Timeliness and 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. Regional differences in appointment availability were present, with Region 4 and Region 9 having lower appointment rates. In addition, Region 4 had less cases within the standard for an initial dental appointment. However, the number of cases reached for Region 4 was lower at 40 providers, compared to 144 cases in Region 7 and 150 cases in Region 9.



**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 service records and IICSP documentation for sampled members from their contracted providers, based on the final sample list provided by HSAG. These documents covered services that occurred during the review period. HSAG reviewed **MER**'s procured service records to evaluate the completeness and accuracy of encounter data by examining key data elements, such as *Date of Service*, *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Units*, as applicable. For personal care services, HSAG also reviewed the associated IICSP documents submitted by **MER** to ensure that the services reported in the encounters were supported by the members' service plans. This review confirmed alignment with authorization dates, scheduled services, units of service, and service providers.

Table 3-69 outlines the key findings for **MER** based on the assessment of encounter data completeness and accuracy, conducted through a review of members' service records and the IICSP documents for services rendered from October 1, 2022, through September 30, 2023.

**Table 3-69—EDV Results for MER**

Analysis	Key Findings
<b>Record Procurement Status</b>	
Service Record Procurement Rate	<ul style="list-style-type: none"> <li>The overall service record procurement rate was notably low at <b>79.8 percent</b>, indicating that more than 20 percent of the requested records were not procured and submitted.</li> <li>Of the service records not submitted, <b>90.4 percent</b> were not submitted due to non-responsive providers or provider did not respond in a timely manner.</li> <li>Submission rates varied across different service categories within <b>MER</b>, ranging from <b>55.8 percent</b> (i.e., Dental) to <b>99.0 percent</b> (i.e., Personal Care Service).</li> </ul>
Second Date of Service Submission Rate	<ul style="list-style-type: none"> <li>Among the procured service records, <b>30.4 percent</b> included a corresponding second date of service. The submission rates for a second date of service varied across different service categories within <b>MER</b>, ranging from <b>10.1 percent</b> (i.e., Vision) to <b>62.7 percent</b> (i.e., Dental).</li> </ul>
IICSP Document Procurement Rate	<ul style="list-style-type: none"> <li>Only <b>80.0 percent</b> of the requested IICSP documents were successfully submitted for reviewed.</li> </ul>

Analysis	Key Findings
<b>Encounter Data Completeness</b>	
Service Record Omission Rate	<ul style="list-style-type: none"> <li>The overall service record omission rate for the <i>Date of Service</i> data element was high at <b>38.8 percent</b>. Rates varied by service category, ranging from <b>18.2 percent</b> (i.e., Vision) to <b>75.2 percent</b> (i.e., Personal Care Service).</li> <li>The overall service record omission rate for the <i>Diagnosis Code</i> data element was high at <b>35.6 percent</b>, with variations across service categories, ranging from <b>21.5 percent</b> (i.e., Vision) to <b>77.1 percent</b> (i.e., Personal Care Service).</li> <li>The overall service record omission rate for the <i>Procedure Code</i> data element was high at <b>36.9 percent</b>. Rates varied by service category, ranging from <b>21.7 percent</b> (i.e., Vision) to <b>75.2 percent</b> (i.e., Personal Care Service).</li> <li>The overall service record omission rate for the <i>Procedure Code Modifier</i> data element was moderately high at <b>12.8 percent</b>. Rates varied by service category, ranging from <b>0 percent</b> (i.e., Hearing) to <b>100 percent</b> (i.e., Personal Care Service).</li> <li>The service record omission rate for the <i>Units</i> data element was high at <b>39.1 percent</b> for NEMT.</li> <li>Higher rates of service record omission rate suggest that the data elements in the encounter data were not adequately supported by the members' service records.</li> </ul>
Encounter Data Omission Rate	<ul style="list-style-type: none"> <li>The overall encounter data omission rates were relatively low for most key data elements, with the <i>Date of Service</i> data element having the highest encounter data omission rate at <b>13.6 percent</b>.</li> </ul>
<b>Encounter Data Accuracy</b>	
Diagnosis Code Rate	<ul style="list-style-type: none"> <li>The <i>Diagnosis Code</i> data element was accurate in <b>99.6 percent</b> of instances where diagnosis codes were present in both the service records and encounter data, with all errors attributed to inaccurate coding.</li> <li>The accuracy rate for Vision was at <b>99.6 percent</b>, while Hearing and Personal Care Service reached <b>100 percent</b> accuracy for diagnosis codes.</li> </ul>
Procedure Code Rate	<ul style="list-style-type: none"> <li>The <i>Procedure Code</i> data element was accurate in <b>100 percent</b> of instances where procedure codes were present in both the service records and encounter data.</li> </ul>
Procedure Code Modifier Rate	<ul style="list-style-type: none"> <li>The <i>Procedure Code Modifier</i> data element was accurate in <b>100 percent</b> of instances where procedure code modifiers were present in both the service records and encounter data.</li> </ul>
Units Rate	<ul style="list-style-type: none"> <li>The <i>Units</i> data element was accurate in <b>71.4 percent</b> of instances where units were present in both the service records and encounter data.</li> </ul>

Analysis	Key Findings
All-Element Rate	<ul style="list-style-type: none"> <li>Dates of service with accurate values for all key data elements relevant to their respective service categories (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, <i>Procedure Code Modifier</i>, and <i>Units</i>) were observed in <b>87.7 percent</b> of the dates of service present in both data sources (i.e., encounter data and service records).</li> </ul>
<b>IICSP Review</b>	
Document Review	<ul style="list-style-type: none"> <li>The percentage of valid IICSP documents submission was low at <b>81.0 percent</b>.</li> <li>The percentage of valid IICSP documents with proper signatures was low at <b>29.4 percent</b>, which largely prevented the assessment of subsequent items requiring signature verification.</li> <li>The alignment of documented servicing providers, procedure codes, and number of units within the IICSP documents with the service records was minimal, with rates not exceeding <b>45.5 percent</b>.</li> </ul>

### 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:** When the *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* data elements were present in both the encounter data and the members' service records and were evaluated independently cross all service categories, the data element values demonstrated high accuracy with rates of at least 99.6 percent. [Quality]

#### Weaknesses and Recommendations

**Weakness #1:** MER was unable to procure all the requested service records from its contracted providers primarily due to the 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 that its contracted providers are held accountable for responding to service record requests in a timely manner to support auditing, inspection, and oversight activities. HSAG recommends that MER strengthen and/or enforce its contractual requirements with its providers to promote timely submission of requested documentation. This may

include implementing clear expectations, regular communication about submission requirements and deadlines, and consequences for non-compliance.

**Weakness #2:** Approximately 38.8 percent of the dates of service in the encounter data were not supported by the members' service records. Furthermore, around 35.6 percent, 36.9 percent, 12.8 percent, and 39.1 percent of the *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Units* data elements, respectively, in the encounter data were not supported by the members' service records (i.e., service record omission). For NEMT, the accuracy rate for the *Units* data element was notably low, at 71.4 percent. [Quality]

**Why the weakness exists:** The findings where encounter data are not supported by the members' service records can stem from several potential reasons, which can involve provider documentation practices (e.g., incomplete or inaccurate documentation, coding errors, insufficient detail in the service records), data submission (e.g., incorrect coding during data submission, data entry errors, or inconsistencies in submitted claims), or processing issues (e.g., data mapping, translation issues, or transmission that result in discrepancies between encounter data and service records).

**Recommendation:** MER should investigate the root causes of these omissions and consider performing periodic service record reviews of submitted claims to verify appropriate coding and data completeness, where appropriate. Findings from these reviews should be used to inform targeted education and training initiatives for providers. These initiatives should focus on encounter data submission practices, comprehensive and accurate documentation of members' service records, and adherence to accurate coding practices to reduce future discrepancies. Given the notably low accuracy rate for *Units* in NEMT, special attention should be given to this area through targeted training and specific guidelines, aiming to enhance accuracy and reduce omissions significantly. These strategies will enhance the reliability of MER's encounter data, improve compliance with regulatory standards, and ultimately elevate the quality of healthcare data reporting.

**Weakness #3:** The submitted documentation for the members' IICSP was incomplete, with only 81.0 percent of valid IICSP document submissions. Furthermore, required signatures were missing from approximately 70.6 percent of those valid IICSP documents. Signatures are essential to validate that the IICSP has been reviewed, approved, and agreed upon by the appropriate parties, in accordance with regulatory and contractual requirements. [Quality]

**Why the weakness exists:**

The low submission rate of valid IICSP documents and absence of signatures highlights potential gaps in compliance with documentation standards and raises concerns about validating care coordination efforts. It may also impact the ability to demonstrate member or provider agreement with the outlined care plan, which is essential for ensuring accountability and alignment with care objectives.

**Recommendation:** MER should take proactive steps to enhance its oversight and management of the IICSP document submission process to improve both the validity and the completion rates of submitted documents. This involves clearly defining and communicating the criteria for valid IICSP documents to all providers and ensuring that these guidelines are easily accessible and understood. MER should also ensure that all IICSP documentation includes the required signatures prior to providing or sharing the members' documentation with the relevant stakeholders. To achieve this,

**MER** should implement robust internal quality assurance processes to review and verify that all documentation is complete and compliant with applicable guidelines prior to submission. Additionally, **MER** should provide targeted education and training for providers to emphasize the importance of obtaining signatures and maintaining accurate, complete documentation. These efforts will enhance compliance with regulatory and contractual requirements while improving the overall integrity and accountability of care coordination documentation.

## Consumer Assessment of Healthcare Providers and Systems Analysis

### Performance Results

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

### Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the HCBS 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 finding did not determine significant impact to the quality, timeliness, and/or accessibility of care.

## Strengths

**Strength #1:** As **MER**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis indicated that the 2024 top-box score for *Rating of Personal Assistance and Behavioral Health Staff* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. **[Quality]**

**Strength #2:** As **MER**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis indicated that the 2024 top-box score for *Rating of Case Manager* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. **[Quality]**

**Strength #3:** As **MER**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis indicated that the 2024 top-box score for *Helpful Case Manager* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. **[Quality]**

**Strength #4:** As **MER**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis indicated that the 2024 top-box score for *Personal Safety and Respect* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. **[Quality]**

**Strength #5:** As **MER**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis indicated that the 2024 top-box score for *Planning Your Time and Activities* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. **[Access]**

## Weaknesses and Recommendations

**Weakness #1:** As **MER**-specific results were not available due to low response rates, no substantial weaknesses could be presented at the individual ICO level. However, program level results identified that while the 2024 top-box score for *Planning Your Time and Activities* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark, it was the lowest performing measure with a 2024 top-box score of 64.14 percent. This composite measure indicates there are opportunities to promote community inclusion and empowerment, as some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day. **[Access]**

**Why the weakness exists:** The program level results indicate there are opportunities for the MI Health Link program to help members with community inclusion and empowerment opportunities.

**Recommendation:** **MER** has reported collaborating with PIHPs and implementing care management interventions to target performance of *Planning Your Time and Activities*. HSAG recommends that **MER** continue these interventions and add measures of effectiveness of the interventions as appropriate. Further, HSAG recommends that **MER** focus on barriers such as transportation or other SDOH. In addition, HSAG recommends that **MER** collect regular feedback throughout the year to identify member input and feedback through town halls, focus groups, and short surveys. HSAG further recommends that **MER** ensure member demographic information is correct to improve response rates.



## 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 that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **MER**'s overall performance contributed to the MI Health Link program's progress in achieving the CQS goals and objectives. Table 3-70 displays each MDHHS CQS goal and the EQR activity results that indicate whether the ICO positively (✓), negatively (✗), or minimally (m) impacted the MI Health Link program'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 if a CQS goal did not include any quality measures for the MI Health Link program or the EQR activities do not produce data to assess the impact of a quality measure(s) under an objective.

**Table 3-70—Overall Performance Impact to CQS and Quality, Timeliness, and Access**

Objective	Quality Measure	Overall Performance Impact	Performance Domain
<b>Goal #1: Ensure high quality and high levels of access to care</b>			
1.1	<i>MI7.3 Annual Dental Visit</i>	✗	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	<i>FUH—Follow-Up After Hospitalization for Mental Illness (30 Days)</i>	✓	
	<i>COL—Colorectal Cancer Screening</i>	m	
1.2	<i>CBP—Controlling High Blood Pressure</i>	✗	
	<i>PCR—Plan All-Cause Readmission</i>	✓ <sup>1</sup>	
	<i>COL—Colorectal Cancer Screening</i>	m	
1.3	<i>Annual Flu Vaccine</i>	NA	
	<i>MI5.6 Medication Review—All Populations</i>	✓	
	<i>TRC—Transitions of Care—Medication Reconciliation Post-Discharge</i>	m	
	<i>PM13 Number and percent of enrollees whose IICSP addressed their assessed health and safety risks (HCBS C-Waiver population)</i>	NA	
	<i>PM15 Number &amp; percent of enrollees with an individualized contingency/back-up plan addressing caregiver absences, severe weather, fire/other emergencies (HCBS C-Waiver population)</i>	NA	
	<i>PM24 Number and percent of files that show enrollee/family/legal guardians (as appropriate) received information and education on how to report abuse, neglect, exploitation, and other critical incidents within 60 days of waiver enrollment.</i>	NA	



Objective	Quality Measure	Overall Performance Impact	Performance Domain
Goal #2: Strengthen person and family-centered approaches			
2.1	MI2.3 Members with documented discussions of care goals	NA	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	Core 9.3 Minimizing Facility Length of Stay—Ratio of Observed to Expected Discharge Rates	✓	
	PM17 Number and percent of enrollee IICSPs that are updated as the enrollee's needs change	NA	
2.2	SNS-E Social Needs Screening & Intervention	NA	
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)			
3.1	FUH—Follow-Up After Hospitalization for Mental Illness (30 Days)	✓	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
3.2	MI2.6 Timely transmission of care transition record to health care professional	✗	
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes			
4.1	Meridian—Statin Therapy for Patients with Diabetes—Decreasing the Disparity Between White and African American Members	✗ <sup>2</sup>	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
Goal #5: Improve quality outcomes through value-based initiatives and payment reform			
5.1	The CQS does not include quality measures for the MI Health Link Program under Goal #5.	NA	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access

✓ = The ICO's rate met the 2026 statewide performance target

m = The ICO's rate did not meet the 2026 statewide performance target, or the ICO's HEDIS rate did not meet the 2026 statewide performance target but the ICO's HEDIS rate increased in performance from the prior year

✗ = The ICO's rate did not meet the 2026 statewide performance target and/or the ICO's HEDIS 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 or the CQS did not include any quality measures for the MI Health Link program.

<sup>1</sup> The CQS did not identify the age stratification associated with the quality measure; therefore, HSAG used the 65+ stratification rate for the assessment.

<sup>2</sup> Evaluation of this quality measure used the results of the QIP activity and not the HEDIS rate reported under the PMV activity. While the disparity was not eliminated, the ICO demonstrated statistically significant improvement over the baseline performance for the disparate population during second remeasurement period.

## Molina Dual Options MI Health Link

### Validation of Quality Improvement Projects

#### Performance Results

HSAG’s validation evaluated the technical methods of **MOL**’s QIP, including an evaluation of statistically significant improvement based on reported results and statistical testing (i.e., the QIP 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 QIP and Validation Rating 2 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence that the QIP achieved significant improvement. Table 3-71 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 3-71—Overall Validation Rating for MOL**

QIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
Addressing Disparities in Controlling Blood Pressure	High Confidence	High Confidence	Controlling high blood pressure—Black members.	36.4%	45.1% ↑	55.5% ↑	No
			Controlling high blood pressure—White members.	47.3%	53.3% ↑	55.8% ↑	

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 QIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White). Table 3-72 displays the barriers identified through quality improvement and causal/barrier analysis processes and the interventions initiated by the ICO to support achievement of the QIP goals and address the barriers.

**Table 3-72—Remeasurement 2 Barriers and Interventions for MOL**

Barriers	Interventions
Many Black members do not have a blood pressure monitor to use at home to monitor their progress toward managing their blood pressure.	Provided digital blood pressure monitors to members with a diagnosis of high blood pressure (HTN) and who are assigned to the Michigan Community Health Network.

Barriers	Interventions
Many providers do not properly document the blood pressure reading in the medical record (failure to take a second reading if the first one is elevated, frequently round up the reading, do not take the lowest systolic and/or diastolic reading when multiple readings are done during the same visit).	Conducted HTN education during quarters 1 and 2, followed by a Quarter 3 medical record audit, scoring each site for compliance related to documentation and member blood pressure level compliance.
Many Black members do not know how to take an accurate blood pressure reading while at home.	Provided members with educational materials showing how to sit and position their arm when using a digital blood pressure monitor. Also provided tracking tools and instructions on when to call the provider if the reading is elevated.
Member education sent by mail to Black members may be perceived as junk mail and not opened or read.	Provided HTN education to members electronically by email to Black members.
Providers need to have the blood pressure monitor used at home by their Black patients so they can teach their patients how to use the blood pressure monitor.	Provided medical sites with two blood pressure monitor units to use to teach patients with HTN the method they should use to take an accurate blood pressure reading at home.
Many providers do not routinely submit CPT II codes to report blood pressure readings. This increases the need to perform a manual review of the medical record.	Encouraged providers—during virtual visits, on tip sheets within the HEDIS Provider Manual, and through fax blast reminders—to use CPT II codes to report blood pressure readings.
Many providers do not capture the blood pressure reading during a telehealth visit with Black patients.	Educated providers—during virtual visits, on tip sheets within the HEDIS Provider Manual, and through fax blast reminders—that they are allowed to collect blood level readings during telehealth/virtual visits.
Direct member interventions were not effectively targeting Black members specifically.	Based on the literature review and suggestions from the member advisory committee, Molina is distributing educational flyers and hypertension warning sign magnets to trusted, heavily utilized locations in the Black community, such as neighborhood organizations, barber shops, and churches.

### Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the QIP 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** used appropriate quality improvement tools to conduct a causal/barrier analysis and to prioritize the identified barriers, and interventions were implemented in a timely manner.  
[Quality and Timeliness]

**Strength #2: MOL** sustained statistically significant improvement over the baseline performance for both performance indicators during the second remeasurement period and eliminated the existing disparity between the two subgroups. [**Quality, Timeliness, and Access**]

## Weaknesses and Recommendations

**Weakness #1:** No substantial weaknesses were identified.

**Why the weakness exists:** NA

**Recommendation:** Although there were no substantial weaknesses, HSAG recommends that **MOL** implement intervention strategies that have demonstrated improvement on the performance indicators and continue to evaluate the success of each intervention.

## Performance Measure Validation

### Performance Results

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

**MOL** received a measure designation of *Reportable (R)* for all measures, signifying that **MOL** had reported the measures in compliance with the MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements and that rates could be reported. Table 3-73 includes the validation designation for each performance measure as well as the validated SFY 2024 performance measure rates.

**Table 3-73—Measure-Specific Validation Designation for MOL**

Performance Measure	Validation Designation	SFY 2024 Rate
<b>Core Measure 9.3:</b> <i>Minimizing Facility Length of Stay</i>	<b>REPORTABLE (R)</b> The ICO reported this measure in alignment with the MMP Core Reporting Requirements.	1.82*
<b>MI2.6:</b> <i>Timely Transmission of Care Transition Record to Health Care Professional</i>	<b>REPORTABLE (R)</b> The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.	49.50%
<b>MI5.6:</b> <i>Care for Adults—Medication Review</i>	<b>REPORTABLE (R)</b> The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.	82.00%
<b>MI7.3:</b> <i>Annual Dental Visit</i>	<b>REPORTABLE (R)</b> The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.	28.65%

\*Please note for Core Measure 9.3 that the SFY 2024 rate is reflective of the ICO's calculated ratio of observed to expected discharges (O/E ratio) rather than a calculated percentage rate, as is reflected for MI2.6, MI5.6, and MI7.3.

## Performance Measure Rates

Table 3-74 shows each of **MOL**'s audited HEDIS measures, rates for HEDIS MY 2022 and HEDIS MY 2023 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2023 with HEDIS MY 2022, and the HEDIS MY 2022 and HEDIS MY 2023 MI Health Link statewide average performance rates. HEDIS MY 2022 and HEDIS MY 2023 measure rates performing better than the MY 2022 and MY 2023 statewide averages are notated by green font.

**Table 3-74—Measure-Specific Percentage Rates for MOL**

HEDIS Measure	HEDIS MY 2022 (%)	HEDIS MY 2023 (%)	HEDIS MY 2022 vs. MY 2023	MY 2022 Statewide Average (%)	MY 2023 Statewide Average (%)
<b>Prevention and Screening</b>					
<i>BCS-E—Breast Cancer Screening</i>	59.22	62.71	+3.49	56.70	58.82
<i>COL—Colorectal Cancer Screening<sup>1</sup></i>	63.19	66.11	+2.92	57.59	60.82
<i>COA—Care for Older Adults—Medication Review</i>	79.08	86.97	+7.89	80.41	90.90
<i>COA—Care for Older Adults—Functional Status Assessment</i>	65.69	75.00	+9.31	62.71	70.13
<i>COA—Care for Older Adults—Pain Assessment</i>	82.24	88.03	+5.79	78.04	83.50
<b>Respiratory Conditions</b>					
<i>SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD</i>	21.73	27.12	+5.39	22.01	23.00
<i>PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid</i>	63.77	56.90	-6.87	74.10	74.05
<i>PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator</i>	83.48	80.91	-2.57	88.82	86.81
<b>Cardiovascular Conditions</b>					
<i>CBP—Controlling High Blood Pressure</i>	64.48	68.16	+3.68	66.14	68.85
<i>PBH—Persistence of Beta-Blocker Treatment After a Heart Attack<sup>2</sup></i>	—	66.67	—	—	56.36
<i>SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy</i>	83.81	84.08	+0.27	80.90	85.02
<i>SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%</i>	75.36	80.28	+4.92	79.55	81.48
<b>Diabetes</b>					
<i>HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (&gt;9.0%)*</i>	41.36	32.44	-8.92	34.07	29.00
<i>HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (&lt;8.0%)</i>	53.53	61.46	+7.93	58.51	63.61
<i>EED—Eye Exam for Patients With Diabetes<sup>1</sup></i>	64.72	67.80	+3.08	62.89	65.27

HEDIS Measure	HEDIS MY 2022 (%)	HEDIS MY 2023 (%)	HEDIS MY 2022 vs. MY 2023	MY 2022 Statewide Average (%)	MY 2023 Statewide Average (%)
<i>BPD—Blood Pressure Control for Patients With Diabetes</i>	65.45	67.80	+2.35	68.13	70.83
<i>SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy</i>	77.87	77.32	-0.55	76.44	76.91
<i>SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%</i>	78.65	80.72	+2.07	78.95	80.60
<b>Musculoskeletal Conditions</b>					
<i>OMW—Osteoporosis Management in Women Who Had a Fracture</i>	13.79	18.75	+4.96	11.18	20.27
<b>Behavioral Health</b>					
<i>AMM—Antidepressant Medication Management—Effective Acute Phase Treatment<sup>1</sup></i>	71.35	72.21	+0.86	73.66	70.76
<i>AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment<sup>1</sup></i>	53.44	57.40	+3.96	57.94	54.20
<i>FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up</i>	37.43	34.02	-3.41	32.79	31.03
<i>FUH—Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up</i>	62.57	60.31	-2.26	58.91	58.83
<i>FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up</i>	22.88	22.75	-0.13	32.06	29.44
<i>FUM—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up</i>	47.03	40.78	-6.25	54.39	48.27
<b>Medication Management and Care Coordination</b>					
<i>TRC—Transitions of Care—Medication Reconciliation Post-Discharge</i>	28.71	37.96	+9.25	47.59	56.17
<i>TRC—Transitions of Care—Notification of Inpatient Admission</i>	2.92	11.92	+9.00	16.53	24.53
<i>TRC—Transitions of Care—Receipt of Discharge Information</i>	4.14	9.73	+5.59	15.38	19.48
<i>TRC—Transitions of Care—Patient Engagement After Inpatient Discharge</i>	78.83	79.08	+0.25	77.74	79.78
<b>Overuse/Appropriateness</b>					
<i>PSA—Non-Recommended PSA-Based Screening in Older Men*</i>	35.52	34.23	-1.29	26.71	27.99
<i>DDE—Potentially Harmful Drug-Disease Interactions in Older Adults*</i>	31.38	32.02	+0.64	33.45	33.54
<i>DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid*</i>	19.57	19.34	-0.23	18.16	17.57
<i>DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis*</i>	4.23	4.05	-0.18	5.23	4.99



HEDIS Measure	HEDIS MY 2022 (%)	HEDIS MY 2023 (%)	HEDIS MY 2022 vs. MY 2023	MY 2022 Statewide Average (%)	MY 2023 Statewide Average (%)
DAE—Use of High-Risk Medications in Older Adults—Total*	22.21	22.00	-0.21	21.78	21.07
<b>Access/Availability of Care</b>					
AAP—Adults’ Access to Preventive/Ambulatory Health Services—20–44 Years	88.36	89.89	+1.53	84.90	85.69
AAP—Adults’ Access to Preventive/Ambulatory Health Services—45–64 Years	96.14	96.11	-0.03	93.83	93.71
AAP—Adults’ Access to Preventive/Ambulatory Health Services—65 Years and Older	93.97	93.87	-0.10	91.69	91.79
AAP—Adults’ Access to Preventive/Ambulatory Health Services—Total	93.76	93.87	+0.11	91.08	91.24
IET—Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total <sup>1</sup>	38.63	40.80	+2.17	34.10	35.83
IET—Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total <sup>1</sup>	4.06	3.11	-0.95	3.84	4.43
<b>Risk-Adjusted Utilization</b>					
PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)*	1.11	0.89	-0.22	1.07	1.11
PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)*	1.17	1.22	+0.05	1.21	1.21

\* Measures for which lower rates indicate better performance.

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

<sup>2</sup> Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between MY 2023 and prior years; therefore, the HEDIS MY 2022 rate and comparison from HEDIS MY 2022 vs. MY 2023 will not be displayed for this measure.

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

## 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** once again improved the MI2.6 reported rate, incorporating a single point of contact to monitor inpatient discharges and the transmission of the discharge summaries. [Quality and Access]



**Strength #2:** In the Prevention and Screening domain, **MOL**'s rates for the *COA—Care for Older Adults—Medication Review, Functional Status Assessment, and Pain Assessment* measure indicators increased by more than 7 percentage points, 9 percentage points, and 5 percentage points, respectively, with the *COA—Care for Older Adults—Functional Status Assessment and Pain Assessment* measure indicators exceeding the HEDIS MY 2023 MI Health Link statewide average, suggesting strength and improvement in adult members 66 years and older having medication reviews, functional status assessments, and pain assessments conducted during the measurement year. As people age, their physical and cognitive function can decline, and pain becomes more prevalent. Older adults may have more complex medication regimens. Screening of elderly patients is effective in identifying functional decline.<sup>49</sup> [Quality and Access]

**Strength #3:** In the Respiratory Conditions domain, **MOL**'s rate for the *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD* measure indicator increased by more than 5 percentage points and exceeded the HEDIS MY 2023 MI Health Link statewide average, suggesting strength and improvement in members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis. Spirometry is one of the most commonly used approaches to test pulmonary function and has proved crucial in diagnosing lung disease, monitoring patients' pulmonary function, and assessing fitness for various procedures.<sup>50</sup> [Quality and Access]

**Strength #4:** In the Diabetes domain, **MOL**'s rate for the *HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* measure indicator increased by more than 7 percentage points from MY 2022 to MY 2023, suggesting strength and improvement in adult members ages 18 to 75 years with diabetes having controlled HbA1c levels. Diabetes is the eighth leading cause of death in the U.S. and was responsible for approximately 103,294 deaths in 2021. 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.<sup>51</sup> [Quality]

**Strength #5:** In the Medication Management and Care Coordination domain, **MOL**'s rates for the *TRC—Transitions of Care—Medication Reconciliation Post-Discharge, Notification of Inpatient Admission, and Receipt of Discharge Information* measure indicators increased by more than 9 percentage points, 9 percentage points, and 5 percentage points, respectively, from MY 2022 to MY 2023, suggesting strength and improvement for adult members in timely medication reconciliation being performed following discharge from an inpatient facility, and timely notification of inpatient admissions and documentation of discharge information. Research shows that when patients are

---

<sup>49</sup> National Committee for Quality Assurance. Care for Older Adults (COA). Available at: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/care-for-older-adults-coa/>. Accessed on: Mar 4, 2025.

<sup>50</sup> National Institutes of Health-National Library of Medicine: Spirometry. Lamb K, Theodore D, Bhutta BS. Spirometry. [Updated 2023 Aug 17]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK560526/>. Accessed on: Mar 4, 2025.

<sup>51</sup> 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: Mar 4, 2025.

engaged in their healthcare, it can lead to measurable improvements in safety and quality. Discharge from hospital to home requires the successful transfer of information from clinicians to the patient and family to reduce adverse events and prevent readmissions. Engaging patients and families in the discharge planning process helps make this transition in care safe and effective.<sup>52</sup> [Quality and Timeliness]

## Weaknesses and Recommendations

**Weakness #1:** Although **MOL** slightly improved its rate for MI5.6, the rate is still below several other Michigan ICOs. [Quality]

**Why the weakness exists:** **MOL** only overread 10 percent of noncompliant charts.

**Recommendation:** HSAG recommends that **MOL** overread a larger portion of noncompliant cases.

**Weakness #2:** **MOL** reported incorrect data counts for Core Measure 9.3 to HPMS. [Quality]

**Why the weakness exists:** **MOL** explained that when reporting the measure data to HPMS, there were discharges that had been inadvertently excluded from the measure due to hospital outpatient stays being counted as hospitalizations or readmissions. This error impacted the reported data counts. **MOL** noted that it had since enhanced the logic for bundling facility stays and validated it by referencing the Core Measure 9.3 FAQ document. **MOL** implemented the correct bill types, which led to the removal of hospital outpatient stays. This adjustment split the bundled facility stay days and impacted 120 records. HSAG confirmed that the revised data were correct, and **MOL** was approved to resubmit its data to CMS.

**Recommendation:** Although **MOL** proactively addressed the findings, HSAG recommends that **MOL** incorporate more stringent quality assurance checks and increased frequency of data validation checks prior to submission of final rates to MDHHS and member-level data to HSAG. HSAG also recommends that **MOL** review the annual release of the Core reporting requirements and Core Measure 9.3 FAQ document to further ensure that the programming logic is in alignment with the reporting requirements.

**Weakness #3:** HSAG identified during source code review for MI2.6 that **MOL** included an invalid revenue code in its denominator logic for data element A. Additionally, **MOL**'s logic did not include code to exclude members who died, left against medical advice, or discontinued care. [Quality]

**Why the weakness exists:** **MOL** agreed that the revenue code should not have been included in its logic and that its logic required updates to appropriately exclude members who died, left against medical advice, or discontinued care. HSAG requested that **MOL** provide revised programming logic addressing these findings and that it rerun its data based on the revised logic. HSAG confirmed that the programming logic and revised data were correct, and **MOL** was approved to resubmit its data to CMS.

<sup>52</sup> Agency for Healthcare Research and Quality (AHRQ). Strategy 4: Care Transitions From Hospital to Home: IDEAL Discharge Planning. Available at: <https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/strategy4/index.html>. Accessed on Mar 7, 2025.

**Recommendation:** Although **MOL** addressed the findings by revising its programming logic, HSAG recommends that **MOL** incorporate more stringent quality assurance checks and increased frequency of data validation checks prior to submission of final rates to MDHHS and member-level data to HSAG. These validations should include checking to ensure that the appropriate value set codes are included in the programming logic. HSAG also recommends that **MOL** review the annual release of the Core reporting requirements and Core Measure 9.3 FAQ document to further ensure that programming logic is in alignment with the reporting requirements.

**Weakness #4:** For 21 of the 42 reported HEDIS measures (50 percent), **MOL**'s rates indicated worse performance than the statewide average, demonstrating an opportunity for improvement across multiple domains including Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Musculoskeletal Conditions, Behavioral Health, Medication Management and Care Coordination, Overuse/Appropriateness, Access/Availability of Care, and Risk-Adjusted Utilization. **[Quality]**

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

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

**Weakness #5:** In the Respiratory Conditions domain, **MOL**'s rate for the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicator decreased by more than 6 percentage points from MY 2022 to MY 2023 and fell below the HEDIS MY 2023 MI Health Link statewide average, indicating that some adult members with COPD were not always receiving appropriate medication therapy to manage an exacerbation. Exacerbations of COPD are episodes of worsening symptoms, leading to substantial morbidity and mortality. Patients with a history of frequent exacerbations have worse quality of life than patients with a history of less frequent exacerbations, and have consistent exacerbation frequencies when studied from year to year. The success of oral corticosteroids in the treatment of COPD exacerbations with reduction of hospital length of stay has prompted much interest in the use of inhaled steroids to reduce exacerbation frequency in COPD.<sup>53</sup> **[Quality and Access]**

**Why the weakness exists:** The rate for the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicator decreasing by more than 6 percentage points from MY 2022 to MY 2023 and falling below the HEDIS MY 2023 MI Health Link statewide

---

<sup>53</sup> National Institutes of Health-National Library of Medicine. COPD exacerbations: defining their cause and prevention. Wedzicha JA, Seemungal TA. COPD exacerbations: defining their cause and prevention. *Lancet*. 2007 Sep 1;370(9589):786-96. doi: 10.1016/S0140-6736(07)61382-8. PMID: 17765528; PMCID: PMC7134993. Available at: <https://pmc.ncbi.nlm.nih.gov/articles/PMC7134993/>. Accessed on Mar 7, 2025.

average suggests that barriers exist for some adult members with COPD to receive medication therapy to manage exacerbation.

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

**Weakness #6:** In the Diabetes domain, **MOL**'s rate for the *HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* measure indicator decreased by more than 8 percentage points from MY 2022 to MY 2023 and fell below the HEDIS MY 2023 MI Health Link statewide average, indicating that some adult members ages 18 to 75 years with diabetes did not have controlled HbA1c levels. Diabetes is the eighth leading cause of death in the U.S. and was responsible for approximately 103,294 deaths in 2021. 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.<sup>54</sup> [Quality]

**Why the weakness exists:** The rate for the *HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* measure indicator decreasing by more than 8 percentage points from MY 2022 to MY 2023 suggests that barriers exist for some adults with diabetes to have controlled HbA1c levels

**Recommendation:** HSAG recommends that **MOL** conduct a root cause analysis or focused study to determine why some adults with diabetes were not having controlled HbA1c levels. Upon identification of a root cause, **MOL** should implement appropriate interventions to improve the performance related to the *HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* measure indicator. **MOL** should consider the nature and scope of the issue (e.g., whether the issue is related to barriers such as a lack of patient and provider communication or education).

**Weakness #7:** In the Behavioral Health domain, **MOL**'s rate for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up* measure indicator decreased by more than 6 percentage points from MY 2022 to MY 2023 and fell below the HEDIS MY 2023 MI Health Link statewide average, indicating that some members were not receiving timely follow-up care for mental illness after an ED visit. Research suggests that patients with mental disorders are among the highest users of ED services, with visits characterized by long lengths of stay, intensive treatment, and elevated rates of hospitalizations. After discharge, fewer than half of these patients successfully transition to outpatient care, with high rates of readmission to the ED. Programs that allow patients with mental disorders to successfully engage with outpatient care hold the potential

---

<sup>54</sup> 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: Mar 4, 2025.

not only to improve quality and outcomes of care for people with mental disorders, but also to free capacity within EDs to provide care for other urgent needs.<sup>55</sup> [Quality, Timeliness, and Access]

**Why the weakness exists:** The rate for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up* measure indicator decreasing by more than 6 percentage points from MY 2022 to MY 2023 suggests that barriers exist for some members to receive follow-up care for mental illness after an ED visit.

**Recommendation:** HSAG recommends that **MOL** conduct a root cause analysis or focused study to determine why some members were not receiving follow-up care for mental illness after an ED visit. Upon identification of a root cause, **MOL** should implement appropriate interventions to improve the performance related to the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up* measure indicator. **MOL** should consider the nature and scope of the issue (e.g., whether the issue is related to barriers such as a lack of patient and provider education or staffing shortages).

## Compliance Review

### Performance Results

Table 3-75 presents an overview of the results of the SFY 2022 and SFY 2023 compliance reviews for **MOL**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. If a requirement was not applicable to **MOL** during the period covered by the review, HSAG used a *Not Applicable (NA)* designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 14 standards.

**Table 3-75—Summary of Standard Compliance Scores**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	NM	NA	
Standard I—Disenrollment: Requirements and Limitations	9	6	6	0	3	100%
Standard II—Member Rights and Member Information	23	23	16	7	0	70%
Standard III—Emergency and Poststabilization Services	13	13	13	0	0	100%
Standard IV—Availability of Services	13	13	13	0	0	100%
Standard V—Assurances of Adequate Capacity and Services	4	4	4	0	0	100%

<sup>55</sup> National Institutes of Health-National Library of Medicine. Druss B, Lally CA, Li J, et al. Comparing Two Ways to Help Patients Get Follow-up Care after a Mental Health Visit to the Emergency Room—The EPIC Study [Internet]. Washington (DC): Patient-Centered Outcomes Research Institute (PCORI); 2021 May. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK601636/> doi: 10.25302/05.2021.IHS.151032431. Accessed on: Mar 7, 2025.



Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	NM	NA	
Standard VI—Coordination and Continuity of Care	31	30	24	6	1	80%
Standard VII—Coverage and Authorization of Services	28	27	23	4	1	85%
Standard VIII—Provider Selection	23	23	20	3	0	87%
Standard IX—Confidentiality	11	11	11	0	0	100%
Standard X—Grievance and Appeal Systems	45	45	32	13	0	71%
Standard XI—Subcontractual Relationships and Delegation	6	5	4	1	1	80%
Standard XII—Practice Guidelines	6	6	6	0	0	100%
Standard XIII—Health Information Systems <sup>1</sup>	9	9	9	0	0	100%
Standard XIV—Quality Assessment and Performance Improvement Program	21	21	17	4	0	81%
<b>Total</b>	<b>242</b>	<b>236</b>	<b>198</b>	<b>38</b>	<b>6</b>	<b>84%</b>

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

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

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

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

<sup>1</sup> This standard includes a comprehensive assessment of the ICO's IS capabilities.

## Review of Corrective Action Plan Implementation

Based on the findings of the SFY 2022 and SFY 2023 compliance review activities, **MOL** was required to develop and submit a CAP for each element assigned a score of *Not Met*. MDHHS and HSAG reviewed the CAP for sufficiency, and **MOL** was responsible for implementing each action plan in a timely manner. Table 3-76 presents an overview of the results of the SFY 2024 compliance review for **MOL**, which consisted of a comprehensive review of the ICO's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Section 2.

**Table 3-76—Summary of CAP Implementation**

Standard	Total CAP Elements	# of CAP Elements Complete	# of CAP Elements Not Complete
Standard II—Member Rights and Member Information	7	7	0
Standard VI—Coordination and Continuity of Care	6	6	0
Standard VII—Coverage and Authorization of Services	4	2	2
Standard VIII—Provider Selection	3	2	1

Standard	Total CAP Elements	# of CAP Elements Complete	# of CAP Elements Not Complete
Standard X—Grievance and Appeal Systems	13	9	4
Standard XI—Subcontractual Relationships and Delegation	1	1	0
Standard XIV—Quality Assessment and Performance Improvement Program	4	3	1
<b>Total</b>	<b>38</b>	<b>30</b>	<b>8</b>

**Total CAP Elements:** The total number of elements within each standard that required a CAP during the SFY 2022 and SFY 2023 compliance review activities.

**# of CAP Elements Complete:** The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirements under review.

**# of CAP Elements Not Complete:** The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirements under review.

<sup>1</sup>This standard includes a comprehensive assessment of the ICO's IS capabilities.

### 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** demonstrated that it successfully remediated 30 of 38 elements, indicating the necessary policies, procedures, and initiatives were implemented to ensure compliance with the Member Rights and Member Information, Coordination and Continuity of Care, and Subcontractual Relationships and Delegation. [Quality, Timeliness, and Access]

#### Weaknesses and Recommendations

**Weakness #1: MOL** did not remediate two elements for the Coverage and Authorization of Services standard, one element for the Provider Selection standard, four elements for the Grievance and Appeal Systems, and one element for the Quality Assessment and Performance Improvement Program standard, indicating continued gaps in the ICO's processes within these program areas. [Quality, Timeliness, and Access]

**Why the weakness exists: MOL** did not submit sufficient evidence to confirm remediation of several deficiencies related to the following requirements: care coordinators have access to adverse benefit determination (ABD) notices generated by its dental delegate; members are provided with a 10-day advance notice for the termination, suspension, or reduction of previously authorized services; disclosures of ownership and control are collected at credentialing/recredentialing; members receive oral and written notice of appeal resolution time frame extensions; a member's



written consent is obtained when a provider files an appeal on the member’s behalf; informing members of their right to request that the ICO vacate an appeal dismissal; services are authorized or provided within 72 hours of an appeal/State fair hearing (SFH) reversal decision; and incorporating the results of efforts to support community integration for members using LTSS in the ICO’s quality assessment and performance improvement (QAPI) program evaluation.

**Recommendation:** HSAG required **MOL** to participate in a mandatory technical assistance meeting with MDHHS and HSAG to further discuss the requirements, expectations, and appropriate action plans to bring the elements into compliance. **MOL** was also required to update its existing CAPs and applicable action plans to align with the expectations addressed during the technical assistance meeting, and subsequently follow MDHHS’ and HSAG’s direction and implement timely interventions to fully remediate the remaining action plans. As **MOL**’s updated action plans were approved by MDHHS and HSAG, HSAG recommends that the ICO conduct an internal audit to verify its action plans were successful in remediating the deficiencies.

## Network Adequacy Validation

### Network Adequacy Analysis

#### Performance Results

##### ISCA Findings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if **MOL**’s interpretation of data was accurate. Table 3-77 summarizes HSAG’s validation ratings for **MOL**, by indicator type.

**Table 3-77—Summary of MOL’s Validation Ratings**

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Time and Distance	100%	0%	0%	0%
Provider Capacity	100%	0%	0%	0%

Of the network adequacy indicators assessed, **MOL** received *High Confidence* for both time and distance and provider capacity indicator types.

##### Analytic Findings

**MOL** submitted its SFY 2024 region-specific member and Medicaid provider data files, and exception requests to HSAG on April 29, 2024. Based on HSAG’s detailed file review findings communicated to **MOL** on June 18, 2024, HSAG asked **MOL** to resubmit its network data files for all regions to address identified data issues. **MOL** resubmitted its region-specific network data files to HSAG on June 26,

2024, and HSAG’s NAV results indicated that **MOL** met all Medicaid and LTSS minimum network standards for Region 7 and Region 9.

Table 3-78 presents **MOL**’s region-specific NAV results by Medicaid and LTSS provider category following all data resubmissions and MDHHS’ exception determinations.

**Table 3-78—SFY 2024 NAV Results for MOL by Region and Provider Category**

Provider Category	Region 7 Validation Result	Region 9 Validation Result
<b>Provider Categories With Travel Time and Distance Standards</b>		
Adult Day Program	Met	Met
Dental	Met	Met
Eye Examinations	Met	Met
Eye Wear	Met	Met
Hearing Aids	Met	Met
Hearing Examinations	Met	Met
<b>Provider Categories Rendering Home-Based Services</b>		
Adaptive Medical Equipment and Supplies	Met	Met
Assistive Technology—Devices	Met	Met
Assistive Technology—Van Lifts and Tie Downs	Met	Met
Chore Services	Met	Met
ECLS	Met	Met
Environmental Modifications	Met	Met
Fiscal Intermediary	Met	Met
Home-Delivered Meals	Met	Met
Medical Supplies	Met	Met
NEMT	Met	Met
Non-Medical Transportation	Met	Met
Personal Care Services	Met	Met
Personal Emergency Response System	Met	Met
Preventive Nursing Services	Met	Met
Private Duty Nursing	Met	Met
Respite	Met	Met

Provider Category	Region 7 Validation Result	Region 9 Validation Result
Skilled Nursing Home	Met	Met
Percent of Total Standards Met	100%	100%

### Strengths, Weaknesses, and Recommendations

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

#### Strengths

**Strength #1: MOL** demonstrated the ability to maintain accurate and complete delegated provider data through regular oversight activities. **[Access]**

**Strength #2: MOL** demonstrated the ability to maintain accurate and complete enrollment data through its enrollment data reconciliation processes. **[Access]**

**Strength #3: MOL** met all Medicaid and LTSS minimum network standards for Region 7, indicating that **MOL** maintained an adequate network for MI Health Link members in this region. **[Access]**

**Strength #4: MOL** met all Medicaid and LTSS minimum network standards for Region 9, indicating that **MOL** maintained an adequate network for MI Health Link members in this region. **[Access]**

#### Weaknesses and Recommendations

**Weakness #1:** HSAG identified no specific opportunities related to the time and distance or provider capacity network standards for **MOL** based on the SFY 2024 NAV results. **[Access]**

**Why the weakness exists:** NA

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

## Network Validation Survey

### Performance Results

HSAG performed a comparison of the provider data submitted to HSAG by **MOL** against **MOL**'s online directory. The sample included 194 providers (Table 3-79). Among this sample, 96.9 percent were located in the online directory at the sampled location, while 1.5 percent of providers were found in the directory but not at the sampled location. Additionally, 1.5 percent of the providers could not be located in **MOL**'s online directory.

Table 3-79 summarizes findings by region, regarding the number of sampled providers and provider locations (i.e., "cases") that HSAG's reviewers were able to locate in the ICO's online provider directory.

**Table 3-79—Summary of Sampled Dental Providers Located in Online Provider Directory**

Region	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 (%)	Count	Rate (%)	Count	Rate (%)
Region 7	128	1	0.8%	3	2.3%	124	96.9%
Region 9	66	2	3.0%	0	0.0%	64	97.0%
<b>MOL Total</b>	<b>194</b>	<b>3</b>	<b>1.5%</b>	<b>3</b>	<b>1.5%</b>	<b>188</b>	<b>96.9%</b>
<b>All ICOs Total</b>	<b>1,179</b>	<b>73</b>	<b>6.2%</b>	<b>18</b>	<b>1.5%</b>	<b>1,088</b>	<b>92.3%</b>

Table 3-80 displays the total number and percent of cases, by region, with matched data values for indicators that were reviewed in the comparison between all ICOs and **MOL**'s submitted provider data and **MOL**'s online provider directory.

**Table 3-80—PDV Study Indicator Match Rates\***

Indicator	Region 7		Region 9		MOL Total		All ICOs Total	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Provider's Name	127	100%	64	100%	<b>191</b>	<b>100%</b>	<b>1,106</b>	<b>100%</b>
Provider Street Address	124	97.6%	64	100%	<b>188</b>	<b>98.4%</b>	<b>1,052</b>	<b>95.1%</b>
Provider Suite Number	127	100%	64	100%	<b>191</b>	<b>100%</b>	<b>1,069</b>	<b>96.7%</b>
Provider City	124	97.6%	63	98.4%	<b>187</b>	<b>97.9%</b>	<b>1,089</b>	<b>98.5%</b>
Provider State	127	100%	64	100%	<b>191</b>	<b>100%</b>	<b>1,106</b>	<b>100%</b>

Indicator	Region 7		Region 9		MOL Total		All ICOs Total	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Provider ZIP Code	124	97.6%	64	100%	188	98.4%	1,090	98.6%
Provider Telephone Number	121	95.3%	64	100%	185	96.9%	1,077	97.4%
Provider Type/Specialty	127	100%	64	100%	191	100%	1,106	100%
Provider Accepting New Patients**	126	99.2%	64	100%	190	99.5%	1,068	99.4%
Provider Gender	127	100%	63	98.4%	190	99.5%	1,077	97.4%

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

\*\* New patient information was not listed in the online directory for specific ICOs and could only be confirmed by contacting the provider's office. New patient acceptance match rates include an exact match or not listed in the online directory. Caution should be exercised when interpreting the new patient acceptance match rates.

HSAG attempted to contact 183 sampled provider locations for **MOL**, with an overall response rate of 86.9 percent. Table 3-81 summarizes the survey response rates for all ICOs and for **MOL**, by region.

**Table 3-81—Secret Shopper Survey Response Rates, by Region**

Region	Total Survey Cases <sup>1</sup>	Cases Reached <sup>2</sup>	Response Rate (%)
Region 7	120	101	84.2%
Region 9	63	58	92.1%
<b>MOL Total</b>	<b>183</b>	<b>159</b>	<b>86.9%</b>
<b>All ICOs Total</b>	<b>1,068</b>	<b>945</b>	<b>88.5%</b>

<sup>1</sup> Total survey 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).

<sup>2</sup> Cases reached includes cases that responded to the survey, confirmed the location, and offered the requested service.

Table 3-82 summarizes the acceptance rates for the requested insurance and new patients for all ICOs and for **MOL**, by region.

**Table 3-82—Requested Insurance and New Patient Acceptance Rates, by Region**

Region	Cases Accepting Insurance <sup>1,2</sup>		Accepting New Patients <sup>1</sup>	
	Count	Rate (%)	Count	Rate (%)
Region 7	78	77.2%	78	77.2%
Region 9	36	62.1%	34	58.6%

Region	Cases Accepting Insurance <sup>1,2</sup>		Accepting New Patients <sup>1</sup>	
	Count	Rate (%)	Count	Rate (%)
<b>MOL Total</b>	<b>114</b>	<b>71.7%</b>	<b>112</b>	<b>70.4%</b>
<b>All ICOs Total</b>	<b>660</b>	<b>69.8%</b>	<b>645</b>	<b>68.3%</b>

<sup>1</sup> The denominator includes cases reached.

<sup>2</sup> Insurance acceptance includes offices that accepted the requested ICO, affiliated DBA, or MI Health Link program.

Table 3-83 displays the number of survey respondents who offered appointments to new patients for routine dental care (i.e., dental cleaning) for all ICOs and **MOL**, by region.

**Table 3-83—New Patient Appointment Availability Results, by Region**

Region	Cases Reached	Cases Offered an Appointment	
		Count	Rate (%)
Region 7	101	67	66.3%
Region 9	58	30	51.7%
<b>MOL Total</b>	<b>159</b>	<b>97</b>	<b>61.0%</b>
<b>All ICOs Total</b>	<b>945</b>	<b>589</b>	<b>62.3%</b>

Table 3-84 displays the new patient wait time statistics for all ICOs and **MOL**, by region.

**Table 3-84—New Patient Appointment Wait Time Results, by Region**

Region	Appointment Wait Time (Calendar Days)				Percent of Cases Within Standard <sup>1,2</sup>
	Min	Max	Average	Median	
Region 7	1	203	25	12	88.1%
Region 9	1	180	29	23	90.0%
<b>MOL Total</b>	<b>1</b>	<b>203</b>	<b>26</b>	<b>14</b>	<b>88.7%</b>
<b>All ICOs Total</b>	<b>0</b>	<b>321</b>	<b>32</b>	<b>13</b>	<b>83.5%</b>

<sup>1</sup> The denominator includes cases that offered an appointment.

<sup>2</sup> Percent of Cases Within Standard represents cases that offered an appointment that is compliant with MDHHS' standard for an initial dental appointment (i.e., appointments offered within eight weeks or 56 calendar days).

### 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 98.5 percent of the sampled providers in **MOL**'s online provider directory. Of the providers matched in **MOL**'s online provider directory, all indicators had match rates above 95.0 percent. [**Quality and Access**]

## Weaknesses and Recommendations

**Weakness #1:** Overall, 86.9 percent of the 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 data included inaccurate provider 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 provider information) to address the provider data deficiencies. In addition, as MDHHS required **MOL** to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.

**Weakness #2:** Among the cases reached, 71.7 percent of provider locations accepted the insurance, including 77.2 percent in Region 7 and 62.1 percent in Region 9. In addition, 70.4 percent accepted new patients, including 77.2 percent in Region 7 and 58.6 percent in Region 9. [**Quality and Access**]

**Why the weakness exists:** **MOL**'s data included inaccurate information regarding the acceptance of the insurance and new patients. Regional differences were present, with Region 9 having lower rates of cases accepting the insurance and new patients.

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

**Weakness #3:** Among the cases reached, 61.0 percent of locations offered an appointment date, including 66.3 percent in Region 7 and 51.7 percent in Region 9. Of the cases that offered an appointment, 88.7 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. Regional differences in appointment availability were present, with Region 9 having a lower appointment rate.

**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 service records and IICSP documentation for sampled members from their contracted providers, based on the final sample list provided by HSAG. These documents covered services that occurred during the review period. HSAG reviewed **MOL**'s procured service records to evaluate the completeness and accuracy of encounter data by examining key data elements, such as *Date of Service*, *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Units*, as applicable. For personal care services, HSAG also reviewed the associated IICSP documents submitted by **MOL** to ensure that the services reported in the encounters were supported by the members' service plans. This review confirmed alignment with authorization dates, scheduled services, units of service, and service providers.

Table 3-85 outlines the key findings for **MOL** based on the assessment of encounter data completeness and accuracy, conducted through a review of members' service records and the IICSP documents for services rendered from October 1, 2022, through September 30, 2023.

**Table 3-85—EDV Results for MOL**

Analysis	Key Findings
<b>Record Procurement Status</b>	
Service Record Procurement Rate	<ul style="list-style-type: none"> <li>The overall service record procurement rate was notably low at <b>79.3 percent</b>, indicating that more than 20 percent of the requested records were not procured and submitted.</li> <li>Of the service records not submitted, <b>92.9 percent</b> were not submitted due to non-responsive providers or provider did not respond in a timely manner.</li> <li>Submission rates varied across different service categories within <b>MOL</b>, ranging from <b>78.3 percent</b> (i.e., Dental) to <b>100 percent</b> (i.e., NEMT).</li> </ul>
Second Date of Service Submission Rate	<ul style="list-style-type: none"> <li>Among the procured service records, <b>52.2 percent</b> included a corresponding second date of service. The submission rates for a second date of service varied across different service categories within <b>MOL</b>, ranging from <b>50.6 percent</b> (i.e., Dental) to <b>100 percent</b> (i.e., NEMT).</li> </ul>
IICSP Document Procurement Rate	<ul style="list-style-type: none"> <li>All requested IICSP documents (<b>100 percent</b>) were submitted for review.</li> </ul>
<b>Encounter Data Completeness</b>	
Service Record Omission Rate	<ul style="list-style-type: none"> <li>The overall service record omission rate for the <i>Date of Service</i> data element was high at <b>17.8 percent</b>. Rates varied by service category, ranging from <b>0.0 percent</b> (i.e., NEMT) to <b>20.0 percent</b> (i.e., Personal Care Service).</li> </ul>

Analysis	Key Findings
	<ul style="list-style-type: none"> <li>The overall service record omission rate for the <i>Diagnosis Code</i> data element was high at <b>18.3 percent</b>, with variations across service categories, ranging from <b>13.6 percent</b> (i.e., Hearing) to <b>20.0 percent</b> (i.e., Personal Care Service).</li> <li>The overall service record omission rate for the <i>Procedure Code</i> data element was high at <b>32.4 percent</b>. Rates varied by service category, ranging from <b>0.0 percent</b> (i.e., NEMT) to <b>82.9 percent</b> (i.e., Personal Care Service).</li> <li>The overall service record omission rate for the <i>Procedure Code Modifier</i> data element was at <b>8.0 percent</b>. Rates varied by service category, ranging from <b>0 percent</b> (i.e., NEMT) to <b>10.0 percent</b> (i.e., Vision).</li> <li>The service record omission rate for the <i>Units</i> data element was at <b>0.0 percent</b> for NEMT.</li> <li>Higher rates of service record omission rate suggest that the data elements in the encounter data were not adequately supported by the members' service records.</li> </ul>
Encounter Data Omission Rate	<ul style="list-style-type: none"> <li>Although the overall encounter data omission rates for the <i>Procedure Code</i>, <i>Procedure Code Modifier</i>, and <i>Units</i> data elements were relatively low, there was significant variation by service category. Notably, NEMT exhibited high omission rates for both <i>Procedure Code</i> and <i>Procedure Code Modifier</i> data elements at <b>50.0 percent</b> and <b>25.0 percent</b>, respectively.</li> <li>The overall encounter data omission rate for the <i>Date of Service</i> data element was moderately high at <b>13.4 percent</b>. Rates varied by service category, ranging from <b>10.8 percent</b> (i.e., Dental) to <b>50.0 percent</b> (i.e., NEMT).</li> <li>The overall encounter data omission rate for the <i>Diagnosis Code</i> data element was high at <b>22.2 percent</b>, with variations across service categories, ranging from <b>0.0 percent</b> (i.e., Personal Care Service) to <b>27.4 percent</b> (i.e., Vision).</li> </ul>
<b>Encounter Data Accuracy</b>	
Diagnosis Code Rate	<ul style="list-style-type: none"> <li>The <i>Diagnosis Code</i> data element was accurate in <b>99.0 percent</b> of instances where diagnosis codes were present in both the service records and encounter data, with all errors attributed to inaccurate coding.</li> <li>The accuracy rate for Personal Care Service was at <b>95.8 percent</b>, while Hearing and Vision reached <b>100 percent</b> accuracy for diagnosis codes.</li> </ul>
Procedure Code Rate	<ul style="list-style-type: none"> <li>The <i>Procedure Code</i> data element was accurate in <b>98.4 percent</b> of instances where procedure codes were present in both the service records and encounter data.</li> <li>The accuracy rate for Dental was at <b>98.2 percent</b>, while all other service categories reached <b>100 percent</b> accuracy for procedure codes.</li> </ul>

Analysis	Key Findings
Procedure Code Modifier Rate	<ul style="list-style-type: none"> <li>The <i>Procedure Code Modifier</i> data element was accurate in <b>100 percent</b> of instances where procedure code modifiers were present in both the service records and encounter data.</li> </ul>
Units Rate	<ul style="list-style-type: none"> <li>The <i>Units</i> data element was accurate in <b>100 percent</b> of instances where units were present in both the service records and encounter data.</li> </ul>
All-Element Rate	<ul style="list-style-type: none"> <li>Dates of services with accurate values for all key data elements relevant to their respective service categories (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, <i>Procedure Code Modifier</i>, and <i>Units</i>) were observed in <b>87.7 percent</b> of the dates of services present in both data sources (i.e., encounter data and service records).</li> </ul>
<b>IICSP Review</b>	
Document Review	<ul style="list-style-type: none"> <li>The percentage of valid IICSP documents with proper signatures was low at <b>30.0 percent</b>, which largely prevented the assessment of subsequent items requiring signature verification.</li> </ul>

### 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:** When the *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Units* data elements were present in both the encounter data and the members' service records and were evaluated independently across all service categories, the data element values demonstrated high accuracy with rates of at least 98.4 percent each. [**Quality**]

#### Weaknesses and Recommendations

**Weakness #1:** **MOL** was unable to procure all the requested service records from its contracted providers primarily due to the 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 that its contracted providers are held accountable for responding to service record requests in a timely manner to support auditing, inspection, and oversight activities. HSAG recommends that **MOL** strengthen and/or enforce its contractual requirements with its providers to promote timely submission of requested documentation. This may

include implementing clear expectations, regular communication about submission requirements and deadlines, and consequences for non-compliance.

**Weakness #2:** Approximately 17.8 percent of the dates of service in the encounter data were not supported by the members' service records. Furthermore, around 18.3 percent and 32.4 percent of the *Diagnosis Code* and *Procedure Code* data elements, respectively, in the encounter data were not supported by the members' service records (i.e., service record omission). [Quality]

**Why the weakness exists:** The findings where encounter data are not supported by the members' service records can stem from several potential reasons, which can involve provider documentation practices (e.g., incomplete or inaccurate documentation, coding errors, insufficient detail in the service records), data submission (e.g., incorrect coding during data submission, data entry errors, or inconsistencies in submitted claims), or processing issues (e.g., data mapping, translation issues, or transmission that result in discrepancies between encounter data and service records).

**Recommendation:** MOL should investigate the root causes of these omissions and consider performing periodic service record reviews of submitted claims to verify appropriate coding and data completeness, where appropriate. Findings from these reviews should be used to inform targeted education and training initiatives for providers. These initiatives should focus on encounter data submission practices, comprehensive and accurate documentation of members' service record, and adherence to accurate coding practices to reduce future discrepancies.

**Weakness #3:** Approximately 13.4 percent of the dates of services from members' service records were not found in MDHHS' encounter data. Furthermore, around 22.2 percent of diagnosis codes in the members' service records were not found in MDHHS' encounter data. [Quality]

**Why the weakness exists:** The presence of the *Date of Service* and *Diagnosis Code* data elements in members' service records that are not reflected in MDHHS' encounter data could suggest issues with data integration between the providers' systems and the State's reporting system. Additionally, the discrepancy could also stem from inconsistent reporting standards or practices among providers. If providers interpret or apply the reporting requirements differently, this could lead to incomplete or incorrect data being sent to MDHHS.

**Recommendation:** To address these issues, MOL should work with MDHHS to enhance the integration and synchronization of data transfer mechanisms. It is crucial to develop and implement standardized reporting procedures and conduct regular training sessions for all providers to ensure consistent and compliant data reporting. Additionally, regular audits of submitted data against members' service records can help identify discrepancies early, and establishing feedback loops will allow for timely corrective actions. Hosting workshops and pilot initiatives, such as automated validations, can further promote accurate and complete reporting of diagnosis codes.

**Weakness #4:** The submitted documentation for the members' IICSPs was incomplete, with required signatures missing for approximately 70.0 percent of the requested cases. Signatures are essential to validate that the IICSP has been reviewed, approved, and agreed upon by the appropriate parties, in accordance with regulatory and contractual requirements. [Quality]

**Why the weakness exists:** The absence of signatures highlights potential gaps in compliance with documentation standards and raises concerns about validating care coordination efforts. It may also

impact the ability to demonstrate member or provider agreement with the outlined care plan, which is essential for ensuring accountability and alignment with care objectives.

**Recommendation:** **MOL** should take proactive steps to ensure that all IICSP documentation includes the required signatures prior to providing or sharing the members' documentation with the relevant stakeholders. To achieve this, **MOL** should implement robust internal quality assurance processes to review and verify that all documentation is complete and compliant with applicable guidelines prior to submission. Additionally, **MOL** should provide targeted education and training for providers to emphasize the importance of obtaining signatures and maintaining accurate, complete documentation. These efforts will enhance compliance with regulatory and contractual requirements while improving the overall integrity and accountability of care coordination documentation.

## Consumer Assessment of Healthcare Providers and Systems Analysis

### Performance Results

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

### Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the HCBS 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 finding did not determine significant impact to the quality, timeliness, and/or accessibility of care.

## Strengths

**Strength #1:** As **MOL**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis indicated that the 2024 top-box score for *Rating of Personal Assistance and Behavioral Health Staff* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. **[Quality]**

**Strength #2:** As **MOL**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis indicated that the 2024 top-box score for *Rating of Case Manager* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. **[Quality]**

**Strength #3:** As **MOL**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis indicated that the 2024 top-box score for *Helpful Case Manager* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. **[Quality]**

**Strength #4:** As **MOL**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis indicated that the 2024 top-box score for *Personal Safety and Respect* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. **[Quality]**

**Strength #5:** As **MOL**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis indicated that the 2024 top-box score for *Planning Your Time and Activities* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. **[Access]**

## Weaknesses and Recommendations

**Weakness #1:** As **MOL**-specific results were not available due to low response rates, no substantial weaknesses could be presented at the individual ICO level. However, program level results identified that while the 2024 top-box score for *Planning Your Time and Activities* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark, it was also the lowest performing measure across ICOs with a 2024 top-box score of 64.14 percent. This composite measure indicates there are opportunities to promote community inclusion and empowerment, as some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day. **[Access]**

**Why the weakness exists:** The program level results indicate there are opportunities for the MI Health Link program to help members with community inclusion and empowerment opportunities.

**Recommendation:** **MOL** has reported collaborating with vendors and implementing care management interventions to target performance of *Planning Your Time and Activities*. HSAG recommends that **MOL** continue these interventions and add measures of effectiveness of the interventions as appropriate. In addition, HSAG recommends that **MOL** collect regular feedback throughout the year to identify member input and feedback through town halls, focus groups, and short surveys. HSAG further recommends that **MOL** ensure member demographic information is correct to improve response rates.



## 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 that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **MOL**'s overall performance contributed to the MI Health Link program's progress in achieving the CQS goals and objectives. Table 3-86 displays each MDHHS CQS goal and the EQR activity results that indicate whether the ICO positively (✓), negatively (✗), or minimally (m) impacted the MI Health Link program'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 if a CQS goal did not include any quality measures for the MI Health Link program or the EQR activities do not produce data to assess the impact of a quality measure(s) under an objective.

**Table 3-86—Overall Performance Impact to CQS and Quality, Timeliness, and Access**

Objective	Quality Measure	Overall Performance Impact	Performance Domain
<b>Goal #1: Ensure high quality and high levels of access to care</b>			
1.1	<i>MI7.3 Annual Dental Visit</i>	✗	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	<i>FUH—Follow-Up After Hospitalization for Mental Illness (30 Days)</i>	✓	
	<i>COL—Colorectal Cancer Screening</i>	m	
1.2	<i>CBP—Controlling High Blood Pressure</i>	m	
	<i>PCR—Plan All-Cause Readmission</i>	✗ <sup>1</sup>	
	<i>COL—Colorectal Cancer Screening</i>	m	
1.3	<i>Annual Flu Vaccine</i>	NA	
	<i>MI5.6 Medication Review—All Populations</i>	✗	
	<i>TRC—Transitions of Care—Medication Reconciliation Post-Discharge</i>	m	
	<i>PM13 Number and percent of enrollees whose IICSP addressed their assessed health and safety risks (HCBS C-Waiver population)</i>	NA	
	<i>PM15 Number &amp; percent of enrollees with an individualized contingency/back-up plan addressing caregiver absences, severe weather, fire/other emergencies (HCBS C-Waiver population)</i>	NA	
	<i>PM24 Number and percent of files that show enrollee/family/legal guardians (as appropriate) received information and education on how to report abuse, neglect, exploitation, and other critical incidents within 60 days of waiver enrollment.</i>	NA	



Objective	Quality Measure	Overall Performance Impact	Performance Domain
Goal #2: Strengthen person and family-centered approaches			
2.1	MI2.3 Members with documented discussions of care goals	NA	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	Core 9.3 Minimizing Facility Length of Stay—Ratio of Observed to Expected Discharge Rates	✓	
	PM17 Number and percent of enrollee IICSPs that are updated as the enrollee's needs change	NA	
2.2	SNS-E Social Needs Screening & Intervention	NA	
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)			
3.1	FUH—Follow-Up After Hospitalization for Mental Illness (30 Days)	✓	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
3.2	MI2.6 Timely transmission of care transition record to health care professional	✗	
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes			
4.1	Molina—Addressing Disparities in Controlling High Blood Pressure Between Black/African American and White Members	✓ <sup>2</sup>	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
Goal #5: Improve quality outcomes through value-based initiatives and payment reform			
5.1	The CQS does not include quality measures for the MI Health Link Program under Goal #5.	NA	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access

✓ = The ICO's rate met the 2026 statewide performance target

m = The ICO's rate did not meet the 2026 statewide performance target, or the ICO's HEDIS rate did not meet the 2026 statewide performance target but the ICO's HEDIS rate increased in performance from the prior year

✗ = The ICO's rate did not meet the 2026 statewide performance target and/or the ICO's HEDIS 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 or the CQS did not include any quality measures for the MI Health Link program.

<sup>1</sup> The CQS did not identify the age stratification associated with the quality measure; therefore, HSAG used the 65+ stratification rate for the assessment.

<sup>2</sup> Evaluation of this quality measure used the results of the QIP activity and not the HEDIS rate reported under the PMV activity. While the disparity was not eliminated, the ICO demonstrated statistically significant improvement over the baseline performance for the disparate population during second remeasurement period.

## Upper Peninsula Health Plan MI Health Link

### Validation of Quality Improvement Projects

#### Performance Results

HSAG’s validation evaluated the technical methods of **UPP**’s QIP, including an evaluation of statistically significant improvement based on reported results and statistical testing (i.e., the QIP 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 QIP and Validation Rating 2 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence that the QIP achieved significant improvement. Table 3-87 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 3-87—Overall Validation Rating for UPP**

QIP Topic	Validation Rating 1	Validation Rating 2	Performance Indicator	Performance Indicator Results			
				Baseline	R1	R2	Disparity
Annual Dental Care	High Confidence	No Confidence	Annual dental visit for UPP American Indian/Alaska Native MI Health Link members.	22.7%	21.2% ⇔	22.6% ⇔	Yes
			Annual dental visit for UPP White MI Health Link members.	34.6%	35.1% ⇔	33.3% ⇔	

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 **UPP**’s QIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (American Indian/Alaskan Native) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White). Table 3-88 displays the barriers identified through quality improvement and causal/barrier analysis processes and the interventions initiated by the ICO to support achievement of the QIP goals and address the barriers.

**Table 3-88—Remeasurement 2 Barriers and Interventions for UPP**

Barriers	Interventions
Only 46 percent of members were able to be reached for intervention.	Partnered with Sault Tribe Dental Clinic which conducted outreach to engage members.

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

### Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the QIP 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 quality improvement tools to conduct a causal/barrier analysis and prioritize the identified barriers, and interventions were implemented in a timely manner. [Quality and Timeliness]

#### Weaknesses and Recommendations

**Weakness #1: UPP** did not achieve the state-specific goal of eliminating the existing disparity between the two subgroups with the second remeasurement period and both subgroups demonstrated declines in performance as compared to the baseline. [Quality and Access]

**Why the weakness exists:** While it is unclear why the goal was not achieved or why both subgroups declined in performance, the data suggest barriers exist within both subgroups in the receipt of annual dental care.

**Recommendation:** HSAG recommends **UPP** revisit its causal barrier analysis to determine whether any new barriers exist for both the disparate and comparison subgroups that require the development of targeted strategies to improve performance.

## Performance Measure Validation

### Performance Results

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

**UPP** received a measure designation of *Reportable (R)* for all measures, signifying that **UPP** had reported the measures in compliance with the MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements and that rates could be reported. Table 3-89 includes the validation designation for each performance measure as well as the validated SFY 2024 performance measure rates.

**Table 3-89—Measure-Specific Validation Designation for UPP**

Performance Measure	Validation Designation	SFY 2024 Rate
<b>Core Measure 9.3:</b> <i>Minimizing Facility Length of Stay</i>	<b>REPORTABLE (R)</b> The ICO reported this measure in alignment with the MMP Core Reporting Requirements.	1.24*
<b>MI2.6:</b> <i>Timely Transmission of Care Transition Record to Health Care Professional</i>	<b>REPORTABLE (R)</b> The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.	72.99%
<b>MI5.6:</b> <i>Care for Adults—Medication Review</i>	<b>REPORTABLE (R)</b> The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.	93.67%
<b>MI7.3:</b> <i>Annual Dental Visit</i>	<b>REPORTABLE (R)</b> The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.	32.85%

\*Please note for Core Measure 9.3 that the SFY 2024 rate is reflective of the ICO's calculated ratio of observed to expected discharges (O/E ratio) rather than a calculated percentage rate, as is reflected for MI2.6, MI5.6, and MI7.3.

Table 3-90 shows each of **UPP**'s audited HEDIS measures, rates for HEDIS MY 2022 and HEDIS MY 2023 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2023 with HEDIS MY 2022, and the HEDIS MY 2022 and HEDIS MY 2023 MI Health Link statewide average performance rates. HEDIS MY 2022 and HEDIS MY 2023 measure rates performing better than the MY 2022 and MY 2023 statewide averages are notated by **green** font.

Table 3-90—Measure-Specific Percentage Rates for UPP

HEDIS Measure	HEDIS MY 2022 (%)	HEDIS MY 2023 (%)	HEDIS MY 2022 vs. MY 2023	MY 2022 Statewide Average (%)	MY 2023 Statewide Average (%)
<b>Prevention and Screening</b>					
BCS-E—Breast Cancer Screening	65.49	66.55	+1.06	56.70	58.82
COL—Colorectal Cancer Screening <sup>1</sup>	64.12	65.76	+1.64	57.59	60.82
COA—Care for Older Adults—Medication Review	94.16	94.65	+0.49	80.41	90.90
COA—Care for Older Adults—Functional Status Assessment	83.94	79.32	-4.62	62.71	70.13
COA—Care for Older Adults—Pain Assessment	92.70	93.92	+1.22	78.04	83.50
<b>Respiratory Conditions</b>					
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	24.07	22.52	-1.55	22.01	23.00
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	89.76	87.25	-2.51	74.10	74.05
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	90.55	87.25	-3.30	88.82	86.81
<b>Cardiovascular Conditions</b>					
CBP—Controlling High Blood Pressure	80.05	81.51	+1.46	66.14	68.85
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack <sup>2</sup>	—	50.00	—	—	56.36
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy	80.12	85.71	+5.59	80.90	85.02
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%	80.45	85.90	+5.45	79.55	81.48
<b>Diabetes</b>					
HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)*	21.90	16.79	-5.11	34.07	29.00
HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)	68.86	74.94	+6.08	58.51	63.61
EED—Eye Exam for Patients With Diabetes <sup>1</sup>	66.91	63.75	-3.16	62.89	65.27
BPD—Blood Pressure Control for Patients With Diabetes	85.64	88.08	+2.44	68.13	70.83
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy	71.22	73.35	+2.13	76.44	76.91
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%	86.53	84.08	-2.45	78.95	80.60
<b>Musculoskeletal Conditions</b>					
OMW—Osteoporosis Management in Women Who Had a Fracture	10.00	30.00	+20.00	11.18	20.27

HEDIS Measure	HEDIS MY 2022 (%)	HEDIS MY 2023 (%)	HEDIS MY 2022 vs. MY 2023	MY 2022 Statewide Average (%)	MY 2023 Statewide Average (%)
<b>Behavioral Health</b>					
AMM—Antidepressant Medication Management—Effective Acute Phase Treatment <sup>1</sup>	82.79	77.89	-4.90	73.66	70.76
AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment <sup>1</sup>	71.31	56.84	-14.47	57.94	54.20
FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	41.54	44.78	+3.24	32.79	31.03
FUH—Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up	73.85	77.61	+3.76	58.91	58.83
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up	29.55	22.22	-7.33	32.06	29.44
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up	61.36	49.21	-12.15	54.39	48.27
<b>Medication Management and Care Coordination</b>					
TRC—Transitions of Care—Medication Reconciliation Post-Discharge	74.94	75.18	+0.24	47.59	56.17
TRC—Transitions of Care—Notification of Inpatient Admission	60.83	52.07	-8.76	16.53	24.53
TRC—Transitions of Care—Receipt of Discharge Information	45.99	42.58	-3.41	15.38	19.48
TRC—Transitions of Care—Patient Engagement After Inpatient Discharge	89.78	90.27	+0.49	77.74	79.78
<b>Overuse/Appropriateness</b>					
PSA—Non-Recommended PSA-Based Screening in Older Men*	21.19	23.16	+1.97	26.71	27.99
DDE—Potentially Harmful Drug-Disease Interactions in Older Adults*	41.20	43.18	+1.98	33.45	33.54
DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid*	21.18	22.04	+0.86	18.16	17.57
DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis*	9.54	8.19	-1.35	5.23	4.99
DAE—Use of High-Risk Medications in Older Adults—Total*	28.19	27.71	-0.48	21.78	21.07
<b>Access/Availability of Care</b>					
AAP—Adults’ Access to Preventive/Ambulatory Health Services—20–44 Years	91.09	90.37	-0.72	84.90	85.69
AAP—Adults’ Access to Preventive/Ambulatory Health Services—45–64 Years	95.55	95.16	-0.39	93.83	93.71
AAP—Adults’ Access to Preventive/Ambulatory Health Services—65 Years and Older	94.93	95.45	+0.52	91.69	91.79



HEDIS Measure	HEDIS MY 2022 (%)	HEDIS MY 2023 (%)	HEDIS MY 2022 vs. MY 2023	MY 2022 Statewide Average (%)	MY 2023 Statewide Average (%)
<i>AAP—Adults’ Access to Preventive/Ambulatory Health Services—Total</i>	94.48	94.48	+/-0.00	91.08	91.24
<i>IET— Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total<sup>1</sup></i>	31.67	28.95	-2.72	34.10	35.83
<i>IET— Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total<sup>1</sup></i>	5.43	9.47	+4.04	3.84	4.43
<b>Risk-Adjusted Utilization</b>					
<i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)*</i>	0.51	1.01	+0.50	1.07	1.11
<i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)*</i>	0.97	0.99	+0.02	1.21	1.21

\* Measures for which lower rates indicate better performance.

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

<sup>2</sup> Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between MY 2023 and prior years; therefore, the HEDIS MY 2022 rate and comparison from HEDIS MY 2022 vs. MY 2023 will not be displayed for this measure.

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

## 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:** As applicable to MI2.6, **UPP** continued to demonstrate improvement with increasing timely care transition record notifications through continued facility engagement and focus on the Upper Peninsula Health Information Exchange (UPHIE) to include ADT alerts. All **UPP**’s in-network hospitals within the Upper Peninsula Region submitted ADTs through the UPHIE portal for timely notifications. In addition, **UPP** continued to engage its contracted clinics, tribal health centers, community mental health centers, and skilled nursing facilities connected to UPHIE. **UPP** plans to continue its improvement efforts by focusing on storing ADT continuity of care documents generated at the time of discharge for care management and provider offices to access. Additionally, **UPP** is looking to further connect provider practices to UPHIE so that they have access to both timely ADTs and continuity of care documents. [**Quality** and **Timeliness**]

**Strength #2:** In the Cardiovascular Conditions domain, **UPP**’s rates for the *SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy* and *Statin Adherence 80%* measure



indicators both increased by more than 5 percentage points from MY 2022 to MY 2023 and exceeded the HEDIS MY 2023 MI Health Link statewide average, suggesting strength and improvement in cardiovascular treatment and prevention for members. Research indicates that statins are the primary treatment choice for cardiovascular diseases, which stand as the leading global cause of mortality. In general, statins are considered safe and well-tolerated medications, and are the most commonly prescribed drugs worldwide. They play a role in preventing stroke, improving outcomes in acute coronary syndrome, reducing the risk of atrial fibrillation after heart surgery, and benefiting patients with heart failure.<sup>56</sup> [Quality, Timeliness, and Access]

**Strength #3:** In the Diabetes domain, **UPP**'s rate for the *HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* measure indicator increased by more than 6 percentage points from MY 2022 to MY 2023 and exceeded the HEDIS MY 2023 MI Health Link statewide average, suggesting strength and improvement in adult members ages 18 to 75 years with diabetes having controlled HbA1c levels. Diabetes is the eighth leading cause of death in the U.S. and was responsible for approximately 103,294 deaths in 2021. 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.<sup>57</sup> [Quality]

**Strength #4:** In the Musculoskeletal Conditions domain, **UPP**'s rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator increased by 20 percentage points from MY 2022 to MY 2023 and exceeded the HEDIS MY 2023 MI Health Link statewide average, suggesting strength and improvement in timely screening and treatment of women who suffered a fracture, with either a bone mineral density test or a prescription for a drug to treat osteoporosis. Osteoporosis is a bone disease that develops when bone mineral density and bone mass decrease, or when the quality or structure of bone changes. This can lead to a decrease in bone strength that can increase the risk of fractures. For older adults, the risk of breaking another bone is highest in the year or two after breakage of the first bone. The risk of another fracture can be reduced, so it is important to take steps as soon as possible after a fracture to prevent another one.<sup>58</sup> [Quality, Timeliness, and Access]

- 
- <sup>56</sup> National Institutes of Health-National Library of Medicine. Khatiwada N, Hong Z. Potential Benefits and Risks Associated with the Use of Statins. *Pharmaceutics*. 2024 Feb 1;16(2):214. doi: 10.3390/pharmaceutics16020214. PMID: 38399268; PMCID: PMC10892755. Potential Benefits and Risks Associated with the Use of Statins. Available at: <https://pmc.ncbi.nlm.nih.gov/articles/PMC10892755/>. Accessed on: Mar 7, 2025.
- <sup>57</sup> 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: Mar 4, 2025.
- <sup>58</sup> National Institutes of Health-National Institute of Arthritis and Musculoskeletal and Skin Diseases. Preventing Another Broken Bone. Available at: <https://www.niams.nih.gov/health-topics/preventing-another-broken-bone>. Accessed on: Mar 7, 2025.
-

## Weaknesses and Recommendations

**Weakness #1:** HSAG identified two cases that were incorrectly reported in data element A, and two cases that were incorrectly reported in data element B for Core Measure 9.3, which resulted in resubmission of Core Measure 9.3 to HPMS. [Quality]

**Why the weakness exists:** For Core Measure 9.3, data element A, two cases were identified that had denied claims for the institutional facility admission and therefore should not have been reported, since data element A should only be based on paid claims. For Core Measure 9.3, data element B, one case was included even though the member was not discharged to the community within 100 days of the institutional facility admission. Additionally, one case was identified in data element B who was readmitted to the facility within 60 days of the day of discharge from the facility. UPP's programming logic needed to be updated for data element A to only be based on paid claims, in alignment with the Core reporting requirements and the Core Measure 9.3 FAQ document. Additionally, programming logic was required to be updated for data element B to allow for paid, partially paid, and denied claims in order to appropriately capture member discharges to the community and allow for identification of readmissions to the facility within 60 days of the day of discharge.

**Recommendation:** HSAG recommends that UPP incorporate more stringent quality checks and increased frequency of validation checks prior to submission of data to MDHHS and HSAG, such as performing PSV for a statistically significant sample of cases to ensure that the cases meet reporting requirements. HSAG also recommends that UPP review the annual release of the Core reporting requirements and current source code for Core Measure 9.3 to further ensure that the programming logic is in alignment with the reporting requirements.

**Weakness #2:** UPP continued to only incorporate race and ethnicity data from the data submitted by the State in the 834 file. [Quality]

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

**Recommendation:** HSAG continues to recommend that UPP explore additional sources for race and ethnicity data, as MDHHS' expectation is that ICOs will validate and supplement the data provided in 834 files through other sources including care coordination activities, member survey data, and EHR data.

**Weakness #3:** While only 10 of the 42 reported HEDIS measures rates (24 percent) indicated worse performance than the statewide average, opportunity exists for UPP to further improve performance across multiple domains including Respiratory Conditions, Cardiovascular Conditions, Diabetes, Behavioral Health, Overuse/Appropriateness, and Access/Availability of Care. [Quality]

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

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

**Weakness #4:** In the Behavioral Health domain, **UPP**'s rates for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* measure indicators decreased by more than 7 percentage points and 12 percentage points, respectively, from MY 2022 to MY 2023, with the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* measure indicator falling below the HEDIS MY 2023 MI Health Link statewide average, indicating that some members were not receiving timely follow-up care for mental illness after an ED visit. Research suggests that patients with mental disorders are among the highest users of ED services, with visits characterized by long lengths of stay, intensive treatment, and elevated rates of hospitalizations. After discharge, fewer than half of these patients successfully transition to outpatient care, with high rates of readmission to the ED. Programs that allow patients with mental disorders to successfully engage with outpatient care hold the potential not only to improve quality and outcomes of care for people with mental disorders, but also to free capacity within EDs to provide care for other urgent needs.<sup>59</sup> [Quality, Timeliness, and Access]

**Why the weakness exists:** The rates for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* measure indicators decreasing by more than 7 percentage points and 12 percentage points, respectively, from MY 2022 to MY 2023, and the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* measure indicator falling below the HEDIS MY 2023 MI Health Link statewide average, suggests that barriers exist for some members to receive follow-up care for mental illness after an ED visit. Potential barriers noted by **UPP** consist of provider offices not receiving ADTs for all ED visits if they are not connected to a facility's electronic medical records (EMR), incorrect coding practices, and claims lag or missing claims data. In addition, EDs not facilitating the follow-up visit can make the timeliness criteria of seven days difficult to attain due to scheduling restrictions on the clinic side.

**Recommendation:** While **UPP** implemented various interventions such as adding the measure to the quality withhold for its subcontracted PIHP, as well as meeting quarterly, distributing quarterly report cards with cumulative rates and comparative rates for facilities, and updating its transitions of care policy to include care manager contact with members within two business days post ED visit, HSAG recommends that **UPP** continue to focus on improvement efforts for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* measure indicators. Current interventions should be reviewed or expanded upon if additional barriers or contributing factors to low performance are identified.

---

<sup>59</sup> National Institutes of Health-National Library of Medicine. Druss B, Lally CA, Li J, et al. Comparing Two Ways to Help Patients Get Follow-up Care after a Mental Health Visit to the Emergency Room—The EPIC Study [Internet]. Washington (DC): Patient-Centered Outcomes Research Institute (PCORI); 2021 May. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK601636/> doi: 10.25302/05.2021.IHS.151032431. Accessed on: Mar 7, 2025.

## Compliance Review

### Performance Results

Table 3-91 presents an overview of the results of the SFY 2022 and SFY 2023 compliance reviews for **UPP**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. If a requirement was not applicable to **UPP** during the period covered by the review, HSAG used a *Not Applicable (NA)* designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 14 standards.

**Table 3-91—Summary of Standard Compliance Scores**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			<i>M</i>	<i>NM</i>	<i>NA</i>	
Standard I—Disenrollment: Requirements and Limitations	9	9	8	1	0	<b>89%</b>
Standard II—Member Rights and Member Information	23	22	16	6	1	<b>73%</b>
Standard III—Emergency and Poststabilization Services	13	13	13	0	0	<b>100%</b>
Standard IV—Availability of Services	13	13	11	2	0	<b>85%</b>
Standard V—Assurances of Adequate Capacity and Services	4	4	3	1	0	<b>75%</b>
Standard VI—Coordination and Continuity of Care	31	30	23	7	1	<b>77%</b>
Standard VII—Coverage and Authorization of Services	28	27	27	0	1	<b>100%</b>
Standard VIII—Provider Selection	23	23	20	3	0	<b>87%</b>
Standard IX—Confidentiality	11	11	7	4	0	<b>64%</b>
Standard X—Grievance and Appeal Systems	45	45	36	9	0	<b>80%</b>
Standard XI—Subcontractual Relationships and Delegation	6	5	3	2	1	<b>60%</b>
Standard XII—Practice Guidelines	6	6	5	1	0	<b>83%</b>
Standard XIII—Health Information Systems <sup>1</sup>	9	9	9	0	0	<b>100%</b>
Standard XIV—Quality Assessment and Performance Improvement Program	21	21	19	2	0	<b>90%</b>
<b>Total</b>	<b>242</b>	<b>238</b>	<b>200</b>	<b>38</b>	<b>4</b>	<b>84%</b>

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

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

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

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

<sup>1</sup> This standard includes a comprehensive assessment of the ICO's IS capabilities.

## Review of Corrective Action Plan Implementation

Based on the findings of the SFY 2022 and SFY 2023 compliance review activities, **UPP** was required to develop and submit a CAP for each element assigned a score of *Not Met*. MDHHS and HSAG reviewed the CAP for sufficiency, and **UPP** was responsible for implementing each action plan in a timely manner. Table 3-92 presents an overview of the results of the SFY 2024 compliance review for **UPP**, which consisted of a comprehensive review of the ICO's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Section 2.

**Table 3-92—Summary of CAP Implementation**

Standard	Total CAP Elements	# of CAP Elements Complete	# of CAP Elements Not Complete
Standard I—Disenrollment: Requirements and Limitations	1	1	0
Standard II—Member Rights and Member Information	6	6	0
Standard IV—Availability of Services	2	2	0
Standard V—Assurances of Adequate Capacity and Services	1	1	0
Standard VI—Coordination and Continuity of Care	7	7	0
Standard VIII—Provider Selection	3	3	0
Standard IX—Confidentiality	4	4	0
Standard X—Grievance and Appeal Systems	9	9	0
Standard XI—Subcontractual Relationships and Delegation	2	2	0
Standard XII—Practice Guidelines	1	1	0
Standard XIV—Quality Assessment and Performance Improvement Program	2	2	0
<b>Total</b>	<b>38</b>	<b>38</b>	<b>0</b>

**Total CAP Elements:** The total number of elements within each standard that required a CAP during the SFY 2022 and SFY 2023 compliance review activities.

**# of CAP Elements Complete:** The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirements under review.

**# of CAP Elements Not Complete:** The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirements under review.

<sup>1</sup>This standard includes a comprehensive assessment of the ICO's IS capabilities.

## 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** demonstrated that it successfully remediated all 36 elements, indicating that the necessary policies, procedures, and interventions were implemented to ensure compliance with the Disenrollment: Requirements and Limitations, Member Rights and Member Information, Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Provider Selection, Confidentiality, Grievance and Appeal Systems, Subcontractual Relationships and Delegation, Practice Guidelines, and Quality Assessment and Performance Improvement Program. [Quality, Timeliness, and Access]

## Weaknesses and Recommendations

**Weakness #1:** HSAG did not identify any substantial weaknesses for **UPP** as all CAPs had been fully implemented and all requirements deemed compliant.

**Why the weakness exists:** NA

**Recommendation:** NA

## Network Adequacy Validation

### Network Adequacy Analysis

### Performance Results

### ISCA Findings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if **UPP**'s interpretation of data was accurate. Table 3-93 summarizes HSAG's validation ratings for **UPP**, by indicator type.

**Table 3-93—Summary of UPP's Validation Ratings**

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Time and Distance	100%	0%	0%	0%
Provider Capacity	100%	0%	0%	0%

Of the network adequacy indicators assessed, **UPP** received *High Confidence* for both time and distance and provider capacity indicator types.

### Analytic Findings

**UPP** submitted its SFY 2024 region-specific member and Medicaid provider data files, and exception requests to HSAG on April 29, 2024. Based on HSAG's detailed file review findings communicated to



**UPP** on June 18, 2024, HSAG asked **UPP** to resubmit its network data files for all regions to address identified data issues. **UPP** resubmitted its region-specific network data files to HSAG on June 26, 2024.

MDHHS approved **UPP**'s requested exceptions for all applicable network standards in Region 1.

Table 3-94 presents **UPP**'s region-specific NAV results by Medicaid and LTSS provider category following all data resubmissions and MDHHS' exception determinations.

**Table 3-94—SFY 2024 NAV Results for UPP by Region and Provider Category**

Provider Category	Region 1 Validation Result
<b>Provider Categories With Travel Time and Distance Standards</b>	
Adult Day Program	Exception Granted
Dental	Exception Granted
Eye Examinations	Met
Eye Wear	Met
Hearing Aids	Exception Granted
Hearing Examinations	Exception Granted
<b>Provider Categories Rendering Home-Based Services</b>	
Adaptive Medical Equipment and Supplies	Met
Assistive Technology—Devices	Met
Assistive Technology—Van Lifts and Tie Downs	Met
Chore Services	Met
ECLS	Met
Environmental Modifications	Met
Fiscal Intermediary	Met
Home-Delivered Meals	Met
Medical Supplies	Met
NEMT	Exception Granted
Non-Medical Transportation	Met
Personal Care Services	Met
Personal Emergency Response System	Met
Preventive Nursing Services	Met
Private Duty Nursing	Met
Respite	Met



Provider Category	Region 1 Validation Result
Skilled Nursing Home	Met
Percent of Total Standards Met*	78.3%
Percentage of Total Standards Met Inclusive of Granted Exceptions*	100%

\*The denominators for Percentage of Total Standards Met and Percentage of Total Standards Met Inclusive of Granted Exceptions include all 23 provider categories.

### 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** demonstrated strength in the ability to maintain accurate and complete provider information through its quarterly directory validation process. [Access]

**Strength #2:** For all Medicaid and LTSS minimum network standards for Region 1, **UPP** either met the minimum network standards or supplied additional documentation to detail the alternative approaches used to ensure adequate services for MI Health Link members (e.g., community supports and resources). [Access]

#### Weaknesses and Recommendations

**Weakness #1:** HSAG identified no specific weaknesses for **UPP** based on the SFY 2024 NAV, as **UPP** demonstrated that it contracted with all available providers for the provider categories that did not meet minimum network standards and supplied evidence of additional supports (e.g., community supports and resources) to provide adequate care to MI Health Link members in Region 1. [Access]

**Why the weakness exists:** Not applicable.

**Recommendation:** **UPP** should make ongoing efforts to identify and contract with additional Adult Day Program, Dental, Hearing Aids, Hearing Examinations, and NEMT providers to assure member access and meet standards. Updated compliance for these provider categories in Region 1 will be evaluated during the SFY 2025 NAV.

## Network Validation Survey

### Performance Results

HSAG performed a comparison of the provider data submitted to HSAG by **UPP** against **UPP**'s online provider directory. The sample included 14 providers (Table 3-95). Among this sample, 92.9 percent were located in the online directory at the sampled location. Additionally, 7.1 percent of the providers could not be located in **UPP**'s online provider directory.

Table 3-95 summarizes findings by region, regarding the number of sampled providers and provider locations (i.e., "cases") that HSAG's reviewers were able to locate in the ICO's online provider directory.

**Table 3-95—Summary of Sampled Dental Providers Located in Online Provider Directory**

Region	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 (%)	Count	Rate (%)	Count	Rate (%)
Region 1	14	1	7.1%	0	0.0%	13	92.9%
<b>UPP Total</b>	<b>14</b>	<b>1</b>	<b>7.1%</b>	<b>0</b>	<b>0.0%</b>	<b>13</b>	<b>92.9%</b>
<b>All ICOs Total</b>	<b>1,179</b>	<b>73</b>	<b>6.2%</b>	<b>18</b>	<b>1.5%</b>	<b>1,088</b>	<b>92.3%</b>

Table 3-96 displays the total number and percent of cases, by region, with matched data values for indicators that were reviewed in the comparison between all ICOs and **UPP**'s submitted provider data and **UPP**'s online provider directory.

**Table 3-96—PDV Study Indicator Match Rates\***

Indicator	Region 1		UPP Total		All ICOs Total	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Provider's Name	13	100%	13	100%	1,106	100%
Provider Street Address	13	100%	13	100%	1,052	95.1%
Provider Suite Number	13	100%	13	100%	1,069	96.7%
Provider City	13	100%	13	100%	1,089	98.5%
Provider State	13	100%	13	100%	1,106	100%
Provider ZIP Code	13	100%	13	100%	1,090	98.6%
Provider Telephone Number	13	100%	13	100%	1,077	97.4%
Provider Type/Specialty	13	100%	13	100%	1,106	100%

Indicator	Region 1		UPP Total		All ICOs Total	
	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
Provider Accepting New Patients**	13	100%	13	100%	1,068	99.4%
Provider Gender	13	100%	13	100%	1,077	97.4%

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

\*\*New patient information was not listed in the online directory for specific ICOs and could only be confirmed by contacting the provider's office. New patient acceptance match rates include an exact match or not listed in the online directory. Caution should be exercised when interpreting the new patient acceptance match rates.

HSAG attempted to contact 13 sampled provider locations for **UPP**, with an overall response rate of 69.2 percent. Table 3-97 summarizes the survey response rates for all ICOs and for **UPP**, by region.

**Table 3-97—Secret Shopper Survey Response Rates, by Region**

Region	Total Survey Cases <sup>1</sup>	Cases Reached <sup>2</sup>	Response Rate (%)
Region 1	13	9	69.2%
<b>UPP Total</b>	<b>13</b>	<b>9</b>	<b>69.2%</b>
<b>All ICOs Total</b>	<b>1,068</b>	<b>945</b>	<b>88.5%</b>

<sup>1</sup> Total survey 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).

<sup>2</sup> Cases reached includes cases that responded to the survey, confirmed the location, and offered the requested service.

Table 3-98 summarizes the acceptance rates for the requested insurance and new patients for all ICOs and for **UPP**, by region.

**Table 3-98—Requested Insurance and New Patient Acceptance Rates, by Region**

Region	Cases Accepting Insurance <sup>1,2</sup>		Accepting New Patients <sup>1</sup>	
	Count	Rate (%)	Count	Rate (%)
Region 1	8	88.9%	7	77.8%
<b>UPP Total</b>	<b>8</b>	<b>88.9%</b>	<b>7</b>	<b>77.8%</b>
<b>All ICOs Total</b>	<b>660</b>	<b>69.8%</b>	<b>645</b>	<b>68.3%</b>

<sup>1</sup> The denominator includes cases reached.

<sup>2</sup> Insurance acceptance includes offices that accepted the requested ICO, affiliated DBA, or MI Health Link program.

Table 3-99 displays the number of survey respondents who offered appointments to new patients for routine dental care (i.e., dental cleaning) for all ICOs and **UPP**, by region.

Table 3-99—New Patient Appointment Availability Results, by Region

Region	Cases Reached	Cases Offered an Appointment	
		Count	Rate (%)
Region 1	9	5	55.6%
<b>UPP Total</b>	<b>9</b>	<b>5</b>	<b>55.6%</b>
<b>All ICOs Total</b>	<b>945</b>	<b>589</b>	<b>62.3%</b>

Table 3-100 displays the new patient wait time statistics for all ICOs and **UPP**, by region.

Table 3-100—New Patient Appointment Wait Time Results, by Region

Region	Appointment Wait Time (Calendar Days)	Percent of Cases Within Standard <sup>1,2</sup>			
	Min	Max	Average	Median	
Region 1	204	321	269	256	0.0%
<b>UPP Total</b>	<b>204</b>	<b>321</b>	<b>269</b>	<b>256</b>	<b>0.0%</b>
<b>All ICOs Total</b>	<b>0</b>	<b>321</b>	<b>32</b>	<b>13</b>	<b>83.5%</b>

<sup>1</sup> The denominator includes cases that offered an appointment.

<sup>2</sup> Percent of Cases Within Standard represents cases that offered an appointment that is compliant with MDHHS' standard for an initial dental appointment (i.e., appointments offered within eight weeks or 56 calendar days).

### 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 92.9 percent of the sampled providers in **UPP**'s online provider directory. 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, 69.2 percent of **UPP**'s locations were reached. [**Access**]

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

**Recommendation:** HSAG recommends that **UPP** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect information) to address the provider data deficiencies. In addition, as MDHHS required **UPP** to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.

**Weakness #2:** Of the cases reached, 88.9 percent of provider locations accepted the insurance, and 77.8 percent accepted new patients. [Access]

**Why the weakness exists:** **UPP**'s data included inaccurate information regarding the provider acceptance of the insurance and new patients.

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

**Weakness #3:** Among the responsive cases, the overall available appointment rate was 62.3 percent. Of the cases that offered an appointment, 0.0 percent were compliant with the appointment wait time standard for routine dental visits (i.e., within eight weeks or 56 calendar days). [Timeliness and Access]

**Why the weakness exists:** For new members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included being required to complete pre-registration or provide additional personal information to schedule an appointment and being required to verify eligibility by providing a member Medicaid ID number. Regarding appointment wait time results, while the **UPP**'s rate was low at 0.0 percent, it is notable that the total number of sampled providers for **UPP** was low, at only 14 providers.

**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 service records and IICSP documentation for sampled members from their contracted providers, based on the final sample list provided by HSAG. These documents covered services that occurred during the review period. HSAG reviewed **UPP**'s procured service records to evaluate the completeness and accuracy of encounter data by examining key data elements, such as *Date of Service*, *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Units*, as applicable. For personal care services, HSAG also reviewed the associated IICSP documents submitted by **UPP** to ensure that the services reported in the encounters were supported by the members' service plans. This review confirmed alignment with authorization dates, scheduled services, units of service, and service providers.

Table 3-101 outlines the key findings for **UPP** based on the assessment of encounter data completeness and accuracy, conducted through a review of members' service records and the IICSP documents for services rendered from October 1, 2022, through September 30, 2023.

**Table 3-101—EDV Results for UPP**

Analysis	Key Findings
<b>Record Procurement Status</b>	
Service Record Procurement Rate	<ul style="list-style-type: none"> <li>The overall service record procurement rate was at <b>97.8 percent</b>, indicating that most of the requested records were procured and submitted.</li> <li>Of the service records not submitted, <b>66.7 percent</b> were not submitted due to non-responsive providers or provider did not respond in a timely manner.</li> <li>Submission rates varied across different service categories within <b>UPP</b>, ranging from <b>96.7 percent</b> (i.e., Vision) to <b>100 percent</b> (i.e., Hearing and NEMT).</li> </ul>
Second Date of Service Submission Rate	<ul style="list-style-type: none"> <li>Among the procured service records, <b>48.4 percent</b> included a corresponding second date of service. The submission rates for a second date of service varied across different service categories within <b>UPP</b>, ranging from <b>29.3 percent</b> (i.e., Vision) to <b>58.6 percent</b> (i.e., Hearing).</li> </ul>
IICSP Document Procurement Rate	<ul style="list-style-type: none"> <li>A total of <b>98.3 percent</b> of the requested IICSP documents were successfully submitted for review.</li> </ul>
<b>Encounter Data Completeness</b>	
Service Record Omission Rate	<ul style="list-style-type: none"> <li>The overall service record omission rate for the <i>Date of Service</i> data element was low at <b>2.7 percent</b>. Rates varied by service category, ranging from <b>0.0 percent</b> (i.e., NEMT) to <b>10.9 percent</b> (i.e., Vision).</li> </ul>

Analysis	Key Findings
	<ul style="list-style-type: none"> <li>The overall service record omission rate for the <i>Diagnosis Code</i> data element was moderately high at <b>13.5 percent</b>, with variations across service categories, ranging from <b>0.0 percent</b> (i.e., Hearing) to <b>17.2 percent</b> (i.e., Vision).</li> <li>The overall service record omission rate for the <i>Procedure Code</i> data element was at <b>6.2 percent</b>. Rates varied by service category, ranging from <b>0.0 percent</b> (i.e., NEMT) to <b>15.5 percent</b> (i.e., Hearing).</li> <li>The overall service record omission rate for the <i>Procedure Code Modifier</i> data element was moderately high at <b>12.5 percent</b>. Rates varied by service category, ranging from <b>3.2 percent</b> (i.e., NEMT) to <b>27.3 percent</b> (i.e., Hearing).</li> <li>The service record omission rate for the <i>Units</i> data element was at <b>0.0 percent</b> for NEMT.</li> <li>High rates of service record omission suggest that the data elements in the encounter data were not adequately supported by the members' service records.</li> </ul>
Encounter Data Omission Rate	<ul style="list-style-type: none"> <li>The overall encounter data omission rates for <i>Date of Service</i>, <i>Procedure Code</i>, <i>Procedure Code Modifier</i>, and <i>Units</i> data elements were relatively low with rates at or below 8.1 percent.</li> <li>The overall encounter data omission rate for the <i>Diagnosis Code</i> data element was slightly elevated at <b>10.6 percent</b>, with variations across service categories ranging from <b>0.0 percent</b> (i.e., Personal Care Service) to <b>15.2 percent</b> (i.e., Hearing).</li> </ul>
<b>Encounter Data Accuracy</b>	
Diagnosis Code Rate	<ul style="list-style-type: none"> <li>The <i>Diagnosis Code</i> data element was accurate in <b>100 percent</b> of instances where diagnosis codes were present in both the service records and encounter data, with all errors attributed to inaccurate coding.</li> </ul>
Procedure Code Rate	<ul style="list-style-type: none"> <li>The <i>Procedure Code</i> data element was accurate in <b>99.6 percent</b> of instances where procedure codes were present in both the service records and encounter data.</li> <li>The accuracy rates for Dental and Vision were at <b>99.6 percent</b>, and <b>99.1 percent</b>, respectively, while all other service categories reached <b>100 percent</b> accuracy for procedure codes.</li> </ul>
Procedure Code Modifier Rate	<ul style="list-style-type: none"> <li>The <i>Procedure Code Modifier</i> data element was accurate in <b>98.4 percent</b> of instances where procedure code modifiers were present in both the service records and encounter data.</li> </ul>
Units Rate	<ul style="list-style-type: none"> <li>The <i>Units</i> data element was accurate in <b>100 percent</b> of instances where units were present in both the service records and encounter data.</li> </ul>



Analysis	Key Findings
All-Element Rate	<ul style="list-style-type: none"> <li>Dates of service with accurate values for all key data elements relevant to their respective service categories (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, <i>Procedure Code Modifier</i>, and <i>Units</i>) were observed in <b>90.8 percent</b> of the dates of service present in both data sources (i.e., encounter data and service records).</li> </ul>
<b>IICSP Review</b>	
Document Review	<ul style="list-style-type: none"> <li>The percentage of valid IICSP documents with proper signatures was low at <b>5.3 percent</b>, which largely prevented the assessment of subsequent items requiring signature verification.</li> </ul>

### 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 dates of service in the encounter data were supported by the members' service records, as evidenced by the overall low service record omission rate of 2.7. [Quality]

**Strength #2:** When the *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Units* data elements were present in both the encounter data and the members' service records and evaluated independently across all service categories, the data element values demonstrated high accuracy, with rates of at least 98.4 percent. [Quality]

#### Weaknesses and Recommendations

**Weakness #1:** Approximately 13.5 percent and 12.5 percent of the *Diagnosis Code* and *Procedure Code Modifier* data elements, respectively, in the encounter data were not supported by the members' service records (i.e., service record omission). [Quality]

**Why the weakness exists:** The findings where encounter data are not supported by the members' service records can stem from several potential reasons, which can involve provider documentation practices (e.g., incomplete or inaccurate documentation, coding errors, insufficient detail in the service records), data submission (e.g., incorrect coding during data submission, data entry errors, or inconsistencies in submitted claims), or processing issues (e.g., data mapping, translation issues, or transmission that result in discrepancies between encounter data and service records).

**Recommendation: UPP** should investigate the root causes of these omissions and consider performing periodic service record reviews of submitted claims to verify appropriate coding and data completeness, where appropriate. Findings from these reviews should be used to inform targeted

education and training initiatives for providers. These initiatives should focus on encounter data submission practices, comprehensive and accurate documentation of members' service record, and adherence to accurate coding practices to reduce future discrepancies.

**Weakness #2:** The submitted documentation for the members' IICSPs was incomplete, with required signatures missing for approximately 94.7 percent of the valid IICSP documents. Signatures are essential to validate that the IICSP has been reviewed, approved, and agreed upon by the appropriate parties, in accordance with regulatory and contractual requirements. [Quality]

**Why the weakness exists:** The absence of signatures highlights potential gaps in compliance with documentation standards and raises concerns about validating care coordination efforts. It may also impact the ability to demonstrate member or provider agreement with the outlined care plan, which is essential for ensuring accountability and alignment with care objectives.

**Recommendation:** UPP should take proactive steps to ensure that all IICSP documentation includes the required signatures prior to providing or sharing the members' documentation with the relevant stakeholders. To achieve this, UPP should implement robust internal quality assurance processes to review and verify that all documentation is complete and compliant with applicable guidelines prior to submission. Additionally, UPP should provide targeted education and training for providers to emphasize the importance of obtaining signatures and maintaining accurate, complete documentation. These efforts will enhance compliance with regulatory and contractual requirements while improving the overall integrity and accountability of care coordination documentation.

## Consumer Assessment of Healthcare Providers and Systems Analysis

### Performance Results

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

### Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the HCBS 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 finding did not determine significant impact to the quality, timeliness, and/or accessibility of care.

## Strengths

**Strength #1:** As UPP-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis indicated that the 2024 top-box score for *Rating of Personal Assistance and Behavioral Health Staff* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. [Quality]

**Strength #2:** As **UPP**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis indicated that the 2024 top-box score for *Rating of Case Manager* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. **[Quality]**

**Strength #3:** As **UPP**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis indicated that the 2024 top-box score for *Helpful Case Manager* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. **[Quality]**

**Strength #4:** As **UPP**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis indicated that the 2024 top-box score for *Personal Safety and Respect* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. **[Quality]**

**Strength #5:** As **UPP**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level. However, statewide analysis indicated that the 2024 top-box score for *Planning Your Time and Activities* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark. **[Access]**

## Weaknesses and Recommendations

**Weakness #1:** As **UPP**-specific results were not available due to low response rates, no substantial weaknesses could be presented at the individual ICO level. However, program level results identified that while the 2024 top-box score for *Planning Your Time and Activities* was statistically significantly higher than the 2024 HCBS CAHPS Database benchmark, it was also the lowest performing measure across ICOs with a 2024 top-box score of 64.14 percent. This composite measure indicates there are opportunities to promote community inclusion and empowerment, as some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day. **[Access]**

**Why the weakness exists:** The program level results indicate there are opportunities for the MI Health Link program to help members with community inclusion and empowerment opportunities.

**Recommendation:** **UPP** has reported conducting a member satisfaction survey to target performance of *Planning Your Time and Activities*. HSAG recommends that **UPP** continue this intervention and follow up on member feedback. HSAG further recommends that **UPP** ensure member demographic information is correct to improve response rates.

## 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 that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **UPP**'s overall performance contributed to the MI Health Link program's progress in achieving the CQS goals and objectives. Table 3-102 displays each MDHHS CQS goal and the EQR activity results that indicate whether the ICO positively (✓), negatively (✗), or minimally (m) impacted the MI Health Link program'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 if a CQS goal did not include any quality measures for the MI Health Link program or the EQR activities do not produce data to assess the impact of a quality measure(s) under an objective.

**Table 3-102—Overall Performance Impact to CQS and Quality, Timeliness, and Access**

Objective	Quality Measure	Overall Performance Impact	Performance Domain
<b>Goal #1: Ensure high quality and high levels of access to care</b>			
1.1	<i>MI7.3 Annual Dental Visit</i>	✗	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	<i>FUH—Follow-Up After Hospitalization for Mental Illness (30 Days)</i>	✓	
	<i>COL—Colorectal Cancer Screening</i>	m	
1.2	<i>CBP—Controlling High Blood Pressure</i>	✓	
	<i>PCR—Plan All-Cause Readmission</i>	✓ <sup>1</sup>	
	<i>COL—Colorectal Cancer Screening</i>	m	
1.3	<i>Annual Flu Vaccine</i>	NA	
	<i>MI5.6 Medication Review—All Populations</i>	✓	
	<i>TRC—Transitions of Care—Medication Reconciliation Post-Discharge</i>	✓	
	<i>PM13 Number and percent of enrollees whose IICSP addressed their assessed health and safety risks (HCBS C-Waiver population)</i>	NA	
	<i>PM15 Number &amp; percent of enrollees with an individualized contingency/back-up plan addressing caregiver absences, severe weather, fire/other emergencies (HCBS C-Waiver population)</i>	NA	
	<i>PM24 Number and percent of files that show enrollee/family/legal guardians (as appropriate) received information and education on how to report abuse, neglect, exploitation, and other critical incidents within 60 days of waiver enrollment.</i>	NA	

Objective	Quality Measure	Overall Performance Impact	Performance Domain
<b>Goal #2: Strengthen person and family-centered approaches</b>			
2.1	MI2.3 Members with documented discussions of care goals	NA	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
	Core 9.3 Minimizing Facility Length of Stay—Ratio of Observed to Expected Discharge Rates	x	
	PM17 Number and percent of enrollee IICSPs that are updated as the enrollee's needs change	NA	
2.2	SNS-E Social Needs Screening & Intervention	NA	
<b>Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)</b>			
3.1	FUH—Follow-Up After Hospitalization for Mental Illness (30 Days)	✓	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness
3.2	MI2.6 Timely transmission of care transition record to health care professional	✓	<input checked="" type="checkbox"/> Access
<b>Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes</b>			
4.1	UPHP—MI 7.3 Annual Dental Visit: AI/AN (American Indian/Alaskan Native) vs White	x <sup>2</sup>	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
<b>Goal #5: Improve quality outcomes through value-based initiatives and payment reform</b>			
5.1	The CQS does not include quality measures for the MI Health Link Program under Goal #5.	NA	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access

✓ = The ICO's rate met the 2026 statewide performance target

m = The ICO's rate did not meet the 2026 statewide performance target, or the ICO's HEDIS rate did not meet the 2026 statewide performance target but the ICO's HEDIS rate increased in performance from the prior year

x = The ICO's rate did not meet the 2026 statewide performance target and/or the ICO's HEDIS 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 or the CQS did not include any quality measures for the MI Health Link program.

<sup>1</sup> The CQS did not identify the age stratification associated with the quality measure; therefore, HSAG used the 65+ stratification rate for the assessment.

<sup>2</sup> Evaluation of this quality measure used the results of the QIP activity and not the HEDIS rate reported under the PMV activity. While the disparity was not eliminated, the ICO demonstrated statistically significant improvement over the baseline performance for the disparate population during second remeasurement period.

## 4. Follow-Up on Prior External Quality Review Recommendations for Integrated Care Organizations

From the findings of each ICO's performance for the SFY 2023 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the MI Health Link program. The recommendations provided to each ICO for the EQR activities in the *State Fiscal Year 2023 External Quality Review Technical Report for Integrated Care Organizations* are summarized in Table 4-1 through Table 4-6. The ICO's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation, and as applicable, identified performance improvement, and/or barriers identified are also provided in Table 4-1 through Table 4-6.

### Aetna Better Health Premier Plan

**Table 4-1—Prior Year Recommendations and Responses for AET**

1. Prior Year Recommendation from the EQR Technical Report for Validation of Quality Improvement Projects
<p>HSAG recommended the following:</p> <ul style="list-style-type: none"> <li>• <b>AET</b> did not demonstrate significant improvement over the baseline performance for the disparate subgroup (Black or African American members). The ICO did not achieve the state-specific goal of eliminating the existing disparity between the two subgroups with the first remeasurement period. HSAG recommends <b>AET</b> revisit its causal/barrier analysis to determine if any new barriers exist for the disparate subgroup that require the development of targeted strategies to improve performance. In accordance with direction from MDHHS, <b>AET</b> is required to identify at least three barriers to care and develop three interventions to address those barriers, specifically for the Black or African American population, within the next annual submission.</li> </ul>
<p><b>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)</b></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"> <li>• In 2023 outreach was begun earlier than previous years, in August, and GIC lists were prioritized by race/ethnicity with Black/African American members managing diabetes and/or hypertension. Additional prioritization went to members with more than two care gaps, maintaining r/e as a primary weight for early targeting and subsequent follow-up if member was UTR or remained non-compliant after 90-days.</li> <li>• Those members identified as UTR were immediately connected with care managers to support care coordination, assessment or assessment follow-up, and close care gaps.</li> <li>• CM caseload assessment to evaluate internal disparities and health equity business unit assessment to evaluate organizational barriers to addressing and managing identified health inequities.</li> </ul>



## 1. Prior Year Recommendation from the EQR Technical Report for Validation of Quality Improvement Projects

- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- The health plan saw statistically significant improvement in the disparate population from baseline (2021MY) to second remeasurement (2023MY), and from first (2022MY) to second remeasurement (2023MY).
  - Additionally, 74.7% members from the disparate population who were non-compliant in both 2021 and 2022 and at the start of early outreach in 2023, received an HbA1c test by 12/31/2024.
  - Post education and awareness of inequities seen within CM caseloads improved in 61.5% of those evaluated.
  - UTRs within the sample population went from 39% in May of 2023 to 1.56% in December of 2023.
- c. Identify any barriers to implementing initiatives:
- N/A

**HSAG Assessment:** HSAG has determined that **AET** addressed the prior year's recommendations based on the responses provided by the ICO and HSAG's review of the ICO's annual QIP submission. The ICO revisited its causal/barrier analysis and initiated revised and targeted interventions. The ICO developed strategies specifically for the disparate subgroup.

## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

HSAG recommended the following:

- Although **AET** improved the MI2.6 rate from the prior year's reported rate, it continued to have a low MI2.6 rate in comparison to the other Michigan ICOs' reported rates. HSAG recommends that **AET** consider implementing targeted interventions to improve its MI2.6 rate.
- Like the prior year, **AET** could not use data from one of its delegated PIHPs in the MI2.6 sample. HSAG recommends that **AET** issue a formal CAP to Detroit Wayne Integrated Health Network to ensure it provides accurate data reflecting member hospital discharges so that **AET** can include these members in future MI2.6 reporting. Although this data gap had a marginal impact on the eligible population, the denominator sample, and the numerator, the MI2.6 data were still underreported as a result of this issue.
- For MI7.3, **AET** did not incorporate any race and ethnicity data other than the data submitted by the State in the 834-enrollment file. HSAG recommends that **AET** explore additional sources for race and ethnicity data including care management, member survey, and EHR data.
- For 26 of the 40 reported HEDIS measures (65 percent), **AET**'s rates indicated worse performance than the statewide average, demonstrating an opportunity for improvement across multiple domains including Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Behavioral Health, Medication Management and Care Coordination, Overuse/Appropriateness, Access/Availability of Care, and Risk-Adjusted Utilization. HSAG recommends that **Aetna** focus on improving performance for measures included in these domains.
- In the Cardiovascular Conditions domain, **AET**'s rate for the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator decreased by more than 13 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, indicating that some adult members were not using a beta-blocker as treatment after a heart attack. Clinical guidelines recommend taking a beta-blocker after a heart attack to prevent another heart attack from occurring. This reduces the amount of force on the heart and blood vessels. Persistent use of a beta-blocker after a heart attack can improve survival and heart disease outcomes. HSAG recommends that **AET** conduct a root cause analysis



## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

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

**MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)**

- a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:
- For MI 2.6, we focused on increasing our access to remote electronic medical records (EMRs) for the large provider groups in MI. The goal was to increase our visibility of providers and hospitals that are on a shared EMR systems and therefore increase our identification of providers who would have immediate access to the care transition record at the time of discharge.
  - CM MI 2.6 interventions: <mailto:CulpepperM@aetna.com>
    - Care Management Post Discharge outreaches and assessments.
    - Review of the Personal Discharge summary record or discharge instructions and educate the member on post discharge recommendations and how to access services.
    - Medication and service reconciliation – comparing preadmission and post discharge medication needs.
    - To encourage follow up with PCP / specialists within 7 days but not to exceed 14 days following discharge.
    - To encourage follow up with BH provider within 7 days and again at 29 days after discharge from a BH admission (HEDIS measure).
    - Assess member's ability to self-manage & their knowledge and understanding of how their medical/behavioral health condition led to the hospitalization including warning signs of when to call the doctor.
  - During PDQ we would try to identify gap for the below items
    - Inadequate control of their condition (frequent hospitalizations, readmission within 30 days, not adhering to their treatment plan, etc.).
    - Lack of caregivers and resources.
    - Multiple co-morbidities requiring multiple providers.
    - High risk for complications (new diagnosis requiring significant education, etc.).
    - Need for behavioral health services.
    - Complex disease states such as diabetes, hemophilia, cancer, etc.
    - Multiple prescriptions that need a pharmacy consultation.
    - Medication reconciliation shows new medications that need to be addressed.
    - When member goes to a facility CM is to place case conference request to admitting facility so that CM can identify what the member needs to discharge and help coordinate those needs with their benefits.
  - On 10/6/2023, a formal CAP was issued to Detroit Wayne Integrated Health Network (DWIHN) to ensure it provides accurate data reflecting member hospital discharges so that Aetna can include these members in future MI2.6 reporting. Corrected encounters were submitted by DWIHN on 12/13/23. On 4/9/2024 it was confirmed that the DWIHN encounters were integrated into our HEDIS software and

## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

included in the eligible population for our MY 23 MI 2.6 measure. The CAP was officially completed on 4/9/2024.

- For MI7.3, we continue to explore options to incorporate additional sources for race and ethnicity data.
- HEDIS MY 22 rates were reviewed, and interventions were implemented to improve rates that address multiple domains including Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Behavioral Health, Medication Management and Care Coordination, Overuse/Appropriateness, Access/Availability of Care, and Risk-Adjusted Utilization. The proportion of measures below the state-wide average continues to decline (73% for MY 21 vs. 65% for MY 22).
- Examples of rate improvement initiatives implemented in 2024 include:
  - Direct member outreach, performed by Care Management and Quality Management staff members, with gaps in care for the Adults' Access to Preventive/Ambulatory Health Services, Breast Cancer Screening, Colorectal Cancer Screening, Controlling High Blood Pressure, Hemoglobin A1c Control for Patients with Diabetes, and/or Eye Exam for Patients with Diabetes,
  - Updated Transition of Care workflow that focuses on additional outreaches to members at high risk for readmission to help lower the Plan All-Cause Readmissions rate.
  - Detailed analysis of claims data to determine why there are low follow up rates for our members in the Follow Up after Hospitalization for Mental Illness measure so that targeted initiatives can be developed.
  - Use of a daily Antidepressant Medication report by the Behavioral Health Clinical Liaison to identify members who may have a potential gap and addresses any barriers to obtaining medication.
- For the PBH—Persistence of Beta-Blocker Treatment After a Heart Attack, our denominators for this measure were 14 in MY 21, 15 in MY 22, and only 3 in MY 23. Due to the small denominator of less than 30, the rates have a NA Status in our audited HEDIS reporting and the rates had significant variance year over year. In MY 22, 13 out of 15 members and in MY 23 2 of the 3 members met the requirements of the measure.

### b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- For MI 2.6, we did see a notable increase in the rate from MY 22 to MY 23. The rate improved 14.3 percentage points from 20.70% for MY 22 to 35.00% for MY 23.
- Several HEDIS measures from the Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, and Medication Management and Care Coordination domains improved from MY 22 to MY 23. The following measures had a 3+ percentage point improvement from MY 22 to MY 23:
  - Prevention and Screening
    - COL—Colorectal Cancer Screening
    - COA—Care for Older Adults—Medication Review
  - Respiratory Conditions
    - PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
  - Cardiovascular Conditions
    - SPC—Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy
  - Diabetes
    - EED—Eye Exam for Patients with Diabetes
    - BPD—Blood Pressure Control for Patients with Diabetes
    - SPD—Statin Therapy for Patients with Diabetes—Received Statin Therapy
    - SPD—Statin Therapy for Patients with Diabetes—Statin Adherence 80%
  - Medication Management and Care Coordination

## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

- TRC—Transitions of Care—Medication Reconciliation Post-Discharge
- TRC—Transitions of Care—Notification of Inpatient Admission
- TRC—Transitions of Care—Receipt of Discharge Information
- TRC—Transitions of Care—Patient Engagement After Inpatient Discharge

### c. Identify any barriers to implementing initiatives:

- For MI 2.6, there were no barriers to implementing the initiative.
- For overall HEDIS rate improvement, difficulty reaching and/or engaging members in needed care remains a barrier.

**HSAG Assessment:** HSAG has determined that **AET** addressed the prior year’s recommendations for the following measures based on the ICO implementing initiatives that appear to be effective in improving performance and/or the issues that resulted in the prior recommendations were not identified during this year’s PMV activity:

- MI2.6—The rate demonstrated improved performance from MY 2022 to MY 2023 and is no longer the lowest reported rate in comparison with other Michigan ICOs. In addition, **AET** worked with its PIHP delegate to improve data accuracy in identifying hospital discharges and to allow these data to be included in performance measure reporting.
- *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack*—The MY 2023 rate is now meeting the HEDIS MY 2023 MI Health Link statewide average. Note that performance could not be evaluated from MY 2022 to MY 2023, as there were changes in the technical specifications for this measure and NCQA recommended a break in trending between MY 2023 and prior years.

HSAG has determined that **AET** has either partially addressed or did not address the prior year’s recommendations for the following measures, and therefore should continue to implement or expand upon interventions to address the continued low performance or findings identified in these areas:

- MI7.3—While **AET** incorporated race and ethnicity data to meet requirements for performance measure reporting by stratification, **AET** did not incorporate any race and ethnicity data other than the data submitted by the State in the 834 file. HSAG recommends that **AET** explore additional sources for race and ethnicity data, as MDHHS expects that ICOs validate and supplement the data provided through the 834 files with other sources, including care coordination activities, member survey, and EHR data.
- HEDIS measures reported in the following domains continued to have rates that indicated worse performance than the MY 2023 statewide average, and therefore require additional efforts in order to meet the MY 2023 statewide average:
  - Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Behavioral Health, Medication Management and Care Coordination, Overuse/Appropriateness, Access/Availability of Care, and Risk-Adjusted Utilization.

## 3. Prior Year Recommendation from the EQR Technical Report for Compliance Review

HSAG recommended the following:

- **AET** received a *Not Met* score for 10 elements within the Grievance and Appeal Systems program area, indicating members may not have access to all rights and required information when filing a grievance or requesting an appeal. While **AET** was required to submit a CAP to address each of the identified deficiencies, HSAG recommends that **AET** continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member grievances and appeals. HSAG further recommends that **AET** implement procedures to ensure model notices used are the

### 3. Prior Year Recommendation from the EQR Technical Report for Compliance Review

most current version required by MDHHS, and that **AET** follow requirements of the Three-Way Contract to guarantee adherence to Medicaid managed care rules for grievance and appeal notices.

**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 has implemented numerous actions to address the 2023 Compliance Review findings and recommendations:
    - Updated all model notices in its Grievance and Appeals System.
    - Developed and implemented a Model Notice Review and Use policy. The purpose of the Model Notice and Use policy is to:
      - 1) Facilitate compliance with federal and state laws and rules and state contractual requirements for the member grievance and appeal notification process.
      - 2) Promote effective management of model notices.
      - 3) Provide for accurate maintenance of required documentation.
    - Updated its Grievance and Appeals System policies to ensure compliance with all requirements of the three-way contract.
    - Developed and implemented process to request member consent when an appeal is submitted by a provider on behalf of the member.
    - Updated its Member Grievance Extension letter to clarify that notification for the resolution will occur within the regulatory timeframe and include expedited grievance rights.
    - Developed and implemented a more robust Quality Review process to ensure complete and accurate system and written notification documentation.
    - Developed and implemented a new Intake Team and process to ensure timely case creation, triaging, and acknowledgement of grievances.
    - Developed and is in the process of implementing a more robust and formalized training program (including training materials) to ensure consistent application of grievance and appeals policies and procedures.
    - Updated the grievance and appeal sections of the Provider Manual and Provider Website to reflect current grievance and appeal information/requirements. Updated Provider Manual Annual Review desktop to include an annual review with departmental sign off.
- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- New Intake Team has improved triage and case entry process.
  - Updated policies and process documents have improved staffs' understanding of regulatory requirements.
  - Implementation of 2025 Model Notices on track for implementation 1/1/2025.
- c. Identify any barriers to implementing initiatives:
- None.

**HSAG Assessment:** HSAG has determined that **AET** addressed the prior year's recommendations. The SFY 2024 CAP review confirmed that **AET**'s action plans were successful at remediating the deficiencies for the Grievance and Appeal Systems program area.

#### 4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

- **AET** failed to meet all Medicaid and LTSS minimum network requirements for Region 4, reflecting opportunities for improvement in maintaining an adequate network for MI Health Link members in this region. **AET** should continue to maintain an internal data verification process to identify and contract with Adult Day Program providers as they become available in Region 4 to improve compliance with Medicaid and LTSS minimum network standards for time/distance and capacity for MI Health Link members in the region. Updated compliance for this provider type in Region 4 will be evaluated during the SFY 2024 NAV.

**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 health plan continues to monitor on a quarterly basis the available Adult Day providers in each Michigan Region for which the health plan operates with a primary focus of those areas within Region 4 for which the health plan is deficient. Since there are no providers available to contract to bring the health plan in compliance the health plan monitors for new entrants into the Adult Day specialty and registered with CHAMPS. To date no new providers have become available.
- Identify any noted performance improvement as a result of initiatives implemented (if applicable):
  - No new providers have entered the Adult Day specialty in deficient counties of Region 4. Unable to gain member accessibility for compliance until new entrants emerge.
- Identify any barriers to implementing initiatives:
  - No providers available to contract in the deficient areas of Region 4 with the Adult Day specialty.

**HSAG Assessment:** **AET** was granted an exception for Adult Day Program providers in Region 4 based on the SFY 2024 NAV. HSAG has determined that **AET** has addressed the prior year's recommendations.

#### 5. Prior Year Recommendation from the EQR Technical Report for Secret Shopper Survey

HSAG recommended the following:

- Of the cases reached, 63.9 percent of provider locations accepted the MI Health Link program, and 59.8 percent accepted new patients. HSAG recommends that **AET** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect MI Health Link acceptance and new patient acceptance) to address the provider data deficiencies and educate provider offices on the MI Health Link program. Additionally, as MDHHS required **AET** to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.
- Among all surveyed cases, the overall appointment rate was 45.5 percent. HSAG recommends that **AET** work with its contracted providers to ensure that members can readily obtain available appointment dates and times. 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.



## 5. Prior Year Recommendation from the EQR Technical Report for Secret Shopper Survey

**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)*:
  - DentaQuest is the health plans dental vendor who sent out communication to their providers and reminds them of the health plan and the MI Health Link program. DentaQuest conducted a secret shopper in February and March with provider education as follow up in an effort to improve provider awareness and education of the MI Health Link program and Aetna Better Health Premier Plan.
- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
  - Awaiting MDHHS secret shopper analysis for 2024.
- c. Identify any barriers to implementing initiatives:
  - Transition of front desk staff in participating provider offices who may not be familiar with the health plan or line of business.

**HSAG Assessment:** HSAG has determined that **AET** has partially addressed the prior year's recommendations. **AET** implemented interventions to ensure directory data accuracy, and conducted provider outreach to validate contact information and training. **AET** should also address the data deficiencies noted in the case-level analytic data files.

## 6. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

HSAG recommended the following:

- **AET** did not indicate timeliness quality checks were performed for claims/encounters originating from its pharmacy and fiscal intermediary subcontractors. **AET** should enhance its timeliness quality checks by considering, among other actions, the implementation of regular timeliness audits, the adoption of automated monitoring systems capable of tracking submission dates and generating alerts or reports for delayed submissions, and periodic reviews and adjustments of timeliness quality checks based on performance data and any alterations in regulations or contractual requirements.
- **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 and stored by **AET**.
- Although greater than 99.9 percent of provider NPIs identified in the medical/dental data were identified in the provider data, approximately 95.2 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data. **AET** should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.
- Although not required to be populated, 21.4 percent of professional encounters contained a billing provider NPI, and 11.3 percent contained a rendering provider NPI. **AET** should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

**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)*:

## 6. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

- Aetna indicated in the survey that we conduct timeliness quality checks on all encounters originating from our pharmacy and fiscal intermediary subcontractors. File trackers are automated to ensure all response files are received for encounter files submitted. The trackers will depict the accuracy, timeliness, and response file status for each file.
  - Reports are generated weekly to ensure the vendors are submitting their encounter files according to the agreed upon schedule. The encounter team conducts regularly scheduled meetings with the subcontracted vendors to review the encounter data accuracy, timeliness, volumes, and outstanding encounter errors.
- 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 detailed 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 instead of weekly.
- **Aetna's** Encounter system (Edifecs) will not allow an encounter to be submitted without a billing provider NPI or Medicaid ID. Internal reporting shows all encounters are being submitted with the billing provider information. Rendering provider NPI is submitted when it is different from the billing provider. Additional data will be required from HSAG to determine why their data shows 21.4 percent of professional encounters contained a billing provider NPI, and 11.3 percent contained a rendering provider NPI.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- 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 instead of weekly.

c. Identify any barriers to implementing initiatives:

- N/A



## 6. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

**HSAG Assessment:** HSAG has determined that **AET** has partially addressed the prior year's recommendations. Regarding timeliness quality checks, while **AET** has improved its monitoring processes, it has not specified how systemic delays or broader timeliness issues are addressed beyond vendor compliance. **AET** should implement periodic audits to assess timeliness trends and identify systemic delays. Collaborating with subcontractors to resolve the root causes of recurring delays would enhance the robustness of these checks. **AET** has fully addressed HSAG's recommendation in the area of comprehensive monitoring reports. The detailed suite of monitoring reports demonstrates **AET**'s commitment to evaluating data quality across multiple dimensions. For the provider NPI completeness recommendation, **AET** indicated that it increased the frequency of state provider file submissions to its PBM, transitioning from weekly to daily submissions. Additionally, its Edifecs system ensures that billing provider NPIs are required for all submissions, with rendering provider NPIs included only when they differ from billing provider NPIs. While billing provider NPI compliance is ensured, rendering provider NPI completeness could be further enhanced, as HSAG identified discrepancies.

In conclusion, **AET** has made progress, particularly in enhancing monitoring systems and improving pharmacy provider NPI accuracy. However, gaps remain in addressing systemic timeliness issues and reconciling discrepancies in professional and rendering provider NPIs. To strengthen addressing HSAG's recommendation, **AET** should:

- Implement periodic audits to identify and address systemic timeliness issues beyond vendor compliance.
- Collaborate with MDHHS to reconcile NPI discrepancies and enhance the rendering provider NPI validation process.
- Conduct periodic reviews of monitoring reports to ensure continued effectiveness and alignment with regulatory requirements.

These steps will help improve data quality, address identified gaps, and align more effectively with HSAG's recommendations.

## 7. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis

HSAG recommended the following:

- As **AET**-specific results were not available due to low response rates, no substantial weaknesses could be presented at the individual ICO level. While no **AET**-specific results could be presented, the statewide analysis identified that the 2024 top-box score for the *Recommend Personal Assistance/Behavioral Health Staff* measure was statistically significantly lower than the 2021 top-box score. This demonstrates a statistically significant decline from 2023, indicating opportunities for improvement for the MI Health Link program. Additionally, the lowest performing measure was *Planning Your Time and Activities* with a 2023 top-box score of 63.70 percent, indicating opportunities to promote community inclusion and empowerment as some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day. Therefore, HSAG recommends that **AET** develop and implement interventions to improve member experience related to the *Recommend Personal Assistance/Behavioral Health Staff* and *Planning Your Time and Activities* measures. HSAG further recommends that **AET** develop innovative approaches to increase the number of members participating in future survey administrations.

## 7. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis

**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)*:
- Personal Assistance/Behavioral Health Staff:
    - The care plan is shared with all participants of the members ICT, inclusive of the personal care assistants. The ICT communicates the level of personal care services required to meet the member's needs. The care management staff collaborates with the members to resolve the concerns about the care they are receiving including offering reeducation to the personal assistants as needed to address specific concerns. The care managers can complete an in-person visit at the time that the personal care assistant is present to address and review the care plan expectations.
    - Care managers connect with the member and their selected ICT every 30 – 90 days to be proactive in solutioning concerns that may be impacting the members outcomes. If needed the CM will provide a referral to another personal assistance provider. Members are also educated on self-determined options and provider options, to support choice and solution if there are varying concerns. The members are educated on how to select a new provider, report abuse, neglect, and exploitation.
    - The care managers work with the grievance and appeals department to resolve the members reported dissatisfaction. In collaboration with the provider experience team the care management staff calls members to complete a random member survey related to their provider experience which includes personal care services. Any concerns involving the competence or professional conduct of an individual, network practitioner, facility, or ancillary provider adversely affects, or could adversely affect the health or welfare of a member are addressed through our Potential Quality of Care Issues (PQOC) and critical incident processes.
  - Planning Your Time and Activities:
    - Member's ability to engage with their communities, family, and friends when they want, doing activities of their choosing is vital to member quality of life. Every 30 to 90 days the member and their care manager meets to address if there are any new needs, which includes determining if additional interventions are required to address social isolation. ABHMI works with HCBS providers to ensure members can have strong influence in the planning of daily activities by signing waiver members up for non-medical transportation enabling them to participate in community activities. All waiver members are educated on the availability of non-medical transportation with no limits on the social setting or the type of event, that they would require transportation to attend. Non-waiver members are educated by their CM on discounted activities in their area and offer community resources for additional transportation and supplies, i.e., face masks and medical equipment such as wheelchairs. Both the care plan and activity schedule are member driven allowing members to self-direct when and how services are provided. Aetna offers value added benefits that assist with social supports allowing members to have community connections. Members are educated on their silver sneakers benefit which includes onsite activities and gym members for social connections.
- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- None

**7. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis**

c. Identify any barriers to implementing initiatives:

- N/A

**HSAG Assessment:** HSAG has determined that **AET** has addressed the prior year's recommendations. **AET** reported implementing interventions to identify and refer members for additional services and assess SDOH. The SFY 2024 HCBS CAHPS activity demonstrated statistically significantly higher top-box scores compared to the 2024 HCBS CAHPS Database benchmarks for the MI Health Link program for *Rating of Personal Assistance and Behavioral Health Staff*, *Rating of Case Manager*, *Helpful Case Manager*, *Personal Safety and Respect*, and *Planning Your Time and Activities*. However, as the 2024 top-box score for *Planning Your Time and Activities* still demonstrated the lowest score of all HCBS CAHPS measures, HSAG recommends that **AET** continue to monitor measures to continue any efforts to increase performance.

## AmeriHealth Caritas VIP Care Plus

**Table 4-2—Prior Year Recommendations and Responses for AMI**

1. Prior Year Recommendation from the EQR Technical Report for Validation of Quality Improvement Projects
<p>HSAG recommended the following:</p> <ul style="list-style-type: none"> <li>Both performance indicators reported by <b>AMI</b> demonstrated a decline in performance as compared to the baseline rate. The ICO did not achieve the state-specific goal of eliminating the existing disparity between the two subgroups with the first remeasurement period without a decline in performance for the comparison subgroup. HSAG recommends that <b>AMI</b> consider evidence-based intervention efforts and risk factors in quality of care for the Black/African-American population for the selected performance indicator and put interventions in place that would support improvement in the White population. In accordance with direction from MDHHS, <b>AMI</b> is required to identify at least three barriers to care and develop three interventions to address those barriers, specifically for the Black/African American population, within the next annual submission.</li> </ul>
<p><b>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)</b></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"> <li>1/2021: Revised internal processes to include Medication Reconciliation Post-Discharge (MRP) as a required step in every Transition of Care (TOC). <ul style="list-style-type: none"> <li>RN care coordinators to complete the process with every TOC, utilizing functionality within the Plan's medical record system, forwarding MRP to primary care provider (PCP), and including it in data for HEDIS abstraction.</li> </ul> </li> <li>9/2021: Notified providers they will receive a \$25 payment for submission of CPTII codes after reconfiguration of the claims system to support this. <ul style="list-style-type: none"> <li>Sent reminders to providers in 2022 regarding availability of this incentive program.</li> </ul> </li> <li>3/2022: Developed and implemented automated fax notifications to providers of admission date based on the daily Admission/Discharge/Transfer (ADT) report received through state Health Information Exchange (HIE).</li> <li>6/2022: Requested new text campaign to remind members who have experienced TOC to follow up with provider within 30 days.</li> <li>2/2023: Requested evaluation of systems where Race/Ethnicity/Language (REL) data are stored and development of a process to ensure all REL data available to the Plan are being included in HEDIS measure reporting.</li> <li>New interventions underway to address barriers identified specific to the Black/African American population: <ul style="list-style-type: none"> <li>Prioritizing outreach to Black/African American members who have experienced a TOC and who do not have an assigned PCP.</li> <li>Revised multiple member communication materials re: importance of PCP relationship to include information about choosing PCP who can meet their REL needs and how Plan can assist with this if needed.</li> </ul> </li> </ul>

## 1. Prior Year Recommendation from the EQR Technical Report for Validation of Quality Improvement Projects

- Prioritizing outreach and support to Black/African American members who have experienced a TOC and who have multiple chronic conditions.
- Engaged provider network via online survey process to assist with identifying additional barriers our Black/African American members may be experiencing related to TOC.

- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Between 2021 and 2022, there was a 12% increase in the number of members for whom provider submitted a CPTII code verifying MRP completion.
  - A notable improvement has been made in the process of capturing REL data for HEDIS reporting from measurement year (MY)2022 to MY2023. There were 187 members identified in the MRP HEDIS sample with “Unknown” race for MY2022 which significantly decreased to 6 members (96.8%) identified with “Unknown” race in MY2023.

- c. Identify any barriers to implementing initiatives:
- Open positions in Care Management in 2022 limited the number of MRPs completed by RN care coordinators.
  - Resource constraints in teams responsible for member communications delayed implementation of the TOC texting campaign until 2023.

**HSAG Assessment:** HSAG has determined that **AMI** addressed the prior year’s recommendations based on the responses provided by the ICO and HSAG’s review of the ICO’s annual QIP submission. The ICO revisited its causal/barrier analysis and prioritized and revised targeted interventions specifically for the disparate subgroup.

## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

HSAG recommended the following:

- Primary source verification (PSV) results for MI7.3 found that **AMI** did not appropriately integrate enrollment data for the continuous enrollment calculation, which resulted in some members not meeting enrollment criteria included in the measure denominator. HSAG recommends that **AMI** consider revising its performance measure production timeline to allow adequate time for review and data quality checks before data are submitted to the FAI Data Collection System (DCS).
- **AMI** was required to resubmit its Core Measure 9.3 data to Health Plan Management System (HPMS), as the data submitted to HSAG differed from the data originally sent to HPMS. HSAG recommends that **AMI** consider revising its performance measure production timeline to allow adequate time for review and data quality checks before data are submitted to HPMS.
- While **AMI** had a strong process for collecting race and ethnicity data, MI7.3 data counts for race and ethnicity stratifications had errors. HSAG recommends that **AMI** ensure that it adds some quality checks for measures that require race and ethnicity stratifications to ensure that the data align with the measure denominator. In addition, HSAG recommends that AmeriHealth perform some internal PSV to help identify potential errors prior to the submission of data.
- For 24 of the 40 reported HEDIS measures (60 percent), **AMI**’s rates indicated worse performance than the statewide average, demonstrating an opportunity for improvement across multiple domains including Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Musculoskeletal Conditions, Behavioral Health, Medication Management and Care Coordination, Access/Availability of Care, and Risk-Adjusted Utilization. HSAG recommends that AmeriHealth focus on improving performance for measures included in these domains.

## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

- In the Respiratory Conditions domain, **AMI**'s rate for the *PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* measure indicator decreased by more than 5 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, indicating that some adult members with COPD were not always receiving appropriate medication therapy to manage an exacerbation. COPD exacerbations make up a significant portion of the costs associated with the disease. However, symptoms can be controlled with appropriate medication. Appropriate prescribing of medication following exacerbation can prevent future flare-ups and drastically reduce the costs of COPD. HSAG recommends that **AMI** conduct a root cause analysis or focused study to determine why some adults with COPD are not receiving appropriate medication therapy to manage exacerbations. Upon identification of a root cause, **AMI** should implement appropriate interventions to improve the performance related to the *PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* measure indicator. **AMI** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or provider education).
- In the Cardiovascular Conditions domain, **AMI**'s rate for the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator decreased by 10 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, indicating that some adult members were not using a beta-blocker as treatment after a heart attack. Clinical guidelines recommend taking a beta-blocker after a heart attack to prevent another heart attack from occurring. This reduces the amount of force on the heart and blood vessels. Persistent use of a beta-blocker after a heart attack can improve survival and heart disease outcomes. HSAG recommends that **AMI** conduct a root cause analysis or focused study to determine why some adults were not using a beta-blocker after a heart attack. Upon identification of a root cause, **AMI** should implement appropriate interventions to improve the performance related to the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator. **AMI** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or provider education).
- In the Musculoskeletal Conditions domain, **AMI**'s rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator was 0 percent, and the measure indicator decreased by 40 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, suggesting that some women who suffered a fracture did not receive a bone mineral density test or prescription for a drug to treat osteoporosis within six months of the fracture. Osteoporosis is a serious disease affecting mostly older adults that can impact their quality of life. Osteoporotic fractures, particularly hip fractures, are associated with chronic pain and disability, loss of independence, decreased quality of life, and increased mortality. With appropriate screening and treatment, the risk of future osteoporosis-related fractures can be reduced. HSAG recommends that **AMI** conduct a root cause analysis or focused study to determine why some women were not always receiving timely bone mineral density tests or a prescription to treat osteoporosis within six months of a fracture. Upon identification of a root cause, **AMI** should implement appropriate interventions to improve the performance related to the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator. **AMI** should consider the nature and scope of the issue (e.g., whether the issues related to patient and provider education or barriers to accessing care).



## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure 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)*:
- **Core Measure 7.3 and 9.3:**
    - As it relates to MI7.3 and Core Measure 9.3, the Plan has expanded the time allotment for validation, along with an increase to the volume of records being validated prior to submission. Staff were re-educated on each measure and taught efficient ways to check data against outlined reporting criteria, range constraints, and checks for data correctness. Specific to Core Measure 9.3, source code updates were made to align with the annual core reporting requirements. The Plan found the CMS issued Core Measure 9.3 FAQs integral in coordination and instructions provided for coding updates. The FAQs document was also utilized for training of technical teams and staff supporting validation of data output. Specific to MI7.3, The Plan performed source code analysis as a means to identify errors and instilled an internal production schedule of the measure output. Lastly, a second level reviewer was added to validate summary counts against raw data records, with added attention placed on race and ethnicity data.
  - **HEDIS Measures:**
    - Sent reminders to members regarding importance of completing annual wellness visit.
    - “Quality Welcome Flyer” is included in all new member welcome packets which addresses preventive care and chronic condition management.
    - Continued letter to members with care gaps re: importance of blood pressure control/screening, cancer screenings, diabetes management/testing, availability of 90-day medication fill option.
    - Continued monthly member texting campaigns for members with gaps in care specific to:
      - Breast Cancer Screening (BCS)
      - Controlling Blood Pressure (CBP)
      - Colorectal Cancer Screening (COL)
      - Diabetes
      - Medication Adherence
    - Call campaigns to members with care gaps for BCS, CBP, Diabetes.
    - Continued member incentive programs for Annual Flu Vaccine, Annual Dental Visit, and COL. Reminders sent to members throughout the year regarding these programs.
    - Continued member education via articles in quarterly member newsletter.
    - Calls to members taking anti-depressant medication to remind of importance of taking medication as prescribed and to assist with refills as needed.
    - Continued focused collaboration and shared member case review with Pre-Paid Inpatient Hospital Plans (PIHP).
    - Concierge Team calls to members with Emergency Department (ED) visit as identified on daily ADT report. to remind/assist with PCP follow-up visit.
    - Monthly report available to providers identifying their performance on key HEDIS measures and the care gaps remaining for members they care for.
    - Reminder sent to providers regarding availability of 90-day medication refills.
    - Reminder sent to providers regarding availability of Clinical Practice Guidelines.
    - Medicare Pharmacy team outreach to members and providers re: medication adherence for blood pressure, cholesterol, and diabetes medications.



## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

- Medicare Pharmacy team member and provider outreach to women in the Osteoporosis Management (OMW) measure denominator to review medication/screening needs.
- Continued provider incentive for submission of CPTII codes for:
  - CBP
  - Care for Older Adults (COA)
  - Diabetes (HgbA1c test results)
  - MRP
- Continued completion of annual medication review by Medicare department pharmacist for all members, mailed to PCP, and data is abstracted for HEDIS reporting.
- Care Coordinators continue to complete COA pain and functional assessments, send to PCP, and data is abstracted for HEDIS reporting.
- Automated fax sent to PCP to notify of member's inpatient admission based on daily ADT report and data is abstracted for HEDIS reporting.
- Care Coordinators increased focus on admission/discharge notification to prioritize contact with member.
- Process in place for Care Coordinators to identify members at high risk for readmission to increase outreach/interventions.
- Partnered with wellness company to complete on-site health screenings during future community events to close care gaps.
- Continued to pursue program with laboratory services provider to provide in-home testing for members.

### b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- **Core Measure 7.3 and 9.3:**
  - N/A
- **HEDIS Measures:**
  - Rates for MY2022 performance compared to MY2021.
    - BCS: Improved 3.3%
    - COA Medication Review: Improved 9.2%, Functional Assessment: Improved 3.7%
    - CBP: Improved 1.2%
    - Diabetes Eye exam (EED): Improved 4.2%; HgbA1c Poor Control (HBD): Improved 1.1%; BP Control (BPD): Improved 5.0%; Statin Adherence (SPD): Improved 5.3%
    - Follow-up after Hospitalization for Mental Illness (FUH): 7 day Improved 7.5%; 30 day Improved: 17.4%
    - TRC Notification of Admission: Improved: 23.1%, Receipt of Discharge Information: Improved: 14.1%

### c. Identify any barriers to implementing initiatives:

- **Core Measure 7.3 and 9.3:**
  - None
- **HEDIS Measures:**
  - Focused review results specific to *PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator*:
    - Measure had small denominator, 49 in MY2021 and 60 in MY2022.
    - Denominator is based on admissions and Emergency Department (ED) visits, not members. Despite total Plan enrollment decrease of 6.36% from MY2021 to MY2022, more members had multiple events (exacerbations) due to COVID.

## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

- In 2021 and 2022, COVID continued to have adverse impact on obtaining bronchodilators; provider availability was limited and due to significant increase in respiratory issues, there was decreased availability of inhalers.
- In 2021 and 2022, members remained reluctant to see physicians in-person due to COVID, limiting timely prescription access. Utilization of Telehealth was limited due to level of technology and technical ability required.
- Members with poor adherence reported dislike of side effects, inconvenience of use, or improper inhaler technique resulting to reduced usage.
- Increased focus on non-pharmacological treatments such as lifestyle interventions (pulmonary rehab, exercise, and smoking cessation) which although potentially improve quality of life, can decrease demand for inhalers and to use newer medications that may be more effective than current agents.
- Measure rate improved 2% in MY2023.
- Focused review results specific to *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack*:
  - Measure had 4 in denominator for MY2021 and 10 in denominator in MY2022, resulting in NA audit status for HEDIS reporting for both years.
  - All 4 members were compliant in MY2021, resulting in the 100% rate. In MY2022, the 90% rate resulted from only 1 of the 10 members noncompliant.
  - Care Coordinators continued to educate members on importance of taking medication as prescribed; medication adherence addressed in member newsletters.
  - Measure denominator in MY2023 was 2.
- Focused review results specific to *OMW—Osteoporosis Management in Women Who Had a Fracture*:
  - Measure had 5 in denominator for MY2021 and 3 in denominator in MY2022, resulting in NA audit status for HEDIS reporting for both years.
    - The noncompliant members in MY2021 and in MY2022 each had multiple co-morbidities and multiple additional care gaps with history of noncompliance to obtain care and services needed.
  - Potential for fracture claim lag prevents timely notification of provider and delays member outreach and scheduling for appropriate follow-up.
  - Need for provider education (ongoing) to ensure proper coding for members who should be excluded for Advanced Illness/Frailty so that members do not remain in the measure denominator in error.
    - Improvement has occurred: Throughout 2021 and 2022, no members were excluded from the measure. Beginning in 2023 and continuing into 2024, several members have been identified as meeting exclusion criteria.
  - Need for provider education (ongoing) regarding billing for new fracture vs history of fracture.
  - As part of an enterprise-wide initiative, the Pharmacy and Quality teams have processes in place to monitor the members in this measure denominator and conduct outreach to members and providers as necessary.
  - Measure denominator in MY2023 was 7.

**HSAG Assessment:** HSAG has determined that **AMI** addressed the prior year's recommendations for the following measures based on the ICO implementing initiatives that appear to be effective in improving performance and/or the issues that resulted in the prior recommendations were not identified during this year's PMV activity:

## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

- MI7.3—HSAG did not identify any issues related to **AMI**'s integration of enrollment data for the continuous enrollment calculation during this year's PMV activity. In addition, HSAG did not identify any errors or issues related to **AMI**'s race and ethnicity data and reporting as part of the measure.
- HEDIS measures reported in the following domain demonstrated improved performance and are now meeting the MY 2023 statewide average:
  - Musculoskeletal Conditions
- *PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator*—The MY 2023 rate increased from MY 2022 and is now meeting the HEDIS MY 2023 MI Health Link statewide average.
- *OMW—Osteoporosis Management in Women Who Had a Fracture*—The MY 2023 rate increased from MY 2022 and is now meeting the HEDIS MY 2023 MI Health Link statewide average.

HSAG has determined that **AMI** has either partially addressed or did not address the prior year's recommendations for the following measures, and therefore should continue to implement or expand upon interventions to address the continued low performance or findings identified in these areas:

- Core Measure 9.3—While related to a different finding than the SFY 2023 PMV activity, **AMI** was again required to resubmit its Core Measure 9.3 data to HPMS during this year's PMV activity. As such, HSAG continues to recommend that **AMI** implement more stringent quality assurance checks and increased validation checks prior to submission of the data to MDHHS and HSAG. HSAG also continues to recommend that **AMI** review the annual release of the MMP Core reporting requirements and to ensure Core Measure 9.3 reporting aligns with the reporting requirements.
- HEDIS measures reported in the following domains continued to have rates that indicated worse performance than the MY 2023 statewide average, and therefore require additional efforts in order to meet the MY 2023 statewide average:
  - Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Behavioral Health, Medication Management and Care Coordination, Access/Availability of Care, and Risk-Adjusted Utilization.
- *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack*—The MY 2023 rate is not meeting the HEDIS MY 2023 MI Health Link statewide average. Note that performance could not be evaluated from MY 2022 to MY 2023, as there were changes in the technical specifications for this measure and NCQA recommended a break in trending between MY 2023 and prior years. However, HSAG continues to recommend that **AMI** implement or expand upon any interventions currently in place in order to improve upon performance related to the measure.

## 3. Prior Year Recommendation from the EQR Technical Report for Compliance Review

HSAG recommended the following:

- **AMI** received a *Not Met* score for three elements within the Confidentiality program area, indicating inadequate processes related to the use and disclosure of individually identifiable health information in accordance with privacy requirements in 45 CFR parts 160 and 164. While **AMI** was required to submit a CAP to address each of the identified deficiencies, HSAG recommends that **AMI** continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal requirements specific to member requests for privacy protection, access of PHI, and member requests for an amendment of PHI or member's record.
- **AMI** received a *Not Met* score for 13 elements within the Grievance and Appeal Systems program area, indicating members may not have access to all rights and required information when filing a grievance or requesting an appeal. While **AMI** was required to submit a CAP to address each of the identified

### 3. Prior Year Recommendation from the EQR Technical Report for Compliance Review

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

**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)*:

- **Confidentiality:**
  - In response to the findings provided by HSAG, AmeriHealth Caritas implemented standard operating procedures (SOPs) related to each of the member rights under HIPAA. Those SOPs outline how to handle requests when received as well as how to respond timely. In addition to the SOPs, individual trainings were created for each of the member rights which outline the requirements under HIPAA, our internal processes, including instructions for routing requests to the appropriate internal departments, and processes for responding timely as outlined within the regulation. We are currently working with our learning and development team to ensure the trainings are presented to all member facing departments, so associates are made aware of the requirements under HIPAA and the internal processes in place to guarantee timely response to those member rights related requests. Finally, we've included member rights routing instructions for our Member Services teams within our "Online Help" system which these associates' reference to determine how to correctly handle calls and requests from members.
- **Grievance and Appeal Systems:**
  - The Grievance and Appeals Department made updates to letter templates, policies, and job aids to ensure that all materials and processes reflect appropriate State and Federal requirements. Additionally, the Department held meetings to review documentation changes with staff members and ensure their understanding and application of correct procedures.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- **Confidentiality:**
  - N/A
- **Grievance and Appeal Systems:**
  - The Appeals and Grievance leadership team reviews daily reports to ensure responses and turnaround times are compliant with State and Federal requirements. The team works closely with Compliance to monitor and address any deficiencies identified. Through our reviews, we have found that Appointment of Representative (AOR) or equivalent forms are being requested when applicable, and cases are being resolved appropriately and addressed in a timely fashion.

c. Identify any barriers to implementing initiatives:

- **Confidentiality:**
  - Due to the number of member-facing associates, presenting the trainings we have developed to all applicable associates timely and getting sign off for completion has presented a challenge. However, as stated above, we have requested assistance from our learning and development team to upload these trainings to our learning management system for easier distribution and completion tracking.

### 3. Prior Year Recommendation from the EQR Technical Report for Compliance Review

- **Grievance and Appeal Systems:**

- The Appeals and Grievance leadership team reviews daily reports to ensure responses and turnaround times are compliant with State and Federal requirements. The team works closely with Compliance to monitor and address any deficiencies identified. Through our reviews, we have found that Appointment of Representative (AOR) or equivalent forms are being requested when applicable, and cases are being resolved appropriately and addressed in a timely fashion.

**HSAG Assessment:** HSAG has determined that **AMI** partially addressed the prior year's recommendations. The SFY 2024 CAP review confirmed that **AMI**'s action plans were successful at remediating the deficiencies for the Confidentiality program area. However, the SFY 2024 CAP review also confirmed that **AMI** did not remediate one element for the Grievance and Appeal Systems program area. During the CAP review, **AMI** explained that if an appeal was untimely, the ICO would notify the member but would continue the appeal and make an approval or denial decision. However, for Medicaid-based appeals, once the time frame expires, the appeal process is deemed exhausted, and **AMI** must send the member the appeal resolution notice as well as provide the member with State fair hearing rights information. As **AMI**'s updated action plans were approved by MDHHS and HSAG, HSAG recommends that the ICO conduct an internal audit to verify its action plans were successful in remediating the deficiencies. HSAG further recommends that **AMI** continue any interventions and internal monitoring that has occurred after the SFY 2024 CAP review to assure future compliance.

### 4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

- HSAG identified no substantial weaknesses for **AMI** based on the SFY 2023 NAV results. **AMI** should continue to monitor its Medicaid and LTSS providers, including verification of provider data accuracy using external data sources, to ensure an adequate network for MI Health Link members in Region 7 and Region 9.

**MCE's Response:** *(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:

- Year over year updating our Business Requirements Document for NAV reporting based on lessons learned.
- Adding indicators to provider records to be able to identify certain provider service offerings more clearly.
- Working more closely with vendors to ensure their data is as accurate as possible, by reconciling vendor's provider rosters to what is maintained in Facets, reviewing vendor data via internet searches and phone calls to offices, and via claim/encounter reconciliation, and where required, identifying locations providers are available at least 20 hours.
- Initiated a plan to perform adequacy validation quarterly beginning approximately October 2024.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- More accurate and timely reporting.
- Improved provider data.



#### 4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation

c. Identify any barriers to implementing initiatives:

- Working with vendors has its barriers since we are not in control of the network or data.

**HSAG Assessment:** HSAG has determined that **AMI** addressed the prior year's recommendations based on its reported initiatives.

#### 5. Prior Year Recommendation from the EQR Technical Report for Secret Shopper Survey

HSAG recommended the following:

- Of the 34 total survey cases, 76.5 percent (n=26) of the provider locations could be contacted. Of the cases reached, 76.9 percent of provider locations accepted **AMI**, and 38.5 percent accepted the MI Health Link program and new patients. HSAG recommends that **AMI** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect phone number, MI Health Link acceptance, and new patient acceptance) to address the provider data deficiencies and educate provider offices on the MI Health Link program. Additionally, as MDHHS required **AMI** to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.
- Among all surveyed cases, the overall appointment rate was 17.6 percent. HSAG recommends that **AMI** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. HSAG further recommends that **AMI** 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)*:

- SKYGEN Dental Office Poster: These colorful posters, which very clearly convey “This office accepts AmeriHealth Caritas VIP Care Plus, a MI (pronounced “MY”) Health Link program”, were mailed to all offices as well as AmeriHealth Caritas staff hand delivering posters to as many dental offices as we could reach.
- Continued efforts, as we believe they did have an impact:
  - Monthly faxing of a SKYGEN Provider Notice
  - SKYGEN Annual Provider Training
  - Quarterly Provider Data Validation Process
- Performed extensive provider data evaluation to ensure data accuracy and availability.
- Contacted each office to make them aware of any deficiency they may have, asked them about new staff training programs/policies, asked how staff new what insurances the office accepted, and confirmed they received the poster/if they posted it.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Improved awareness of who AmeriHealth Caritas and MI Health Link are.
- More accurate provider data.

c. Identify any barriers to implementing initiatives:

- Working with vendors has its barriers since we are not in control of the network or data.



#### 5. Prior Year Recommendation from the EQR Technical Report for Secret Shopper Survey

- Feel like we must supplement what the vendor is doing from a training perspective in order to ensure provider knowledge of who we are.

**HSAG Assessment:** HSAG has determined that **AMI** has addressed the prior year's recommendations. **AMI** implemented interventions to ensure directory data accuracy and appointment availability. **AMI** also conducted provider outreach to validate provider information and provided additional training.

#### 6. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

HSAG recommended the following:

- **AMI** did not indicate timeliness quality checks were performed for claims/encounters originating from its LTSS subcontractors. **AMI** should enhance its timeliness quality checks by considering, among other actions, the implementation of regular timeliness audits, the adoption of automated monitoring systems capable of tracking submission dates and generating alerts or reports for delayed submissions, and periodic reviews and adjustments of timeliness quality checks based on performance data and any alterations in regulations or contractual requirements.
- Although nearly all key data elements had high validity rates across all categories of service, CPT/HCPCS codes with PTP edits was valid 88.1 percent of the time in institutional data. **AMI** should continue to evaluate its data for accuracy and evaluate CPT/HCPCS codes with PTP edit checks to ensure proper 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)*

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)*:

- **Claims/Encounters:**
  - AmeriHealth has timeliness quality checks for Encounters from all their subcontractors in the form of validation of monthly file submissions and reporting. AmeriHealth is very consistent in their encounter timeliness and has only missed timeliness once in the past 12 months, and that was reported on in advance to AmeriHealth management, as it is tracked.
- **CPT/HCPCS:**
  - The Plan has just instituted Optum CES editing in the Medicare Facets region which should increase the accuracy of NCCI PTP substantially.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- N/A

c. Identify any barriers to implementing initiatives:

- N/A

**HSAG Assessment:** HSAG has determined that **AMI** has partially addressed the prior year's recommendations. **AMI** indicated in its response that it has timeliness quality checks for encounters from all subcontractors, utilizing monthly file submission validations and reporting. **AMI** reported consistent timeliness, missing submission deadlines only once in the past 12 months, and proactively communicated the issue to management. While **AMI** demonstrated consistency in monitoring timeliness, it did not provide evidence of implementing automated systems, conducting detailed audits, or adopting proactive solutions to address systemic delays.

## 6. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

Regarding the recommendation related to CPT/HCPCS code validity, **AMI** noted that it has recently implemented Optum CES editing in the Medicare Facets region, which is expected to improve the accuracy of National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits. While **AMI** has taken steps to enhance PTP edit accuracy, no evidence was provided to demonstrate the effectiveness or outcomes of these changes.

In conclusion, **AMI** has made progress in addressing HSAG's recommendations, particularly in maintaining timeliness consistency and implementing new tools to improve data accuracy. However, gaps remain in demonstrating comprehensive systemic improvements and measurable outcomes related to timeliness checks and CPT/HCPCS code accuracy. To strengthen compliance with HSAG's recommendations, **AMI** should:

- Implement automated tracking and alert systems for encounter submissions and perform periodic audits to identify and address systemic delays.
- Assess the impact of Optum CES editing on PTP edit accuracy and provide documented evidence of improvements.

These actions will improve data quality, address identified gaps, and align more effectively with HSAG's recommendations.

## 7. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis

HSAG recommended the following:

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

**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)*:
  - Care Coordinators have been re-educated during care plan discussion and monthly monitoring to discuss with members community inclusion and personal goals. At that time, community events and services such as non-medical transportation to get to these events is explored with the member/family. Different things such as church events, community events, library classes, etc. are explored and offered to the members.

## 7. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis

- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- We have seen a slight increase in members choosing to receive non-medical transportation to go out to the community more.
- c. Identify any barriers to implementing initiatives:
- Some members are apprehensive about going out to events and choose to stay home instead.

**HSAG Assessment:** HSAG has determined that **AMI** has addressed the prior year’s recommendations. **AMI** reported implementing interventions to provide training to care coordinators about care plans and member community inclusion, although staff noted some members were apprehensive about accessing the community. The SFY 2024 HCBS CAHPS activity demonstrated statistically significantly higher top-box scores compared to the 2024 HCBS CAHPS Database benchmarks for the MI Health Link program for *Rating of Personal Assistance and Behavioral Health Staff*, *Rating of Case Manager*, *Helpful Case Manager*, *Personal Safety and Respect*, and *Planning Your Time and Activities*. However, as the 2024 top-box score for *Planning Your Time and Activities* still demonstrated the lowest score of all HCBS CAHPS measures, HSAG recommends that **AMI** continue to monitor measures to continue any efforts to increase performance.

## HAP CareSource

**Table 4-3—Prior Year Recommendations and Responses for HCS**

1. Prior Year Recommendation from the EQR Technical Report for Validation of Quality Improvement Projects
<p>HSAG recommended the following:</p> <ul style="list-style-type: none"> <li>• <b>HCS</b> partially achieved the state-defined goals. While the existing disparity was eliminated between the two subgroups with the first remeasurement period, the comparison subgroup demonstrated a decline in performance as compared to the baseline. HSAG recommends <b>HCS</b> continue efforts to maintain, or improve, its performance for the comparison subgroup. The ICO should also determine if any new barriers exist that are driving down performance for this subgroup. Also, in accordance with direction from MDHHS, <b>HCS</b> is required to identify at least three barriers to care and develop three interventions to address those barriers, specifically for the African American population, within the next annual submission.</li> </ul>
<p><b>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)</b></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"> <li>• 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 implemented include the following: <ul style="list-style-type: none"> <li>○ Primary Care Incentive Program: an incentive program to reward primary care providers for high quality, cost-effective primary care services. Controlling High Blood Pressure (CBP) is included in the program.</li> <li>○ Continued Provider Gaps in Care Report to share members due for services with Provider Organization (PO) groups on a monthly basis.</li> <li>○ Continued Care Coordination and customer service staff members engaging members due for services.</li> <li>○ Continued medication adherence program through Pharmacy Benefits Manager (PBM).</li> <li>○ Continued targeted analysis, outreach, and strategies based on geo-mapping data broken down by member race and gaps in care by zip code.</li> <li>○ Implemented multimodal approach to member outreach by the Quality Improvement team such as mail, text, and an Interactive Voice Response phone system.</li> </ul> </li> </ul>
<p>b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):</p> <ul style="list-style-type: none"> <li>• Below is a summary of effectiveness of interventions during remeasurement 2: <ul style="list-style-type: none"> <li>○ Two provider organizations (PO) met the threshold for the Controlling High Blood Pressure (CBP) measure. The following provider groups earned the incentive for the 2023 HAP Best Practice Incentive program: GMP Network and Henry Ford Health</li> <li>○ 14 PO groups received Primary Care Physician (PCP) Detail Gaps in Care Reports, and 11 PO groups did not receive reports. Intervention data for the African American population is below. There were 248 African American members out of a total of 402 African American members who were compliant with CBP and had a PCP who was part of a PO group that received monthly provider gap reports, for a rate of 61.69%. There were 103 out of 202 African American members</li> </ul> </li> </ul>

## 1. Prior Year Recommendation from the EQR Technical Report for Validation of Quality Improvement Projects

who were compliant with CBP and had a PCP under a PO group that did not receive a provider report, for a rate of 50.99%.

- 544 African American members were included in the adherence program outreach. Of those targeted for outreach, 195 (35.84%) African American members increased their adherence.
- HAP CareSource analyzes Healthcare Effectiveness Data and Information Set (HEDIS®) results to measure the effectiveness of interventions and to identify additional opportunities for improvement. The MY2023 final hybrid Controlling High Blood Pressure (CBP) rate for Caucasians was 78.29% compared to the Black/African American rate of 70.83%. The p value was calculated and found to be 0.1458, therefore, a statistically significant disparity did not exist between these two populations. There was a statistically significant improvement in the Black/African American rate between the Baseline (51.50%) to Remeasurement 2 (70.83%) time periods,  $p = 0.00016$ . Although the Caucasian population CBP HEDIS® rate increased between Baseline (74.24%) to Remeasurement 2 (78.29%), this improvement was not statistically significant ( $p = 0.4418$ ). HAP CareSource continues to identify opportunities for improvement and interventions.

### c. Identify any barriers to implementing initiatives:

- HAP CareSource identified there are continued barriers to members having controlled hypertension.
- COVID-19 Pandemic exacerbated pre-existing health inequities, such as access to healthcare services, and the long-term effects from the pandemic on the healthcare of our Michiganders continues to impact their ability to self-manage their hypertension.
- SDOH (Social Determinants of Health) barriers, in part due to history of structural inequities against disparate group as well as mistrust of the healthcare system.

**HSAG Assessment:** HSAG has determined that **HCS** addressed the prior year's recommendations based on the responses provided by the ICO and HSAG's review of the ICO's annual QIP submission. The ICO received a *Met* score for 100 percent of the requirements for implementation of improvement strategies and for outcomes, which includes achievement of the state-defined goals.

## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

HSAG recommended the following:

- Although **HCS** improved the MI5.6 rate from the prior measurement year's reported rate, it continued to have a low MI5.6 rate in comparison to the other Michigan ICOs' reported rates. HSAG recommends that **HCS** overread a portion of the vendor's noncompliant cases.
- The member-level data provided to HSAG for PMV included incorrect race and ethnicity data counts for MI7.3. HSAG recommends that **HCS** incorporate more stringent quality assurance checks and validation checks prior to submission of member-level data to HSAG. The validation checks should include ensuring that the appropriate race and ethnicity data counts are reported and in alignment with the reported MI7.3 numerator and denominator counts.
- While only 13 of the 40 reported HEDIS measures rates (33 percent) indicated worse performance than the statewide average, opportunity exists for **HCS** to further improve performance across multiple domains including Prevention and Screening, Diabetes, Behavioral Health, Medication Management and Care Coordination, Overuse/Appropriateness, and Access/Availability of Care. HSAG recommends that **HCS** focus on further improving performance for measures included in these domains.

## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure 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)*:
  - Transitions of Care: Medication Reconciliation Post Discharge & Notification of Inpatient Admission (MI5.6)
    - Both measures were included in the Annual Medical Record Review Project in MY 2022 and MY 2023. HAP CareSource did start the Annual Medical Record Review Project earlier than usual in MY 2023 to allow the team more time to get into the Electronic Medical Record (EMRs) systems and pull the compliant charts. HAP CareSource has direct access to the Henry Ford Health EPIC EMR System and can pull charts from all members who have records in EPIC using Care Everywhere. This has proved to be a fruitful source of information.
  - (MI5.6) Care for Older Adults: Medication Review – for MY 2022, HAP CareSource had a member reward that any MMP member could earn if they completed an annual medication review with a HAP Clinical Pharmacist. This reward was continued into MY 2023 and actually increased from \$15 to \$25. Additionally, HAP CareSource has identified that it has historically found a large volume of Healthcare Effectiveness Data and Information Set (HEDIS) compliant records during the Medical Record Review Project. To allow the team more time to gather compliant records, HAP CareSource started its Annual Medical Record Review season earlier than usual. HAP CareSource also has direct access to Henry Ford Health's Epic Care Everywhere and had dedicated resources to searching and pulling compliant charts for this measure.
  - (MI7.3) HAP CareSource's data infrastructure includes processes for performing data quality assurance to ensure that race and ethnicity data is ingested correctly from 834 files and stored in Facets. The data is regularly reviewed to determine gaps.
- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
  - (MI5.6) Transitions of Care: Medication Reconciliation Post Discharge – While this measure is below the State Average by 5.5 percentage points, HAP CareSource did improve its rate by 2.9 percentage points from MY 2022. Additionally, HAP CareSource has shown continued improvement in this measure for MY 2023 with a final rate of 58.9%, a 16.8 percentage point improvement from MY 2022 and exceeds the MY 2022 MMP Michigan State average.
  - (MI5.6) Care for Older Adults: Medication Review – HAP CareSource improved its rate from 59.2% in MY 2021 to 61.7% in MY 2023. Despite this small improvement, HAP CareSource remains 18.7 percentage points behind the Michigan MMP Average. With the focused efforts during the Medical Record Review Season, HAP CareSource was able to improve its rate dramatically for MY 2023 with a final rate of 73.47%. While this is still below the Michigan MMP Average, it is significant improvement and allowed HAP CareSource to identify that this data is not coming to the Plan administratively.
- c. Identify any barriers to implementing initiatives:
  - A number of these Healthcare Effectiveness Data and Information Set (HEDIS) measures are time sensitive and therefore have the added barrier of ensuring that HAP CareSource gets the data early enough for intervention from providers and/or vendors.



## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

**HSAG Assessment:** HSAG has determined that **HCS** addressed the prior year's recommendations for the following measures based on the ICO implementing initiatives that appear to be effective in improving performance and/or the issues that resulted in the prior recommendations were not identified during this year's PMV activity:

- MI7.3—HSAG did not identify any issues related to **HCS'** race and ethnicity data counts for MI 7.3 during this year's PMV activity.
- HEDIS measures reported in the following domain demonstrated improved performance and are now meeting the MY 2023 statewide average:
  - Medication Management and Care Coordination

HSAG has determined that **HCS** has either partially addressed or did not address the prior year's recommendations for the following measures, and therefore should continue to implement or expand upon interventions to address the continued low performance or findings identified in these areas:

- MI5.6—Although **HCS** improved the SFY 2024 rate from SFY 2023, it continued to have a low MI5.6 rate in comparison to the other Michigan ICOs' reported rates. Therefore, HSAG continues to recommend that **HCS** overread a portion of its vendor's noncompliant cases and continue to expand upon any improvement efforts currently in place.
- HEDIS measures reported in the following domains continued to have rates that indicated worse performance than the MY 2023 statewide average, and therefore require additional efforts in order to meet the MY 2023 statewide average:
  - Prevention and Screening, Diabetes, Behavioral Health, Overuse/Appropriateness, and Access/Availability of Care.

## 3. Prior Year Recommendation from the EQR Technical Report for Compliance Review

HSAG recommended the following:

- **HCS** received a Not Met score for three elements within the Provider Selection program area, indicating providers were not being credentialed in accordance with the ICO's contractual obligations with MDHHS. While **HCS** was required to submit a CAP to address each of the identified deficiencies, HSAG recommends that **HCS** continually evaluate its processes, procedures, and monitoring efforts, including oversight of delegated entities, to ensure compliance with all federal and MDHHS-set standards specific to the credentialing and recredentialing of network providers.
- **HCS** received a Not Met score for 10 elements within the Grievance and Appeal Systems program area, indicating members may not have access to all rights and required information when filing a grievance or requesting an appeal. While **HCS** was required to submit a CAP to address each of the identified deficiencies, HSAG recommends that **HCS** continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member grievances and appeals. HSAG further recommends that **HCS** implement procedures to ensure model notice language used is the most current version required by MDHHS, and that **HCS** follow requirements of the Three-Way Contract to guarantee adherence to Medicaid managed care rules for processing of grievances and appeals and use of required model notices.

### 3. Prior Year Recommendation from the EQR Technical Report for Compliance Review

**MCE's Response:** *(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

- a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:
  - HAP CareSource has updated policies and procedures outlining oversight of delegated entities performing credentialing functions to require that all quality indicators are reviewed when credentialing and re-credentialing network providers as outlined by contractual obligation with MDHHS. HAP CareSource will perform file reviews during annual audits and at re-credentialing to ensure all quality indicators are being performed by delegated entities.
  - HAP CareSource reviewed its grievance and appeals policies and made several revisions. The revised policies were reviewed by the internal Business Owners and Stakeholders prior to being published in our internal policy repository. Staff members received training after the policies were formally approved. Team Leads and Managers will conduct a review of a random sample of cases every month and report results/deficiencies directly to the team for education. Results/deficiencies will also be tracked via an internal scorecard to measure compliance and will be reported to Leadership.
- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
  - The audit process noted above will be implemented as of 10/1/24.
  - HAP CareSource is currently aggregating data for the first set of cases reviewed. Performance data will be reviewed for an increase in performance during subsequent monthly audits.
- c. Identify any barriers to implementing initiatives:
  - The updated 2024 model document for Notice of Receipt Oral Appeal has been received and is currently with our internal configuration team for creation and testing in our internal tracking system. Staff members are utilizing the previous 2024 model document until the updated 2024 model document can be auto generated.
  - Internal reporting had to be enhanced to capture acknowledgement letter turnaround time. This would allow us to have more robust oversight to ensure we are in compliance with the writing acknowledgement requirement. Enhancements were completed by 09/13/2024, therefore, oversight began after the enhancements were deployed and HAP CareSource is currently aggregating data for a full month of case review.
  - Additional clarification needs to be obtained by HAP CareSource from MDHHS in regard to providers acting on behalf of members with written consent. MDHHS clarification was received 08/19/2024. Grievance and Appeal materials are currently being updated in accordance with the MDHHS correspondence and staff training can now take place. Full implementation is scheduled for no later than 10/25/2024.

**HSAG Assessment:** HSAG has determined that **HCS** partially addressed the prior year's recommendations. The SFY 2024 CAP review confirmed that **HCS'** action plans were successful at remediating the deficiencies for one of two elements for the Provider Selection program area and four of six elements for the Grievance and Appeal Systems program area. However, the SFY 2024 CAP review also confirmed that **HCS** did not remediate the remainder of the deficient elements for these two standards. The recredentialing case examples provided by **HCS** did not contain evidence that the delegated entities performing credentialing functions on behalf of the ICO reviewed UM information, member satisfaction surveys, or performance indicators obtained through the QIP during the recredentialing process. Further, **HCS** demonstrated several opportunities for improvement in the processing of member grievances and appeals specific to the acknowledgement and

### 3. Prior Year Recommendation from the EQR Technical Report for Compliance Review

resolution of grievances, obtaining written consent of the member for a provider to file an appeal on the member's behalf, and the acknowledgement of member appeals. As **HCS**' updated action plans were approved by MDHHS and HSAG, HSAG recommends that the ICO conduct an internal audit to verify its action plans were successful in remediating the deficiencies. HSAG further recommends that **HCS** continue any interventions and internal monitoring that has occurred after the SFY 2024 CAP review to assure future compliance.

### 4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

- HSAG identified no substantial weaknesses for **HCS** based on the SFY 2023 NAV results. **HCS** should continue to monitor its Medicaid and LTSS providers, including verification of provider data accuracy using external data sources, to ensure an adequate network for MI Health Link members in Region 7 and Region 9.

**MCE's Response:** *(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:

- HAP CareSource continues to monitor Medicaid and Long-Term Services and Supports (LTSS) provider data accuracy in Regions 7 and 9 through multiple data validations of files received daily, weekly, and monthly; as well as random sampling and auditing of provider information to ensure accuracy.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- HAP CareSource received a score of 100% on the MI ICO SFY2024 Network Adequacy Validation.

c. Identify any barriers to implementing initiatives:

- None.

**HSAG Assessment:** HSAG has determined that **HCS** addressed the prior year's recommendations based on the reported initiatives.

### 5. Prior Year Recommendation from the EQR Technical Report for Secret Shopper Survey

HSAG recommended the following:

- Of the cases reached, 57.4 percent of provider locations accepted **HCS**, 49.7 percent accepted the MI Health Link program, and 47.8 percent accepted new patients. HSAG recommends that **HCS** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect phone number, MI Health Link acceptance, and new patient acceptance) to address the provider data deficiencies and educate provider offices on the MI Health Link program. Additionally, as MDHHS required **HCS** to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.
- Among all surveyed cases, the overall appointment rate was 34.5 percent. HSAG recommends that **HCS** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. 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.

## 5. Prior Year Recommendation from the EQR Technical Report for Secret Shopper Survey

**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 has updated processes to ensure optimal access to healthcare for members in accordance with MDHHS guidelines. HAP CareSource Health Partners monitor the contracted network to ensure access to quality healthcare services through reporting to illustrate services and locations are available and accessible in accordance with set guidelines. Dental providers are reviewed on a monthly basis, and any deficiencies noted are analyzed and remediated.
- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
  - HAP CareSource Secret Shopper Survey resulted in a pass rate of 100% for SFY2024.
- c. Identify any barriers to implementing initiatives:
  - None.

**HSAG Assessment:** HSAG has determined that **HCS** has partially addressed the prior year's recommendations. **HCS** implemented interventions to ensure directory data accuracy and access to healthcare for members. **HCS** also conducted provider outreach to validate provider information. **HCS** should also address the data deficiencies noted in the case-level analytic data files.

## 6. 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.
- **HCS** did not indicate timeliness quality checks were performed for claims/encounters originating from all of its subcontractors. **HCS** should enhance its timeliness quality checks by considering, among other actions, the implementation of regular timeliness audits, the adoption of automated monitoring systems capable of tracking submission dates and generating alerts or reports for delayed submissions, and periodic reviews and adjustments of timeliness quality checks based on performance data and any alterations in regulations or contractual requirements.
- Although 99.9 percent of provider NPIs identified in the medical/dental data were identified in the provider data, 96.1 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data. **HCS** should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.
- Approximately 33 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 field is after the payment date field.
- Although not required to be populated, 51.2 percent of professional encounters contained a billing provider NPI, and 0 percent contained a rendering provider NPI. **HCS** should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

## 6. 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)*:
- 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.
  - HAP CareSource acceptance on Pharmacy encounters is above 99% with no identified provider issues. HAP CareSource will continue to collaborate with MDHHS to ensure pharmacy provider data reported is accurate and in sync with MDHHS expectations.
  - Pertaining to pharmacy encounters, Express Scripts, Inc. (ESI) will be delaying 24 hours between the encounters being released and the financial check run to ensure the encounters submit dates are not prior to the check date.
  - HAP CareSource began populating rendering provider information on all Encounters as of date of service, January 1, 2024.

- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- None.

- c. Identify any barriers to implementing initiatives:
- None.

**HSAG Assessment:** HSAG has determined that **HCS** has partially addressed the prior year's recommendations. **HCS** provided clarity on encounter modifications, ensuring compliance with MDHHS expectations. Regarding timeliness quality checks, **HCS** indicated that vendors perform quality checks on 837 encounter files prior to submission and that internal audits are conducted for data completeness. However, there is no evidence of automated systems, timeliness audits, or regular performance reviews. While vendor quality checks and internal audits are in place, gaps remain in implementing automated monitoring systems and comprehensive timeliness audits.

For provider NPI completeness, **HCS** reported a pharmacy provider data accuracy rate of over 99 percent and committed to ongoing collaboration with MDHHS to align provider data. While progress has been made, no specific evidence was provided on the outcomes of these collaborative efforts or steps taken to reconcile discrepancies.

**HCS** has fully addressed the recommendation regarding pharmacy encounter submission dates occurring after the payment date by implementing a 24-hour delay between encounters being released and the financial check run. Regarding rendering provider NPIs for professional encounters, **HCS** indicated that it began populating rendering provider information on all encounters with dates of service from January 1, 2024. However, the



## 6. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

response does not confirm the implementation of quality checks to ensure the consistent and accurate inclusion of rendering provider NPIs.

In conclusion, **HCS** has made progress, particularly in clarifying encounter modifications and addressing submission date discrepancies. However, additional efforts are needed to strengthen timeliness monitoring, provider data reconciliation, and rendering provider NPI validation. To strengthen compliance with HSAG's recommendations, **HCS** should:

- Implement automated timeliness monitoring systems and conduct regular audits to address systemic delays.
- Collaborate closely with MDHHS to reconcile provider data discrepancies and ensure alignment.
- Establish quality checks to validate rendering provider NPIs and improve data completeness.

These steps will help **HCS** ensure data quality, address identified gaps, and align more effectively with HSAG's recommendations.

## 7. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis

HSAG recommended the following:

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

**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 is in the initial phase of partnering with local community-based organizations (CBOs) in order to increase member engagement with the health system and survey administrations, along with improving member experience by encouraging them to engage with family and friends through the community. These CBOs are also able to refer members to different areas of the health system and share recommendations of health care providers.
- Identify any noted performance improvement as a result of initiatives implemented (if applicable):
  - None.
- Identify any barriers to implementing initiatives:
  - CBO Collaboration includes ensuring appropriate contracting and funding is in place for a fruitful partnership.



**HSAG Assessment:** HSAG has determined that **HCS** has addressed the prior year's recommendations. **HCS** reported implementing interventions to partner with community-based organizations to assist with member engagement. The SFY 2024 HCBS CAHPS activity demonstrated statistically significantly higher top-box scores compared to the 2024 HCBS CAHPS Database benchmarks for the MI Health Link program for *Rating of Personal Assistance and Behavioral Health Staff*, *Rating of Case Manager*, *Helpful Case Manager*, *Personal Safety and Respect*, and *Planning Your Time and Activities*. However, as the 2024 top-box score for *Planning Your Time and Activities* still demonstrated the lowest score of all HCBS CAHPS measures, HSAG recommends that **HCS** continue to monitor measures to continue any efforts to increase performance.

## MeridianComplete

**Table 4-4—Prior Year Recommendations and Responses for MER**

1. Prior Year Recommendation from the EQR Technical Report for Validation of Quality Improvement Projects
<p>HSAG recommended the following:</p> <ul style="list-style-type: none"> <li><b>MER</b> did not achieve the state-specific goal of eliminating the existing disparity between the two subgroups with the first remeasurement period, and the comparison subgroup demonstrated a decline in performance as compared to the baseline. HSAG recommends <b>MER</b> revisit its causal barrier analysis to determine if any new barriers exist for both the disparate and comparison subgroups that require the development of targeted strategies to improve performance. In accordance with direction from MDHHS, <b>MER</b> is required to identify at least three barriers to care and develop three interventions to address those barriers, specifically for the African American/Black population.</li> </ul>
<p><b>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)</b></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"> <li>Meridian conducted an evaluation of its Quality Improvement Project (QIP), which aimed to reducing racial and ethnical disparities in statin therapy adherence for diabetes patients, focusing on African American/Black and White populations. The project utilized the HEDIS® SPD Rate 2 (80% adherence) to measure performance.</li> <li>Through this evaluation, Meridian identified three key barriers to adherence: <ul style="list-style-type: none"> <li>(1) early discontinuation of therapy by providers,</li> <li>(2) lack of culturally appropriate educational materials, and</li> <li>(3) inconsistent access to timely prescription refills.</li> </ul> </li> <li>To address these barriers, Meridian implemented three key interventions: <ul style="list-style-type: none"> <li>(1) distributed culturally tailored educational flyers to raise diabetes awareness and adherence,</li> <li>(2) launched a prescription reminder campaign to ensure members maintained their medication schedules, and</li> <li>(3) increased year-end outreach efforts by Care Managers (CM) to target members with adherence gaps.</li> </ul> </li> <li>As a result, slight improvements in adherence rates were observed in both populations in 2023, although the White population's rate decreased by 2.64 percentage points to 83.19%. Meridian remains committed to continuous monitoring and enhancement of these interventions to further reduce disparities in adherence rates.</li> </ul>
<p>b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):</p> <ul style="list-style-type: none"> <li>In Measurement Year (MY) 2023, the African American/Black population's performance rate increased by 0.84 percentage points, from 75.00% to 75.84%. Despite this improvement, the performance did not reach statistical significance, as indicated by the Chi-Square test result of 0.1403 with a p-value of 0.0708. Meridian implemented several interventions to improve the HEDIS® SPD 80% adherence rates and reduce disparities between African American/Black and White populations. These interventions included: (1) distributing culturally appropriate educational flyers to 51 African</li> </ul>

## 1. Prior Year Recommendation from the EQR Technical Report for Validation of Quality Improvement Projects

American/Black members, with 17 (33.33%) becoming adherent, (2) a prescription reminder campaign in November 2023 targeting 37 non-adherent African American/Black members, with 9 (24.32%) becoming adherent, and (3) Care Managers (CM) outreach prioritized members with adherence gaps, resulting in 11 successful contacts and 3 members (27.27%) becoming adherent.

- Meridian observed a promising decrease in the disparity between the African American/Black and White populations, with a decrease of 0.11 percentage points when comparing the remeasurement one's variance rate of 7.35%. This improvement is validated by the statistical significance of 4.1282 with a p-value of 0.421 when compared to the baseline statistical significance of 12.2289 with a p-value of 0.0005.

### c. Identify any barriers to implementing initiatives:

- Meridian encountered delays in the approval process for the member rewards program, resulting in a launch in the third quarter of 2024, retroactive to January 1, 2024. Additionally, approval delays impacted the distribution of a culturally appropriate educational flyer, pushing the release to the first quarter of 2024.

**HSAG Assessment:** HSAG has determined that **MER** addressed the prior year's recommendations based on the responses provided by the ICO and HSAG's review of the ICO's annual QIP submission. The ICO revisited its causal/barrier analysis to identify barriers to care and developed targeted intervention strategies which included efforts specific to the disparate subgroup.

## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

HSAG recommended the following:

- The member-level data provided to HSAG for PMV contained errors that resulted in resubmission of Core Measure 9.3 data to HPMS. HSAG recommends that **MER** review the annual release of the Core Reporting Requirements in comparison to current source code for Core Measure 9.3. HSAG also recommends that **MER** implement more stringent quality assurance checks and increased frequency of validation checks prior to submission of member-level data.
- While only 17 of the 40 reported HEDIS measures rates (43 percent) indicated worse performance than the statewide average, opportunity exists for **MER** to further improve performance across multiple domains including Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Musculoskeletal Conditions, Behavioral Health, Medication Management and Care Coordination, and Access/Availability of Care. HSAG recommends that **MER** focus on further improving performance for measures included in these domains.
- In the Prevention and Screening domain, **MER**'s rate for the COA—Care for Older Adults—Medication Review measure indicator decreased by more than 10 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, indicating that adult members ages 66 years and older were not always having medication reviews conducted during the measurement year. Older adults may have more complex medication regimens. This measure ensures that older adults receive the care they need to optimize their quality of life. HSAG recommends that **MER** conduct a root cause analysis or focused study to determine why some adults ages 66 years and older are not having medication reviews completed. **MER** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or education).
- In the Cardiovascular Conditions domain, **MER**'s rate for the PBH—Persistence of Beta-Blocker Treatment After a Heart Attack measure indicator decreased by more than 9 percentage points from MY

## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, indicating that some adult members were not using a beta-blocker as treatment after a heart attack. Clinical guidelines recommend taking a beta-blocker after a heart attack to prevent another heart attack from occurring. This reduces the amount of force on the heart and blood vessels. Persistent use of a beta-blocker after a heart attack can improve survival and heart disease outcomes. HSAG recommends that **MER** conduct a root cause analysis or focused study to determine why some adults were not using a beta-blocker after a heart attack. Upon identification of a root cause, **MER** should implement appropriate interventions to improve the performance related to the PBH—Persistence of Beta-Blocker Treatment After a Heart Attack measure indicator. **MER** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or provider education).

- In the Medication Management and Care Coordination domain, **MER**'s rates for the TRC—Transitions of Care—Medication Reconciliation Post-Discharge and Patient Engagement After Inpatient Discharge measure indicators decreased by more than 7 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, indicating that there was not always evidence of medication reconciliations and patient engagement being provided within 30 days after discharge. Transition from the inpatient (hospital) setting back to home often results in poor care coordination, including communication lapses between inpatient and outpatient (a setting other than a hospital) providers; intentional and unintentional medication changes; incomplete diagnostic workups; and inadequate patient, caregiver and provider understanding of diagnoses, medication, and follow-up needs. HSAG recommends that **MER** conduct a root cause analysis or focused study to determine why there was not always evidence of medication reconciliation or patient engagement being provided within 30 days after discharge. Upon identification of a root cause, **MER** should implement appropriate interventions to improve the performance related to the TRC—Transitions of Care—Medication Reconciliation Post-Discharge and Patient Engagement After Inpatient Discharge measure indicators. **MER** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of care coordination or provider education).

**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 completed a root cause analysis to determine the reason for resubmission and identified a new database release in Meridian's reporting system impacted report filters resulting in the inaccurate capture of admission dates. The previous Structured Query Language (SQL) in Meridian's reporting system was promptly updated to reflect the new database release. As part of Meridian's commitment to continuous improvement, an annual review of the Core Reporting Requirements in comparison to the current source code for Core Measure 9.3 has been implemented. Meridian has implemented up-to-date structures to ensure updates are accurately reflected in pertinent workflows, data collection processes, and reporting systems. In addition, close collaborations between Meridian departments have been implemented to ensure the source code for Core Measure 9.3 is up-to-date and aligned with the latest reporting standards. Furthermore, Meridian has taken initiatives to implement more stringent quality assurance and validation checks prior to submission upon notice of resubmission.
  - In review of the SFY 2023 External Quality Review – for Integrated Care Organization (EQRO) report, Meridian focused on further improving HEDIS® performance across the following eight domains; Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes,

## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

Musculoskeletal Conditions, Behavioral Health, Medication Management and Care Coordination, and Access/Availability of Care. Meridian reviewed the year over year (YoY) performance for each of the 32 measures within the categories. As a result of this review, Meridian implemented internal Process Improvement Plans (PIPs) for measures that continued to decline and did not achieve the MMP state average. The implemented PIP process allows Meridian to track HEDIS® measure rates to review the progress of interventions dedicated to achieving the targeted benchmarks. The Quality Improvement (QI) team shares the PIP results during the quarterly Quality Improvement and Utilization Management Committee (QIUMC) meeting. Meridian's QI team will continue to monitor the measures through quarterly reporting and collaborative workgroups to further improve measure performances.

- In review of the SFY 2023 EQRO report, Meridian completed the recommended root cause analysis on the HEDIS® measure; COA- Care for Older Adult – Medication Review. The analysis identified that members may not attend routine annual wellness visits, providers may not conduct, document, or bill appropriately, and members may inconsistently pick up prescriptions or multiple providers may prescribe medications. Due to these findings, Meridian implemented an internal PIP for COA- Care for Older Adults Medication Review. The PIP process allows Meridian to track HEDIS® measure rates and review the progress of interventions dedicated to achieving the targeted benchmarks. The QI team shares the PIP results during the quarterly QIUMC meeting. To increase performance, the QI and Pharmacy teams collaborated on vendor assisted Complete Medication Reviews (CMRs). In review of the MY 2023 performance rate of 91.97%, Meridian resolved the PIP as the measure exceeded the state average of 80.41%. The QI team will continue to monitor the measure through QI's Medicare-Medicaid Plan (MMP) collaborative workgroup.
- In review of the SFY 2023 EQRO report, Meridian completed the recommended root cause analysis on HEDIS® measure; PBH – Persistence of Beta Blocker Treatment After a Heart Attack measure. The analysis identified that members may not be adherent with medication regimes, may not pick up medications post discharge, and providers may not follow up with the member post discharge or schedule timely follow up appointments. These findings resulted in Meridian implementing an internal PIP for the PBH- Persistent of Beta Blocker Treatment After a Heart Attack measure. The PIP process allows Meridian to track HEDIS® measure rates and review the progress of interventions dedicated to achieving the targeted benchmarks. The QI team shares the PIP results during the quarterly QIUMC meeting. The PIP will continue with interventions like transitions of care post discharge follow up outreach and member focused medication adherence education. The QI team will monitor the measure through the collaborative QI and Pharmacy workgroup.
- In review of the SFY 2023 EQRO report, Meridian completed the recommended root cause analysis on HEDIS® measure; TRC-Transitions of Care—Medication Reconciliation Post-Discharge and Patient Engagement After Inpatient Discharge measures. The analysis identified that members may not follow up with a provider within 30-days of discharge, providers may fail to conduct or bill correctly for medication reconciliation post discharge, or members may be hard to reach or do not engage with care coordination post discharge. Due to these findings, Meridian implemented an internal PIP for the TRC– Transitions of Care – Medication Reconciliation Post–Discharge. The PIP process allows Meridian to track HEDIS® measure rates and review the progress of interventions dedicated to achieving the targeted benchmarks. The QI team shares the PIP results during the quarterly QIUMC meeting. In addition, Meridian's Medical Management team developed and implemented a transition of care team in quarter three of 2023. In review of the MY 2023 performance the PIP will continue with interventions like transition of care post -discharge follow up outreach and assisting members with scheduling appointments and/or transportation services. The QI team will monitor the measures through the MMP collaborative workgroup.



## 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):
- Meridian anticipates conducting an annual review of Core Reporting Requirements compared to current source codes for Core Measure 9.3, will improve Meridian's understanding of the report. Meridian's implementation of more stringent quality assurance and validation checks prior to submission has strengthened internal standards and performance.
  - Meridian analyzed the MY 2023 HEDIS® for the 32 measures across the eight identified domains and observed performance rates increased for 18 measures when compared to the MY 2022 rates and 14 of the measures were above the MMP state average. However, 13 measures declined in performance YoY and eight measures have a PIP in place. In addition, the Controlled Blood Pressure (CBP) measure remained the same YoY and the HbA1c Poor Control >9%, a reverse measure, decreased and performed lower than the MMP state average.
  - Meridian observed the MY 2023 HEDIS® COA – Care for Older Adults Medication Review performance rate of 91.97% increased by 25.79 percentage points when compared to the MY 2022 rate of 66.18% and it exceeded the MMP state average of 80.41%.
  - Meridian observed the MY 2023 HEDIS® PBH – Persistent Beta Blocker Treatment After a Heart Attack performance rate of 33.33% decreased by 57.30 percentage points when compared to the MY2022 rate of 90.63% and it is below the MMP state average of 90.85%. In addition, Meridian compared the MY 2022 and MY 2023 measure populations which revealed the denominator significantly decreased from 29 to six and the number of exclusions increased from seven to 28, respectively.
  - Meridian observed the MY 2023 HEDIS® TRC-Transitions of Care—Medication Reconciliation Post-Discharge performance rate of 43.31% increased by 4.62 percentage points when compared to the MY 2022 rate of 38.69% and it is below the MMP state average of 47.59%. In addition, the TRC – Transition of Care Engagement After Inpatient Discharge performance rate of 78.59% increased by 0.97 percentage points when compared to the MY 2022 rate of 77.62% and it exceeded the MMP state average of 77.74%.
- c. Identify any barriers to implementing initiatives:
- Meridian did not identify any barriers to implementing a conducted annual review of Core Measure 9.3 Reporting Requirements in comparison to current source code, stringent quality assurance checks, or increased frequency of validation checks prior to submission of member-level data.
  - Meridian encountered material approval delays which impacted the 2024-member incentive program known as My Meridian Rewards. The program was live in quarter three of 2024.
  - Meridian did not identify any barriers to implementing initiatives for the HEDIS® COA – Care for Older Adults Medication Review measure.
  - Meridian did not identify any barriers to implementing initiatives for the HEDIS® PBH – Persistent Beta Blocker Treatment After a Heart Attack measure.
  - Meridian identified unable to reach (UTR) members as a barrier when conducting transition of care outreach to member post discharge.

**HSAG Assessment:** HSAG has determined that **MER** addressed the prior year's recommendations for the following measures based on the ICO implementing initiatives that appear to be effective in improving performance and/or the issues that resulted in the prior recommendations were not identified during this year's PMV activity:

- HEDIS measures reported in the following domain demonstrated improved performance and are now meeting the MY 2023 statewide average:



## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

- Musculoskeletal Conditions
- *COA—Care for Older Adults—Medication Review*—The MY 2023 rate increased from MY 2022 and is now meeting the HEDIS MY 2023 MI Health Link statewide average.

HSAG has determined that **MER** has either partially addressed or did not address the prior year's recommendations for the following measures, and therefore should continue to implement or expand upon interventions to address the continued low performance or findings identified in these areas:

- Core Measure 9.3—**MER** was again required to resubmit its Core Measure 9.3 data to HPMS during this year's PMV activity as the final reported data counts did not align between the member-level detail file submission and the final reported counts to MDHHS. As such, HSAG continues to recommend that **MER** implement more stringent quality assurance checks and increased validation checks prior to submission of the data to MDHHS and HSAG.
- HEDIS measures reported in the following domains continued to have rates that indicated worse performance than the MY 2023 statewide average, and therefore require additional efforts in order to meet the MY 2023 statewide average:
  - Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Behavioral Health, Medication Management and Care Coordination, and Access/Availability of Care.
- *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack*—The MY 2023 rate is not meeting the HEDIS MY 2023 MI Health Link statewide average. Note that performance could not be evaluated from MY 2022 to MY 2023, as there were changes in the technical specifications for this measure and NCQA recommended a break in trending between MY 2023 and prior years. However, HSAG continues to recommend that **MER** implement or expand upon any interventions currently in place in order to improve upon performance related to the measure.
- *TRC—Transitions of Care—Medication Reconciliation Post-Discharge and Patient Engagement After Inpatient Discharge*—While the MY 2023 rates increased from MY 2022 to MY 2023, both rates are not meeting the HEDIS MY 2023 MI Health Link statewide average. Therefore, HSAG continues to recommend that **MER** implement appropriate interventions to improve performance related to the measures.

## 3. Prior Year Recommendation from the EQR Technical Report for Compliance Review

HSAG recommended the following:

- **MER** received a *Not Met* score for three elements within the Provider Selection program area, indicating providers were not being credentialed in accordance with the ICO's contractual obligations with MDHHS. While **MER** was required to submit a CAP to address each of the identified deficiencies, HSAG recommends that **MER** continually evaluate its processes, procedures, and monitoring efforts, including oversight of delegated entities, to ensure compliance with all federal and MDHHS-set standards specific to the credentialing and recredentialing of network providers.
- **MER** received a *Not Met* score for 10 elements within the Grievance and Appeal Systems program area, indicating members may not have access to all rights and required information when filing a grievance or requesting an appeal. While **MER** was required to submit a CAP to address each of the identified deficiencies, HSAG recommends that **MER** continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to grievances and appeals. HSAG further recommends that **MER** implement procedures to ensure model notices used are the most current version required by MDHHS, and that **MER** follow requirements of the Three-Way Contract to guarantee adherence to Medicaid managed care rules for grievance and appeal notices.

### 3. Prior Year Recommendation from the EQR Technical Report for Compliance Review

**MCE's Response:** *(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

- a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:
  - As outlined in the corrective action submitted to HSAG, Meridian Credentialing Department updated the Quality Performance Document (QPD) template with clarifying language that the results identified in Column B “Performance Concerns (including Utilization, Quality of Care and Member Complaint Data)” includes results of monitoring of Quality of Care; Quality of Service Concerns, Utilization Management Reviews, Substantiated Member Grievances threshold results, Member Satisfaction Survey results, Medical Records Review, and Performance Indicators. In addition, Meridian issued CAPs to the Area Agencies on Aging (AAA) identified as being non-compliant with National Committee for Quality Assurance (NCQA) credentialing requirements. Through CAP remediation activities and continued routine monitoring and auditing, Meridian has identified all issues of noncompliance and provided training to the AAAs through the quarterly Joint Operations Committees.
  - Meridian's Grievance and Appeals leadership has since conducted a formal comprehensive discussion and training with coordinators regarding regulatory requirements applicable to Grievance and Appeal requests. To further support Meridian Appeal Coordinators, a quick reference guide was developed and distributed to ensure all staff have readily accessible guidance related to regulatory requirements applicable to appeal requests submitted by purported representatives and the required member's written consent. Meridian's Quality Assurance team has since implemented ongoing audit reviews of Grievance and Appeal cases to ensure compliance with regulatory requirements monthly, and review related to purported representatives and the required written consent was incorporated within these audits immediately after training occurred. In addition, Meridian's Appeal team enhanced the internal process to conduct monitoring and mock audit activities that will simulate external audit scenarios, allowing us to pressure test our compliance posture and adherence to three-way contract requirements. These activities allow for a mechanism where findings from audits are immediately communicated to leadership and coordinators, while ensuring prompt coaching and remediation of any deficiencies. Furthermore, ongoing Annual and ad-hoc reviews of all Grievance and Appeal related policies and procedures have been implemented and conducted to ensure adherence to evolving regulations, three-way contract requirements, and best practices in the industry. Meridian's goal is to proactively address any compliance issues while maintaining alignment with three-way contract requirements.
- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
  - As outlined in the corrective action submitted to HSAG, Meridian Credentialing Department updated the Quality Performance Document (QPD) template with clarifying language that the results identified in Column B “Performance Concerns (including Utilization, Quality of Care and Member Complaint Data)” includes results of monitoring of Quality of Care; Quality of Service Concerns, Utilization Management Reviews, Substantiated Member Grievances threshold results, Member Satisfaction Survey results, Medical Records Review, and Performance Indicators.
  - Meridian's Grievance and Appeal team have already identified positive outcomes in conducting in-depth discussions with Coordinators ensuring full understanding of processes and requirements. This deliberate approach has led to greater clarity and precision in completed work. In addition, the quick reference guidance provided to Appeals coordinators has empowered the team with accessible written

### 3. Prior Year Recommendation from the EQR Technical Report for Compliance Review

and structured guidance. Through ongoing feedback from quality audits and monitoring activities, Meridian Grievance and Appeal teams continually assess progress and address any concerns.

c. Identify any barriers to implementing initiatives:

- Meridians did not identify any barriers to implementing initiatives.

**HSAG Assessment:** HSAG has determined that **MER** partially addressed the prior year's recommendations. The SFY 2024 CAP review confirmed that **MER**'s action plans were successful at remediating the deficiencies for both elements for the Provider Selection program area and six of eight elements for the Grievance and Appeal Systems program area. However, the SFY 2024 CAP review also confirmed that **MER** did not remediate the remainder of the deficient elements for the Grievance and Appeal Systems standards. **MER** did not provide sufficient evidence to confirm that it conducted adequate staff training to ensure staff are obtaining the member's written consent when a provider files an appeal on the member's behalf. Additionally, for one acknowledgement notice, it only included the authorization number and did not specify the name of the service/drug decision being appealed, and for a second acknowledgement notice, **MER** did not use the required MDHHS model notice, and the appeal was not acknowledged until nine calendar days after receipt of the appeal, when the ICO's policy requires acknowledgement within three calendar days. As **MER**'s updated action plans were approved by MDHHS and HSAG, HSAG recommends that the ICO conduct an internal audit to verify its action plans were successful in remediating the deficiencies. HSAG further recommends that **MER** continue any interventions and internal monitoring that has occurred after the SFY 2024 CAP review to assure future compliance.

### 4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

- HSAG identified no substantial weaknesses for **MER** based on the SFY 2023 NAV, as **MER** demonstrated that it contracted with all available providers for the provider types that did not meet minimum network requirements and supplied evidence of additional supports (e.g., community supports and resources) to provide adequate care to MI Health Link members in Region 4. **MER** should maintain an internal data verification process to continually identify and contract with Adult Day Program providers as they become available in Region 4 to improve compliance with Medicaid and LTSS minimum network standards for time/distance and capacity for MI Health Link members in the region.

**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 ensured the Area Agencies on Aging (AAA) in Region 4 have contracted with all available Adult Day providers and are continuing to develop their network strategy to onboard new providers as they become available.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Not applicable.

c. Identify any barriers to implementing initiatives:

- No additional Adult Day providers have opened in Region 4.

#### 4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation

**HSAG Assessment:** HSAG has determined that **MER** did not address the prior year’s recommendation. **MER** did not meet the minimum network requirements for Adult Day Program and did not demonstrate that it contracted with all available providers for the provider categories that did not meet minimum network requirements and supply evidence of additional supports (e.g., community supports and resources) to provide adequate care to MI Health Link members in Region 4. **MER** should continue to make all reasonable attempts to mitigate barriers to why available providers will not contract with the ICO.

#### 5. Prior Year Recommendation from the EQR Technical Report for Secret Shopper Survey

HSAG recommended the following:

- Of the cases reached, 56.6 percent of provider locations accepted **MER**, 44.8 percent accepted the MI Health Link program, and 42.8 percent accepted new patients. HSAG recommends that **MER** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect phone number, MI Health Link acceptance, and new patient acceptance) to address the provider data deficiencies and educate provider offices on the MI Health Link program. Additionally, as MDHHS required **MER** to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.
- Among all surveyed cases, the overall appointment rate was 31.1 percent. HSAG recommends that **MER** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. 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)*

- Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:
  - On March 1, 2024, Meridian went live with a new Dental Benefit Administrator (DBA), Delta Dental of Michigan (DDMI). Prior to contracting with DDMI, Meridian conducted a pre-delegation audit and reviewed DDMI’s process for confirming network adequacy and timely access to dental services. DDMI has a much larger provider network and more robust oversight and monitoring to ensure dental providers are aware of MeridianComplete and MI HealthLink and access and availability standards.
  - Meridians’ decision to transition to a new DBAs was influenced by the overall quality of DDMI, including their network strategy and provider directory oversight. Since transitioning, Meridian has established a strong working relationship with DDMIs’ contracted providers ensuring that members are able to readily obtain available appointment dates and times in addition to ensuring procedural efficiencies by providing clear and direct information to members about appointment availability.
- Identify any noted performance improvement as a result of initiatives implemented (if applicable):
  - As part of DDMIs’ routine oversight, secret shopper calls are conducted to 20 providers each month, with an average pass rate of 86% which includes appointment availability and knowledge of the MI Health Link program questions. In partnership with Meridian, Delta provides an audit letter to the provider offices who did not pass the audit to inform them of the identified non-compliance. If a data discrepancy is identified with the provider data, DDMI follows up with the office to obtain the correct provider directory information.

## 5. Prior Year Recommendation from the EQR Technical Report for Secret Shopper Survey

- Meridian conducts quarterly secret shopper call audits to 30 providers. Meridian incorporated HSAG's recommendations to utilize provider data to target provider offices who have failed previous audits. For all future monitoring activities, Meridian is adopting HSAG's recommendation to use case-level data to conduct targeted follow-up to providers who failed to successfully offer an appointment time to the auditor. Since transitioning to a new DBA, Meridian identified a significant performance improvement within the Quarter 3 (Q3) 2024 secret shopper call audits with an increase in performance.

### c. Identify any barriers to implementing initiatives:

- Meridian did not identify any barriers to implementing initiatives.

**HSAG Assessment:** HSAG has determined that **MER** has addressed the prior year's recommendations. **MER** implemented interventions to ensure directory data accuracy (i.e., audits, collaborating with DBA and provider offices). **MER** also conducted provider outreach to validate provider information. **MER** is also working on addressing the data deficiencies noted in the case-level analytic data files.

## 6. 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 **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 timeliness quality checks were performed for claims/encounters originating from its behavioral health and pharmacy subcontractors. **MER** should enhance its timeliness quality checks by considering, among other actions, the implementation of regular timeliness audits, the adoption of automated monitoring systems capable of tracking submission dates and generating alerts or reports for delayed submissions, and periodic reviews and adjustments of timeliness quality checks based on performance data and any alterations in regulations or contractual requirements.
- MER** took slightly longer than other ICOs to submit its data to MDHHS. At 180 days from payment date, **MER** had submitted 82.4 percent of professional encounters, 93.7 percent of institutional encounters, and 94.3 percent of pharmacy encounters. **MER** should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment.
- Although not required to be populated, 64.4 percent of professional encounters contained a billing provider NPI, and 16.2 percent contained a rendering provider NPI. **MER** should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

**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 Health Plan of Michigan recognizes the importance of integrating subcontractor encounter data within its system. Efforts are currently focused on developing a business case and securing the necessary funding to initiate this project.
- Meridian Health Plan of Michigan is taking steps to improve the tracking of timeliness, completeness, and accuracy for subcontractor encounter data. The development of a business case is in progress, with funding being pursued to support these enhancements.



## 6. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

- Meridian Health Plan of Michigan has consistently maintained a weekly submission process, with over 99% of submissions completed within 30 days of the paid date. Monthly reports are produced for all lines of business, including Medicaid and MMP. For 2024, the combined timeliness rate is 96.13%, accounting for reworked and resubmitted encounters. Continued monitoring and process improvements are ongoing to address any factors affecting timeliness scores.
- Ensuring encounter data quality remains a top priority. Although provider information is not mandatory, Meridian includes it whenever available on billed claims. At present, billing provider information is submitted for all professional and institutional encounters. Continuous monitoring efforts will be maintained to ensure data integrity.

### b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Meridian Health Plan retains encounter data files and has a system that allows for viewing of data fields as needed. Additionally, regular reporting from each subcontracted vendor has been established for key data points while also working towards long-term storage of all subcontractor data.
- Meridian Health Plan retains encounter data files and uses a system that enables the analysis of file paid date information relative to submission date. Regular reporting has been set up with each subcontracted vendor for key data points, and efforts are underway to develop long-term storage solutions for all subcontractor data.
- Plan submissions are currently meeting timeliness benchmarks. Continued monitoring will support ongoing process improvement efforts, with mitigation activities highlighted, as necessary.
- Current processes include capturing provider information for billing, rendering, ordering, attending, operating, and referring, whenever provided in the billed claim.

### c. Identify any barriers to implementing initiatives:

- There are no foreseeable barriers currently. The business case and funding are currently pending.

**HSAG Assessment:** HSAG has determined that **MER** has partially addressed the prior year's recommendations. Concerning subcontractor data storage, **MER** acknowledged the importance of integrating subcontractor encounter data within its claims system and reported that efforts are underway to develop a business case and secure funding for this initiative. However, there has been no concrete action or timeline established for implementation. In terms of timeliness quality checks, **MER** reported an improved submission process, achieving a timeliness rate of 96.13 percent in 2024, with over 99 percent of submissions completed within 30 days of the paid date. Monthly reports for all lines of business are being produced. Despite these improvements, the response lacks details on the implementation of automated systems or audits for proactive monitoring of delays, which HSAG had recommended. **MER** has shown improvements in encounter submission timeliness, meeting benchmarks, and maintaining regular reporting. However, HSAG's concerns regarding the timeliness of subcontractor data submissions remain unaddressed. Regarding provider NPI completeness, **MER** includes provider information when available and captures a wide range of provider data fields (e.g., billing, rendering, ordering). However, no evidence of additional quality checks to enhance data completeness was provided.

**MER** cited no specific barriers to implementation but noted that the business case and funding for integrating subcontractor data and improving tracking systems are pending.

In conclusion, **MER** has made progress, particularly in improving submission timeliness and monitoring processes. However, gaps remain in integrating subcontractor data, addressing systemic delays, and enhancing rendering provider NPI completeness. To enhance compliance with HSAG's recommendation, **MER** should:

- Prioritize the completion of the business case and secure funding to initiate the integration of subcontractor data into **MER**'s claims system, ensuring long-term accessibility and usability.



## 6. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

- Implement automated systems and regular audits to proactively identify and address delays in encounter submissions, particularly for subcontractor data.
- Develop and implement quality checks to ensure completeness and accuracy of rendering provider NPI data on all applicable encounters.

Implementing these steps will improve data quality, address identified gaps, and align more effectively with HSAG's recommendations.

## 7. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis

HSAG recommended the following:

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

**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)*:
  - In CY 2023, Meridian focused on improving the member experience for the Recommended Personal Assistance/Behavioral Health Staff measure in the Home and Community-Based Services (HCBS) Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. Care Managers reviewed and documented members' satisfaction with personal care and waiver services during their individualized care plan reviews. If a member raised concerns or expressed dissatisfaction with the services, the Care Manager helped facilitate a resolution. Meridian collaborated with Southwest Michigan Behavioral Health (SWMBH) and Macomb County Community Mental Health (MCCMH) to integrate behavioral health services into the health plan, with oversight and coordination provided by the case management team. These services targeted individuals with mental illness, intellectual/developmental disabilities, and substance use disorders. Meridian also worked with Prepaid Inpatient Health Plans (PIHPs) to ensure coordination of mental and physical health services for members, providing updates on member statuses and areas requiring additional support. Meridian hosts quarterly Joint Operations Committee (JOC) meetings with Wayne County PIHP and key staff to review operational and quality performances. Additionally, in response to the HCBS CAHPS CY 2023 survey, Meridian prioritized the Planning Your Time and Activities measure, fostering partnerships between members and Care Managers (CM). All MMP members were assigned a Care Manager upon enrollment. Flyers were distributed to introduce the care manager program and its benefits, while the

## 7. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis

Medical Management team created materials to promote care services. Care Managers conducted in-person visits and annual Health Risk Assessments (HRAs), with a drop-in visit program regularly updated member activities within their care plans. Meridian's Care Managers made in-person visits to members and utilized a drop-in visit program implemented to engage hard-to-reach members, utilizing door hangers and flyers when members were unavailable. Meridian also hosted in-person community events to further enhance member engagement throughout the year.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Meridian observed a CY 2023 HCBS CAHPS® survey rate of 85.07% for Recommended Personal Assistance/Behavioral Health Staff, which is 0.04% below the MI Health Link rate of 85.11%. Meridian's Medical Management team successfully implemented the 2023 drop-in program aimed at engaging hard-to-reach members. As of December 2023, Care Managers (CMs) conducted 787 drop-in visits, achieving 108 successful contacts (13.7%). At the time of this response, the CY 2024 HCBS CAHPS® survey results are not available. Meridian will assess performance upon receipt of the survey results.

c. Identify any barriers to implementing initiatives:

- Meridian did not identify any barriers implementing initiatives.

**HSAG Assessment:** HSAG has determined that **MER** addressed the prior year's recommendations. **MER** reported partnering with PIHPs and prioritizing partnerships between members and case managers. The SFY 2024 HCBS CAHPS activity demonstrated statistically significantly higher top-box scores compared to the 2024 HCBS CAHPS Database benchmarks for the MI Health Link program for *Rating of Personal Assistance and Behavioral Health Staff*, *Rating of Case Manager*, *Helpful Case Manager*, *Personal Safety and Respect*, and *Planning Your Time and Activities*. However, as the 2024 top-box score for *Planning Your Time and Activities* still demonstrated the lowest score of all HCBS CAHPS measures, HSAG recommends that **MER** continue to monitor measures to continue any efforts to increase performance.

## Molina Dual Options MI Health Link

**Table 4-5—Prior Year Recommendations and Responses for MOL**

1. Prior Year Recommendation from the EQR Technical Report for Validation of Quality Improvement Projects
<p>HSAG recommended the following:</p> <ul style="list-style-type: none"> <li><b>MOL</b> did not achieve the state-specific goal of eliminating the existing disparity between the two subgroups with the first remeasurement period. HSAG recommends <b>MOL</b> revisit its causal/barrier analysis to determine if barriers exist for the disparate subgroup that require the development of interventions. In accordance with direction from MDHHS, <b>MOL</b> is required to identify at least three barriers to care and develop three interventions to address those barriers, specifically for the Black population.</li> </ul>
<p><b>MCE's Response:</b> <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"> <li>Molina Healthcare of Michigan (Molina) conducted a member focus group to inquire how Black members would prefer to obtain education surrounding high blood pressure symptoms, medication adherence, and disease management.</li> <li>Molina completed a literature review of research based on how to improve high blood pressure outcomes specifically for Black members.</li> <li>Molina is partnering with community entities (community centers, faith organizations, barber / beauty shops, etc.) that are primarily attended by Black members. These partners will help Molina distribute educational materials on controlling blood pressure.</li> </ul>
<p>b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):</p> <ul style="list-style-type: none"> <li>Performance in Molina's overall controlling blood pressure measure increased by 13.66 percentage points from 2021 (54.50%) to 2023 (68.16%).</li> <li>The disparity between Black and White Molina members decreased by 9.30 percentage points from 2021 (9.51%) to 2023 (0.21%).</li> <li>The rate between Black and White Molina members in 2023 resulted in a non-significant disparity (55.75% for White members and 55.54% for Black members). The two-tailed <i>p</i> value equals 0.9538, which is not a statistically significant disparity.</li> </ul>
<p>c. Identify any barriers to implementing initiatives:</p> <ul style="list-style-type: none"> <li>Molina has no known barriers to report.</li> </ul>
<p><b>HSAG Assessment:</b> HSAG has determined that <b>MOL</b> addressed the prior year's recommendations based on the responses provided by the ICO and HSAG's review of the ICO's annual QIP submission. The ICO revisited its causal/barrier analysis including focus groups and literature reviews to identify barriers to care.</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"> <li>For MI7.3, <b>MOL</b> did not incorporate any race and ethnicity data other than the data submitted by the State in the 834-enrollment file. Nearly all members were identified with an unknown race. HSAG recommends that <b>MOL</b> explore additional sources for race and ethnicity data, as MDHHS expects that the ICOs will</li> </ul>

## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

validate and supplement the data provided in 834 files through other sources including care coordination activities, member surveys, and EHR data.

- For 21 of the 40 reported HEDIS measures (53 percent), **MOL**'s rates indicated worse performance than the statewide average, demonstrating an opportunity for improvement across multiple domains including Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Behavioral Health, Medication Management and Care Coordination, Overuse/Appropriateness, and Risk-Adjusted Utilization. HSAG recommends that **MOL** focus on improving performance for measures included in these domains.
- In the Respiratory Conditions domain, **MOL**'s rates for the *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD*, and the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid and Bronchodilator* measure indicators decreased by more than 5 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide averages, indicating that some adult members with newly diagnosed or active COPD were not always receiving spirometry testing to confirm the diagnosis, and that some adult members with COPD were not always receiving appropriate medication therapy to manage an exacerbation. Approximately 15 million adults in the United States have COPD, an irreversible disease that limits airflow to the lungs. Despite being the gold standard for diagnosis and assessment of COPD, spirometry testing is underused. Earlier diagnosis using spirometry testing supports a treatment plan that may protect against worsening symptoms and decrease the number of exacerbations. COPD exacerbations make up a significant portion of the costs associated with the disease. However, symptoms can be controlled with appropriate medication. Appropriate prescribing of medication following exacerbation can prevent future flare-ups and drastically reduce the costs of COPD. HSAG recommends that **MOL** conduct a root cause analysis or focused study to determine why some adults with COPD are not receiving spirometry testing and appropriate medication therapy to manage exacerbations. Upon identification of a root cause, **MOL** should implement appropriate interventions to improve the performance related to the *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD*, and the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid and Bronchodilator* measure indicators. **MOL** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or provider education).
- In the Cardiovascular Conditions domain, **MOL**'s rate for the *SPC—Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%* measure indicator decreased by more than 19 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, indicating that some adults with clinical ASCVD were not adhering to statin therapy. Cardiovascular disease is the leading cause of death in the United States. ACC/AHA guidelines state that statins of moderate or high intensity are recommended for adults with established clinical ASCVD. HSAG recommends that **MOL** conduct a root cause analysis or focused study to determine why some adults with ASCVD were not adhering to statin therapy. Upon identification of a root cause, **MOL** should implement appropriate interventions to improve the performance related to the *SPC—Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%* measure indicator. **MOL** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or education).
- In the Cardiovascular Conditions domain, **MOL**'s rate for the *SPD—Statin Therapy for Patients with Diabetes—Statin Adherence 80%* measure indicator decreased by more than 12 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, indicating that some adults with diabetes were not adhering to statin therapy. The American Diabetes Association (ADA)

## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

and ACC/AHA guidelines recommend statins for primary prevention of cardiovascular disease in patients with diabetes, based on age and other risk factors. Guidelines also state that adherence to statins will aid in ASCVD risk reduction. HSAG recommends that **MOL** conduct a root cause analysis or focused study to determine why some adults with diabetes were not adhering to statin therapy. Upon identification of a root cause, **MOL** should implement appropriate interventions to improve the performance related to the *SPD—Statin Therapy for Patients with Diabetes—Statin Adherence 80%* measure indicator. **MOL** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or education).

- In the Behavioral Health domain, **MOL**'s rates for the *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators decreased by more than 13 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, indicating that some adults with a diagnosis of major depression, who were newly treated with antidepressant medication, did not remain on antidepressant medication for at least 84 and 180 days. Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy, and self-esteem, and can lead to suicide, the 10th leading cause of death in the United States each year. Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness, and identifying and managing side effects. HSAG recommends that **MOL** conduct a root cause analysis or focused study to determine why some adults with a diagnosis of major depression did not remain on antidepressant medication. Upon identification of a root cause, **MOL** should implement appropriate interventions to improve the performance related to the *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators. **MOL** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or patient education).

**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)*:
  - After Molina started collecting member-reported race and ethnicity data in the level 1 care management assessments in April 2023, Molina was able to use this information to improve its race and ethnicity data. Molina has continued to collect this information with every level 1 assessment and presently uses this member-reported information first before using data on the 834 file to fill in gaps.
  - For measures: SPC—Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%, SPD—Statin Therapy for Patients with Diabetes—Statin Adherence 80%, and AMM—Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment, Molina provides data directly to providers with the expectation that they are following-up with the members to ensure complete adherence.
  - Molina provides direct provider education outreach for SPC—Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%.
  - Molina is working to analyze SPR and PCE HEDIS data for non-compliant members and determine if there are any trends related to provider group or primary care provider. Molina will conduct provider education campaigns if appropriate. Molina will also analyze member-level data to determine if



## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

members in certain geographies are impacted more than others. When possible, Molina will inform and connect members to local resources.

- Molina is working to analyze SPC and SPD data for non-compliant members and determine if there are any trends to further explore related to provider groups or primary care providers. Molina will analyze the overlap of non-compliant members with our pharmacy team to coordinate outreach efforts and ensure statin adherence is proactively addressed.
- Molina is working to analyze AMM data for non-compliant members and determine if there are any trends to further explore related to provider groups or primary care providers. Molina will also ensure both care management and our Care Connections outreach team are aware of the importance of this HEDIS measure and identifying members with depression to work with.
- Based on results of previous analysis, Molina will evaluate the need for member communications for all identified HEDIS measures with lower performance than the statewide average.

### b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- The changes noted above improved the reporting of members' racial identities, significantly reducing the number of "Unknown" values. In 2021, 20.93% of member's race was reported as unknown (2,309 out of 11,032 members). By 2022, this figure had decreased to 9.41% (1,046 out of 11,108 members). The *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD* measure improved by 5.02 percentage points from 2022 (21.63%) to 2023 (26.65%).
- The *SPC—Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%* measure improved by 5 percentage points from 2022 (75.59%) to 2023 (80.59%).
- The *SPD—Statin Therapy for Patients with Diabetes—Statin Adherence 80%* measure improved by 0.11 percentage points from 2022 (79.56%) to 2023 (79.67%).
- The *AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment* measure improved by 1.38 percentage points from 2022 (54.05%) to 2023 (55.43%).

### c. Identify any barriers to implementing initiatives:

- Molina has no known barriers to report.

**HSAG Assessment:** HSAG has determined that **MOL** addressed the prior year's recommendations for the following measures based on the ICO implementing initiatives that appear to be effective in improving performance and/or the issues that resulted in the prior recommendations were not identified during this year's PMV activity:

- *MI7.3*—HSAG did not identify any issues related to **MOL**'s race and ethnicity data and reporting as part of the measure during this year's PMV activity.
- *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD*—The MY 2023 rate increased from MY 2022 and is now meeting the HEDIS MY 2023 MI Health Link statewide average.
- *SPD—Statin Therapy for Patients with Diabetes—Statin Adherence 80%*—The MY 2023 rate increased from MY 2022 and is now meeting the HEDIS MY 2023 MI Health Link statewide average.
- *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment*—The MY 2023 rates increased from MY 2022 and are now meeting the HEDIS MY 2023 MI Health Link statewide average.

HSAG has determined that **MOL** has either partially addressed or did not address the prior year's recommendations for the following measures, and therefore should continue to implement or expand upon interventions to address the continued low performance or findings identified in these areas:



## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

- HEDIS measures reported in the following domains continued to have rates that indicated worse performance than the MY 2023 statewide average, and therefore require additional efforts in order to meet the MY 2023 statewide average:
  - Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Behavioral Health, Medication Management and Care Coordination, Overuse/Appropriateness, and Risk-Adjusted Utilization.
- *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid and Bronchodilator*—Both MY 2023 rates decreased from MY 2022 to MY 2023 and are not meeting the HEDIS MY 2023 MI Health Link statewide average. Therefore, HSAG continues to recommend that **MOL** implement or expand upon any interventions currently in place in order to improve upon performance related to the measures.
- *SPC—Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%*—While the MY 2023 rate increased from MY 2022 to MY 2023, the rate is not meeting the HEDIS MY 2023 MI Health Link statewide average. Therefore, HSAG continues to recommend that **MOL** implement appropriate interventions to improve performance related to the measure.

## 3. Prior Year Recommendation from the EQR Technical Report for Compliance Review

HSAG recommended the following:

- **MOL** received a *Not Met* score for three elements within the Provider Selection program area, indicating providers were not being credentialed in accordance with the ICO's contractual obligations with MDHHS. While **MOL** was required to submit a CAP to address each of the identified deficiencies, HSAG recommends that **MOL** continually evaluate its processes, procedures, and monitoring efforts, including oversight of delegated entities, to ensure compliance with all federal and MDHHS-set standards specific to the credentialing and recredentialing of network providers.
- **MOL** received a *Not Met* score for 13 elements within the Grievance and Appeal Systems program area, indicating members may not have access to all rights and required information when filing a grievance or requesting an appeal. While **MOL** was required to submit a CAP to address each of the identified deficiencies, HSAG recommends that **MOL** continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to grievances and appeals. HSAG further recommends that **MOL** implement procedures to ensure model notices used are the most current version required by MDHHS, and that **MOL** follow requirements of the Three-Way Contract to guarantee adherence to Medicaid managed care rules for grievance and appeal notices.
- **MOL** received a *Not Met* score for four elements within the Quality Assessment and Performance Improvement program area, indicating the ICO has not implemented a QAPI program in accordance with the ICO's contractual obligations with MDHHS related to the quality program structure, and quality improvement functions, responsibilities, and projects. While **MOL** was required to submit a CAP to address each of the identified deficiencies, HSAG recommends that **MOL** continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to the QAPI program.

**MCE's Response:** *(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

- a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:

### 3. Prior Year Recommendation from the EQR Technical Report for Compliance Review

- **Provider Selection:**

- Molina's credentialing leadership completed efforts to incorporate the missing details including member appeals and UM information. Our Recredentialing Performance Review (RPR) worksheets will be updated to include member appeal outcomes (# of overturned and # of upheld) and Utilization Management denials and approvals.
- Credentialing Processing expectations have been reviewed in daily huddles with Production Supervisors and we will continue to monitor compliance of requirements.
- Molina has required a Disclosure of Ownership (DOO) for all new providers joining the Molina provider network since 11/1/2021. As we receive these DOO forms, Molina adds to the catalogue of DOO and monitors the age of the DOO, ensuring Molina maintains an updated DOO (under 36 months) or requests an updated DOO if any changes occur. Molina will also be meeting with MDHHS as requested by HSAG to discuss Molina processes.

- **Grievance and Appeal Systems:**

- All Model language letters have gone through a review and where recommended additional language has been added. Additional monitoring steps have been placed for review of letters prior to sending to a member.
- Molina's A&G team implemented additional monitoring to ensure that all acknowledgement letters are sent within the corporate standard of five (5) business days.
- Molina has completed a procedure update for first call resolution cases to receive written acknowledgement/resolution letters. Additional monitoring has been implemented as it relates to the grammar of the letter. All letters have been implemented to the correct model language as of January 2023. Continuous monitoring and staff training have been implemented to ensure that letters are complete, and all issues are resolved.
- Molina's A&G team have implemented processes to ensure when the case cannot be resolved and an extension has been provided with identification of the needed resolution (such as receipt of an AOR), that such a case will be resolved prior to the 44th day when the 44th day occurs on the weekend and/or holiday.
- Molina has updated the procedure to ensure appropriate oral and written notification when an extension has been taken. Additional monitoring, through monthly KPIs, has been implemented to ensure compliance.
- Molina has updated policy to state that we must acknowledge receipt of each appeal in writing using the Notice of Receipt of Appeal/Grievance and Notice of Receipt of Oral Appeal model notices which will be sent to the member within five business days.
- Molina has updated a policy to include the requirement to mail or otherwise transmit a written notice of the dismissal of the appeal to the parties. The notice must state the reason for the dismissal and the right to request that the ICO vacate the dismissal action.
- Additional monitoring has been implemented to ensure timeliness with effectuation of the ICO or SFH officer decisions. Additionally, the expectations for timeframes have been reviewed in team huddle training.

- **Quality Assessment and Performance Improvement:**

- Molina has created a separate Quality Program Document, specific to the MMP line of business.
- Molina has developed a separate medical record review process aimed at monitoring the provider network compliance with utilization management. The process will include valid sampling methodology and will be constructed proportionately to utilization by service type. The plan will

### 3. Prior Year Recommendation from the EQR Technical Report for Compliance Review

- Molina has updated policy to state that we must acknowledge receipt of each appeal in writing using the Notice of Receipt of Appeal/Grievance and Notice of Receipt of Oral Appeal model notices which will be sent to the member within five business days.
- Molina has updated a policy to include the requirement to mail or otherwise transmit a written notice of the dismissal of the appeal to the parties. The notice must state the reason for the dismissal and the right to request that the ICO vacate the dismissal action.
- Additional monitoring has been implemented to ensure timeliness with effectuation of the ICO or SFH officer decisions. Additionally, the expectations for timeframes have been reviewed in team huddle training.
- **Quality Assessment and Performance Improvement:**
  - Molina has created a separate Quality Program Document, specific to the MMP line of business.
  - Molina has developed a separate medical record review process aimed at monitoring the provider network compliance with utilization management. The process will include valid sampling methodology and will be constructed proportionately to utilization by service type. The plan will conduct a full quantitative and qualitative analysis of the results and implement actions for improvement, as necessary.
  - Molina completed a full evaluation of the prior year quality program and included principles of continuous quality improvement for all aspects of the program. Molina has combined all reports included as a part of the evaluation into one document to make the review more succinct.
  - Molina has incorporated each Performance Improvement Project in the annual QAPI Evaluation, including outcomes, trended results and actions taken.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Molina has had increased KPI performance for the Credentialing and A&G team.

c. Identify any barriers to implementing initiatives:

- No barriers have been identified at this time.

**HSAG Assessment:** HSAG has determined that **MOL** partially addressed the prior year's recommendations. The SFY 2024 CAP review confirmed that **MOL**'s action plans were successful at remediating the deficiencies for one of two elements for the Provider Selection program area, five of nine elements for the Grievance and Appeal Systems program area, and two of three elements for the QAPI program area. However, the SFY 2024 CAP review also confirmed that **MOL** did not remediate the remainder of the deficient elements for these standards. **MOL** did not submit sufficient evidence to confirm remediation of several deficiencies related to the following requirements: care coordinators have access to ABD notices generated by its dental delegate; members are provided with a 10-day advance notice for the termination, suspension, or reduction of previously authorized services; disclosures of ownership and control are collected at credentialing/recredentialing; members receive oral and written notice of appeal resolution time frame extensions; a member's written consent when a provider files an appeal on the member's behalf; informing members of their right to request that the ICO vacate an appeal dismissal; services are authorized or provided within 72 hours of an appeal/SFH reversal decision; and incorporating the results of efforts to support community integration for members using LTSS in the ICO's QAPI program evaluation. As **MOL**'s updated action plans were approved by MDHHS and HSAG, HSAG recommends that the ICO conduct an internal audit to verify its action plans were successful in remediating the deficiencies. HSAG further recommends that **MOL** continue any interventions and internal monitoring that has occurred after the SFY 2024 CAP review to assure future compliance.

#### 4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

- **MOL** failed to meet all Medicaid and LTSS minimum network requirements for Region 7, reflecting opportunities for improvement in maintaining an adequate network for MI Health Link members in this region. HSAG recommends that **MOL** identify and contract with additional Assistive Technology—Van Lifts and Tie Downs providers in Region 7 to improve compliance with Medicaid and LTSS minimum network standards for time/distance and capacity for MI Health Link members in the region. Updated compliance for this provider type in Region 7 will be evaluated during the SFY 2024 NAV. Additionally, **MOL** should continue to make all reasonable attempts to mitigate barriers to why available providers will not contract with the ICO.
- **MOL** failed to meet all Medicaid and LTSS minimum network requirements for Region 9, reflecting opportunities for improvement in maintaining an adequate network for MI Health Link members in this region. HSAG recommends that **MOL** identify and contract with additional Assistive Technology—Van Lifts and Tie Downs providers in Region 9 to improve compliance with Medicaid and LTSS minimum network standards for time/distance and capacity for MI Health Link members in the region. Updated compliance for this provider type in Region 9 will be evaluated during the SFY 2024 NAV. Additionally, **MOL** should continue to make all reasonable attempts to mitigate barriers to why available providers will not contract with the ICO.

**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)*:
  - Molina continues to monitor all lines of business encompassing MI Health Link and conduct ongoing provider outreach to ensure an adequate network is available through the support of external data sources (i.e., current/prior contracted providers, Quest, and Zellis, etc.).
  - At the time of the reported gap Molina was actively recruiting an Assistive Technology—Van Lifts and Tie Downs provider that would close the gap in Regions 7 and 9; successfully obtaining a contract start date of March 1, 2024.
  - In addition, Molina continues to review the challenges and barriers providers experience with health plan contracting and launched a new online provider enrollment tool on June 10, 2024, to support the onboarding and ongoing maintenance process.
- Identify any noted performance improvement as a result of initiatives implemented (if applicable):
  - Through Molina's above-mentioned activities there are no gaps within Regions 7 and 9 for LTSS Assistive Technology—Van Lifts and Tie Downs providers; contract was secured March 1, 2024.
- Identify any barriers to implementing initiatives:
  - Molina has no known barriers to report.

**HSAG Assessment:** HSAG has determined that **MOL** has addressed the prior year's recommendations since **MOL** met the requirements for all Medicaid or LTSS NAV standards.

## 5. Prior Year Recommendation from the EQR Technical Report for Secret Shopper Survey

HSAG recommended the following:

- Of the cases reached, 59.5 percent of provider locations accepted **MOL**, 58.7 percent accepted the MI Health Link program, and 54.8 percent accepted new patients. HSAG recommends that **MOL** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect phone number, MI Health Link acceptance, and new patient acceptance) to address the provider data deficiencies and educate provider offices on the MI Health Link program. Additionally, as MDHHS required **MOL** to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.
- Among all surveyed cases, the overall appointment rate was 39.6 percent. HSAG recommends that **MOL** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. 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)*

- Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:
  - Providers received education about the MI Health Link Program through:
    - Analysis of the Secret Shopper provider data deficiencies report to conduct a full assessment of data deficiencies and educate provider offices.
    - Dental Service Provider Orientation Training, which provides additional detail on both access and availability requirements and the importance of providing timely updates.
    - Distributed MI Health Link Program educational flyer.
    - Through DentaQuest, we are receiving monthly updates on providers who have terminated as well as monthly rosters of the DentaQuest Network to update and maintain the provider directory.
- Identify any noted performance improvement as a result of initiatives implemented (if applicable):
  - Molina and DentaQuest meet monthly and review network adequacy and access standards to ensure compliance, and that MI Health Link Program information is being communicated to the dental providers. DentaQuest reported outcomes of completed analysis on the provider data deficiencies.
- Identify any barriers to implementing initiatives:
  - No barriers have been identified at this time.

**HSAG Assessment:** HSAG has determined that **MOL** has partially addressed the prior year's recommendations. **MOL** implemented interventions to ensure directory data accuracy through provider education and network monitoring activities. **MOL** also conducted provider outreach to validate provider information. **MOL** should also address the data deficiencies noted in the case-level analytic data files.

## 6. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

HSAG recommended the following:

- **MOL** indicated that it did not store its pharmacy subcontractor data. To support **MOL**'s overall capabilities, it should consider storing its subcontractor encounter data within its claims systems, ensuring accessibility for various purposes.



## 6. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

- **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** did not indicate timeliness quality checks were performed for claims/encounters originating from its pharmacy subcontractors. **MOL** should enhance its timeliness quality checks by considering, among other actions, the implementation of regular timeliness audits, the adoption of automated monitoring systems capable of tracking submission dates and generating alerts or reports for delayed submissions, and periodic reviews and adjustments of timeliness quality checks based on performance data and any alterations in regulations or contractual requirements.
- **MOL** took the longest to submit encounters to MDHHS after the payment date in three of the four categories of service out of all ICOS. At 180 days from payment date, **MOL** submitted 60.2 percent of professional encounters, 85.5 percent of institutional encounters, and 13.1 percent of dental encounters. **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 95.3 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.
- Although not required to be populated, 34.6 percent of professional encounters contained a billing provider NPI, and 16.9 percent contained a rendering provider NPI. **MOL** should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

**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)*:
  - Effective June 2023, Molina is storing data from its pharmacy subcontractor.
  - Molina does not modify subcontractor's data before submitting to MDHHS.
  - Molina tracks timeliness quality via reports received from pharmacy vendor. In addition, Molina has monthly meetings with pharmacy subcontractors to review all encounter performance measures including timeliness quality checks.
  - Molina implemented a code logic to fix the way Molina was reporting Coordination of Benefits (COB) on ICO 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.
  - Molina has implemented use of the MDHHS CHAMPS provider file when validating provider's 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 plans to allow pharmacists to be the prescriber for Covid tests, but due to Michigan 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.
  - Molina has implemented use of the MDHHS CHAMPS provider file when validating providers. Molina currently submits both the Billing Provider NPI and Rendering Provider NPI on professional encounters unless the Rendering and the Pay To are the same.



## 6. 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):
  - 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:
  - No barriers identified at this time.

**HSAG Assessment:** HSAG has determined that **MOL** has partially addressed the prior year's recommendations. **MOL** began storing data from its pharmacy subcontractor as of June 2023, demonstrating progress in integrating subcontractor data within its claims systems to enhance accessibility. Regarding encounter modifications, **MOL** clarified that it does not alter subcontractor data before submission to MDHHS, aligning with compliance expectations. However, no evidence of collaboration with MDHHS was provided to confirm that this practice fully meets state requirements. For timeliness quality checks, **MOL** relies on reports from its pharmacy vendor and monthly meetings to review encounter performance measures, including timeliness. While these efforts indicate improvement, the absence of automated monitoring systems and periodic audits limits **MOL**'s ability to proactively address timeliness issues. Regarding provider NPI completeness, **MOL** has implemented the use of MDHHS CHAMPS provider files for NPI validation. While COVID test-related discrepancies are no longer an issue, rendering provider NPI completeness remains a concern. Additional quality checks are needed to improve the accuracy and consistency of these data. In conclusion, **MOL** has made progress in addressing several of HSAG's recommendations. However, further actions are necessary to ensure full compliance and improve data quality. To strengthen its processes, **MOL** should:

- Develop and implement automated monitoring systems and conduct regular comprehensive audits to proactively address timeliness and submission delays.
- Enhance validation processes and maintain rigorous checks on provider data completeness, especially for rendering provider NPIs.

By prioritizing these steps, **MOL** can improve its overall data quality, address identified gaps, and align more effectively with HSAG's recommendations.

## 7. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis

HSAG recommended the following:

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

## 7. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis

**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)*:
  - Non-medical transportation (NMT) is provided to help members socialize at events like church, volunteering, family events, community centers, fitness centers, and many more. Molina works with multiple vendors to provide NMT services, which increases timely availability and access to NMT so members can attend activities and events.
  - Adult Daycare allows Molina members with reduced informal supports and/or family/friend support to engage in the community at a center that also helps the member with their daily needs/supports.
  - Personal Care Services (PCS) - Respite care is offered to support non-professional caregivers of Molina members, helping to prevent burnout. This service provides caregivers with time to mentally and physically recuperate while creating more opportunities for Molina members to engage with the community.
  - Molina is also working with Trualta, a vendor that provides several tools and resources to caregivers to help manage and mitigate stress, time management, and caregiver responsibilities to reduce caregiver burnout.
  - CAHPS participation- Molina has a centralized member services team that uses multiple outreach campaigns to alert members about surveys that will be upcoming and the importance of participation. Molina also utilizes assigned case managers and support staff to outreach when surveys are about to become available to complete.
- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
  - The composite category for *Recommended Personal Assistance / Behavioral Health Staff* increased by 3.03% from 2022 (88.50%) to 2023 (91.53%). This was also higher than the statewide score for the category (89.96%).
- c. Identify any barriers to implementing initiatives:
  - Member utilization of available services: Molina often discusses and promotes the non-medical transportation (NMT) and Adult Daycare opportunities with members; however, some members choose not to utilize and participate in the offered services.
  - Difficulty reaching members: Molina has challenges contacting and engaging some members. Some members do not have an accurate address or telephone number on file. Often these updates are not made because if a member moves or changes phone numbers, the members must notify MDHHS to make such changes. Other times, members simply choose not to engage with their health plan. For these Unable to Reach (UTR) members, Molina lacks the opportunity to provide information, support, and services including survey notification and/or community engagement opportunities. This is especially prominent within the members with behavioral health needs as Molina and Molina's prepaid inpatient health plan (PIHP) partners also have difficulty engaging these members.

**HSAG Assessment:** HSAG has determined that **MOL** addressed the prior year's recommendations. **MOL** reported implementing interventions to utilize vendors, community programs, and case management to address performance improvement. The SFY 2024 HCBS CAHPS activity demonstrated statistically significantly higher top-box scores compared to the 2024 HCBS CAHPS Database benchmarks for the MI Health Link program for *Rating of Personal Assistance and Behavioral Health Staff, Rating of Case Manager, Helpful Case Manager, Personal Safety and Respect, and Planning Your Time and Activities*. However, as the 2024 top-box

## 7. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis

score for *Planning Your Time and Activities* still demonstrated the lowest score of all HCBS CAHPS measures, HSAG recommends that **MOL** continue to monitor measures to continue any efforts to increase performance.

## Upper Peninsula Health Plan MI Health Link

**Table 4-6—Prior Year Recommendations and Responses for UPP**

1. Prior Year Recommendation from the EQR Technical Report for Validation of Quality Improvement Projects
<p>HSAG recommended the following:</p> <ul style="list-style-type: none"> <li>• <b>UPP</b> did not achieve the state-specific goal of eliminating the existing disparity between the two subgroups with the first remeasurement period. HSAG recommends <b>UPP</b> revisit its causal barrier analysis to determine if any new barriers exist for the disparate subgroup that require the development of targeted strategies to improve performance. In accordance with direction from MDHHS, <b>UPP</b> is required to identify at least three barriers to care and develop three interventions to address those barriers, specifically for the American Indian/Alaska Native population.</li> </ul>
<p><b>MCE's Response:</b> <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"> <li>• UPHP revisited the causal barrier analysis and based on continued member and provider feedback, determined no new barriers exist. Environmental barriers continue to be a top priority as lack of dentists and hygienists in the area continue to impact members ability to get into clinics. To assist with regional shortages, which impact wait times and access, UPHP's dental network provider, Delta Dental is financially supporting a feasibility study for a local college to determine if implementing a dental hygiene education program in the region will help to meet workforce needs of regional offices and enhance oral health services for Upper Peninsula residents. There are currently no dental hygiene programs in northern Michigan. UPHP continues to work with a local tribal dental office to close dental gaps in care for members served by their medical clinic. UPHP also reached out to the local Federally Qualified Health Center (FQHC) in 2024 that has three dental clinics in the Upper Peninsula to engage them in collaboration.</li> </ul> <p>b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):</p> <ul style="list-style-type: none"> <li>• UPHP shared a gap list with a champion dental clinic in 2023. Results were mixed as there was staffing turnover and outreach was not tracked in 2023. In 2024, UPHP provided a template for staff to fill out during outreach to help determine barriers and eliminate duplicate outreach if appropriate. Staff reported upon initial review that many members already had schedule appointments or had received care, indicating perhaps the previous year's interventions were effective, yet due to long wait times getting into the office, there may have been a delay in data results. UPHP is continuing to work with the provider office and expects reports back during Q3 of 2024 for analysis.</li> </ul> <p>c. Identify any barriers to implementing initiatives:</p> <ul style="list-style-type: none"> <li>• Due to ongoing staffing shortages, UPHP has been unable to engage any new clinics in collaboration including the FQHC.</li> </ul>
<p><b>HSAG Assessment:</b> HSAG has determined that <b>UPP</b> addressed the prior year's recommendations based on the responses provided by the ICO and HSAG's review of the ICO's annual QIP submission. The ICO revisited its causal/barrier analysis, identifying barriers to care and developing intervention strategies.</p>

## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

HSAG recommended the following:

- While **UPP** had processes to audit claims processing, **UPP** did not have formalized performance benchmarks to convey the results of its performance. HSAG recommends that **UPP** consider establishing internal performance benchmarks related to procedural and financial accuracy as a mechanism to assess performance and communicate results more formally.
- **UPP** did not have a formalized delegation oversight process of Delta Dental related to the delegation of claims processing, which could impact the accuracy and completeness of dental data used for MI7.3. HSAG recommends that **UPP** formalize its delegation oversight of Delta Dental to include the review of claims processing timeliness and accuracy.
- **UPP** was required to update its Core Measure 9.3 source code and to resubmit its Core Measure 9.3 data to HPMS. HSAG recommends that **UPP** review its member-level detail file for any potential errors, including the review of any blank data to determine if this is valid for a given field. **UPP** should also review its results against the prior year's data results and review any significant changes and explore factors impacting the change to determine if there was a coding error or if the performance is consistent with its expectations.
- **UPP** was required to update its MI2.6 sampling methodology and resubmit its data to HPMS due to the hybrid sampling methodology not adhering to oversample substitution to keep the sample at 411 members. HSAG recommends that **UPP** implement its processes to incorporate the guidance related to hybrid sampling and use of the oversample in future years for all measures that use hybrid reporting.
- **UPP** did not integrate PIHP data from behavioral health discharges to be considered for sampling. HSAG recommends that **UPP** ensure it carefully reviews the annual release of the Michigan-Specific Reporting Requirements and ensure all data necessary for reporting are integrated. **UPP** should ensure that there is a process to review the potential unanticipated consequences of removing any data from reporting to help mitigate the introduction of material bias due to data integration errors.
- **UPP** only incorporated race and ethnicity data from the data submitted by the State in the 834-enrollment file. HSAG recommends that **UPP** explore additional sources for race and ethnicity data, as MDHHS expects that the ICOs will validate and supplement the data provided in 834 files through other sources including care coordination activities, member surveys, and EHR data.
- While only 9 of the 40 reported HEDIS measures rates (22 percent) indicated worse performance than the statewide average, opportunity exists for **UPP** to further improve performance across multiple domains including Cardiovascular Conditions, Diabetes, Musculoskeletal Conditions, and Behavioral Health. HSAG recommends that **UPP** focus on further improving performance for measures included in these domains.
- In the Cardiovascular Conditions domain, **UPP**'s rate for the *SPC—Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy* measure indicator decreased by more than 9 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, indicating that some adults with clinical ASCVD were not receiving statin therapy. Cardiovascular disease is the leading cause of death in the United States. ACC/AHA guidelines state that statins of moderate or high intensity are recommended for adults with established clinical ASCVD. HSAG recommends that **UPP** conduct a root cause analysis or focused study to determine why some adults with ASCVD were not receiving statin therapy. Upon identification of a root cause, **UPP** should implement appropriate interventions to improve the performance related to the *SPC—Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy* measure indicator. **UPP** should consider the nature and

## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or education).

- In the Musculoskeletal Conditions domain, **UPP**'s rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator decreased by more than 13 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, suggesting that some women who suffered a fracture did not receive a bone mineral density test or prescription for a drug to treat osteoporosis within six months of the fracture. Osteoporosis is a serious disease affecting mostly older adults that can impact their quality of life. Osteoporotic fractures, particularly hip fractures, are associated with chronic pain and disability, loss of independence, decreased quality of life, and increased mortality. With appropriate screening and treatment, the risk of future osteoporosis-related fractures can be reduced. HSAG recommends that **UPP** conduct a root cause analysis or focused study to determine why some women were not always receiving timely bone mineral density tests or a prescription to treat osteoporosis within six months of a fracture. Upon identification of a root cause, **UPP** should implement appropriate interventions to improve the performance related to the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator. **UPP** should consider the nature and scope of the issue (e.g., whether the issues related to patient and provider education or barriers to accessing care).
- In the Behavioral Health domain, **UPP**'s rate for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* measure indicator decreased by more than 19 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, indicating that some members were not receiving follow-up care for mental illness within seven days of an ED visit. Research suggests that follow-up care for people with mental illness is linked to fewer repeat ED visits, improved physical and mental function, and increased compliance with follow-up instructions. HSAG recommends that **UPP** conduct a root cause analysis or focused study to determine why some members were not receiving follow-up care for mental illness within seven days of an ED visit. Upon identification of a root cause, **UPP** should implement appropriate interventions to improve the performance related to the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* measure indicator. **UPP** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider education or staffing shortages).

**MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)**

- Describe initiatives implemented based on recommendations (*include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation*):
  - UPHP established an internal claim processing accuracy benchmark of 98% starting with Q22023 claims data.
  - UPHP requested that Delta Dental provide quarterly claims processing reports which include claim processing turnaround times and number of claims fully paid, partially paid, and denied which started with Q12024 claims data. Delta Dental claim monitoring was also added to the 2024 **UPHP** Auditing and Monitoring Workplan.
  - UPHP strengthened its review process for all measures. The steps to complete include review of documentation and common-sense checks against previous years data. Data was resubmitted.
  - UPHP updated our sampling methodology as suggested. Data was resubmitted.
  - UPHP integrated PIHP data. We have built in a step to carefully review the annual release of reporting requirements.



## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

- *SPC—Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy*: Chart reviews were conducted to help determine root cause. A noted increase in rates did occur between MY2022 and 2023, however, UPHP noted that in many instances of members declining statin therapy is due to myalgia side effects. UPHP clinical staff are working with pharmacists on a provider newsletter update to address the issue and provide recommendations.
- *OMW—Osteoporosis Management in Women Who Had a Fracture*: UPHP conducted a review of claims of unmet population without significant findings aside from decline of treatment. Denominator continues to be small which facilitates rate volatility. UPHP clinical staff are working with pharmacists on a newsletter update to address the issue and provide recommendations.
- *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up*: Measure added to HIP UP VBP and to quality withhold for PIHP. Quarterly report cards distributed with cumulative rate and comparative rate for facility. UPHP holds quarterly meetings with NorthCare. As part of UPHP's 2024 program audit it was noted that ED follow-up was not included in the UPHP care manager follow-up protocol, therefore care managers were not contacting members after ED visit. Q4 UPHP will update TOC policy to include care manager contact members within 2 business days post ED visit.

### b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- UPHP exceeded the internal claims processing benchmark for Q22023 claims.
- *SPC—Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy*: 2023 rate increased to 85.71% an improvement of 5.59 percentile points when compared to 2022. MY 2023 rate exceeds both the Michigan and National MMP 2022 average.
- *OMW—Osteoporosis Management in Women Who Had a Fracture*: MY 2023 rate is 30.00% which exceeds both the Michigan and National MMP 2022 average.
- *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up*:
  - Interventions to start in quarter 4 of 2024, therefore, it is too early to measure improvement.

### c. Identify any barriers to implementing initiatives:

- *SPC—Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy*: Chart review has demonstrated patients may refuse/decline medications due to myalgia side-effects.
- *OMW—Osteoporosis Management in Women Who Had a Fracture*: Medication intolerances noted due to ingestion criteria. Denominators consistently 20 or less which leads to rate volatility.
- *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up*: Provider offices do not receive ADTs for all ED visits if they are not connected to facility EMR. UPHP is dependent on claims data from PIHP if diagnosis deemed severe per MDHHS contract language – lag or missing claims data is a potential barrier. Additionally, if the ED does not facilitate the follow-up visit, timeliness for seven days is difficult to attain due to scheduling restrictions on the clinic side. Claim review reveals that incorrect coding practices have an impact on both the denominator and numerator for this measure:
  - Incorrect principal diagnosis coding: for example, a person with schizophrenia comes in for COPD exacerbation and schizophrenia is coded principally instead; follow-up visit diagnosis would be COPD as principal not mental health illness.
  - Different coding between ED provider and laboratory: for example, ED provider codes for accidental self-harm but the hospital lab coded for intentional self-harm.
  - Imprecise or 'vague' coding: "depression unspecified" – leads to questioning whether this was in fact the primary reason for the ED visit.

## 2. Prior Year Recommendation from the EQR Technical Report for Performance Measure Validation

**HSAG Assessment:** HSAG has determined that **UPP** addressed the prior year's recommendations for the following measures/findings based on the ICO implementing initiatives that appear to be effective in improving performance and/or the issues that resulted in the prior recommendations were not identified during this year's PMV activity:

- No formalized performance benchmarks to convey results of claims processing audits—This finding is considered addressed as it was not an identified issue during this year's PMV activity.
- No formalized delegation oversight process of Delta Dental for claims processing—This finding is considered addressed as it was not an identified issue during this year's PMV activity.
- MI2.6—HSAG did not identify any issues related to **UPP**'s MI2.6 hybrid sampling methodology during this year's PMV activity.
- HEDIS measures reported in the following domain demonstrated improved performance and are now meeting the MY 2023 statewide average:
  - Musculoskeletal Conditions
- *SPC—Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy*—The MY 2023 rate increased from MY 2022 and is now meeting the HEDIS MY 2023 MI Health Link statewide average.
- *OMW—Osteoporosis Management in Women Who Had a Fracture*—The MY 2023 rate increased from MY 2022 and is now meeting the HEDIS MY 2023 MI Health Link statewide average.

HSAG has determined that **UPP** has either partially addressed or did not address the prior year's recommendations for the following measures, and therefore should continue to implement or expand upon interventions to address the continued low performance or findings identified in these areas:

- MI7.3—**UPP** continued to incorporate only race and ethnicity data from the data submitted by the State in the 834 file. As such, HSAG continues to recommend that **UPP** explore additional sources for race and ethnicity data, as MDHHS expects that ICOs validate and supplement the data provided through the 834 files with other sources including care coordination activities, member survey, and EHR data.
- Core Measure 9.3—While related to different findings than the SFY 2023 PMV activity, **UPP** was again required to resubmit its Core Measure 9.3 data to HPMS during this year's PMV activity. As such, HSAG continues to recommend that **UPP** implement more stringent quality assurance checks and increased validation checks prior to submission of the data to MDHHS and HSAG. HSAG also continues to recommend that **UPP** review the annual release of the MMP Core reporting requirements and to ensure Core Measure 9.3. reporting aligns with the reporting requirements.
- HEDIS measures reported in the following domains continued to have rates that indicated worse performance than the MY 2023 statewide average, and therefore require additional efforts in order to meet the MY 2023 statewide average:
  - Cardiovascular Conditions, Diabetes, and Behavioral Health.
- *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up*—The MY 2023 rate decreased from MY 2022 to MY 2023 and is not meeting the HEDIS MY 2023 MI Health Link statewide average. Therefore, HSAG continues to recommend that **UPP** implement or expand upon any interventions currently in place in order to improve upon performance related to the measure.

## 3. Prior Year Recommendation from the EQR Technical Report for Compliance Review

HSAG recommended the following:

- **UPP** received a *Not Met* score for three elements within the Provider Selection program area, indicating providers were not being credentialed in accordance with the ICO's contractual obligations with MDHHS. While **UPP** was required to submit a CAP to address each of the identified deficiencies, HSAG

### 3. Prior Year Recommendation from the EQR Technical Report for Compliance Review

recommends that **UPP** continually evaluate its processes, procedures, and monitoring efforts, including oversight of delegated entities, to ensure compliance with all federal and MDHHS-set standards specific to the credentialing and recredentialing of network providers.

- **UPP** received a *Not Met* score for four elements within the Confidentiality program area, indicating inadequate processes related to the use and disclosure of individually identifiable health information in accordance with privacy requirements in 45 CFR parts 160 and 164. While **UPP** was required to submit a CAP to address each of the identified deficiencies, HSAG recommends that **UPP** continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to privacy requirements. HSAG further recommends **UPP** continue to implement procedures to ensure all policies clearly delineate how **UPP** complies with confidential communication requests and restrictions of PIHP requests.
- **UPP** received a *Not Met* score for nine elements within the Grievance and Appeal Systems program area, indicating members may not have access to all rights and required information when filing a grievance or requesting an appeal. While **UPP** was required to submit a CAP to address each of the identified deficiencies, HSAG recommends that **UPP** continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to grievances and appeals. HSAG further recommends that **UPP** implement procedures to ensure model notices used are the most current version required by MDHHS, and that **UPP** follow requirements of the Three-Way Contract to guarantee adherence to Medicaid managed care rules for grievance and appeal notices.

**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 has an annual audit for oversight of delegates responsible for credentialing. This audit has and will be used as tool for auditing areas of deficiency identified by HSAG to implement any necessary action to be taken with delegates who are not compliant with all credentialing standards.
  - For the Confidentiality program area, UPHP updated several of its HIPAA policies and created a new standard operating procedure for handling the following HIPAA member rights requests: accounting of disclosures, requests to restrict use of disclosures of protected health information (PHI), and confidential communications. Staff training related to HIPAA member right requests was completed in May 2024 and the UPHP Compliance Intake Application (CIA) was updated in June 2024 for all staff to have the ability to report disclosures in a secure manner.
  - UPHP created a Clinical Services – Appeals department in Q1 2024 to improve support and oversight of appeal processes; clinical appeal processes were previously handled by the Clinical Services – Utilization Management department. Goals for this new department in 2024 include completing in-depth review and updates to related policies, procedures and reports. The UPHP Appeals Committee was established and has been meeting on a quarterly basis to review trends, overturn rates and other appeal related items as needed. The Strategic Initiatives, Pharmacy and Clinical Services – Appeals departments met in Q2 2024 to discuss process improvements for receiving, reviewing, and requesting model notice and member material updates. The Strategic Initiatives department has completed staff training for improvement of grievance investigation and resolution writing. The Clinical Services – Appeals and Strategic Initiatives teams have also implemented several workflow changes in UPHP's

### 3. Prior Year Recommendation from the EQR Technical Report for Compliance Review

appeal and grievance system, Beacon Appeals Manager (BAM), to ensure adherence to policy changes as a result of HSAG findings.

- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- The deficiencies identified by HSAG were called out as a focus area during the most recent annual audit with the delegate. No further issues were identified.
  - There has been an increase in member disclosure reporting since the HIPAA staff training and updates to the UPHP CIA.
  - The task workflow changes made in UPHP's appeal and grievance system, BAM, have increased staff confidence in understanding and adhering to policy requirements for situations that are not encountered frequently (e.g. applying time frame extensions).
- c. Identify any barriers to implementing initiatives:
- None.
  - Updates to the UPHP CIA were delayed due to UPHP programmer resources.
  - The Strategic Initiatives team has noted that it can be difficult to get in touch with grieving members after the initial intake has been completed. This leaves us unable to follow up with the member to get more details or clarifying information for full grievance investigation.

**HSAG Assessment:** HSAG has determined that **UPP** addressed the prior year's recommendations. The SFY 2024 CAP review confirmed that **UPP**'s action plans were successful at remediating the deficiencies for the Grievance and Appeal Systems program area.

### 4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

- HSAG identified no specific weaknesses for **UPP** based on the SFY 2023 NAV, as **UPP** demonstrated that it contracted with all available providers for the provider types that did not meet minimum network requirements and supplied evidence of additional supports (e.g., community supports and resources) to provide adequate care to MI Health Link members in Region 1. **UPP** should maintain an internal data verification process to continually identify and contract with Adult Day Program, Dental, Eye Examinations, Hearing Aids, Hearing Examinations, and NEMT providers as they become available in Region 1 to improve compliance with Medicaid and LTSS minimum network standards for time/distance and capacity for MI Health Link members in the region.

**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 Quest Enterprise Solutions to monitor provider network and conduct outreach to providers and provider offices for contract requests. Network Monitoring is conducted monthly by the Quality Review Specialist within the Provider Relations Department. Follow Standard Operating Procedure 510-1051 Provider Network Testing and Outreach.

#### 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):
  - UPHP was able to identify providers listed within Quest Enterprise to conduct contracting request outreach to providers that were not contracted or credentialed with Health Plan.
- c. Identify any barriers to implementing initiatives:
  - No barriers when implementing initiatives. Utilizing Quest Enterprise has had a positive impact on reviewing the provider network.

**HSAG Assessment:** HSAG has determined that **UPP** has addressed the prior year's recommendations since **UPP** met or received an MDHHS exception for all Medicaid or LTSS NAV standards.

#### 5. Prior Year Recommendation from the EQR Technical Report for Secret Shopper Survey

HSAG recommended the following:

- Of the cases reached, 66.7 percent of provider locations accepted **UPP** and the MI Health Link program, and 50.0 percent accepted new patients. HSAG recommends that **UPP** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect phone number, MI Health Link acceptance, and new patient acceptance) to address the provider data deficiencies and educate provider offices on the MI Health Link program. Additionally, as MDHHS required **UPP** to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.
- Among all surveyed cases, the overall appointment rate was 28.6 percent. HSAG recommends that **UPP** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. 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 member wait times for available dates through Provider Newsletters, Provider In-service, 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.



## 5. Prior Year Recommendation from the EQR Technical Report for Secret Shopper Survey

### 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 interventions to ensure directory data accuracy and access to healthcare for members through quarterly audits. **UPP** also conducted provider outreach to validate provider information and provide education/training.

## 6. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

HSAG recommended the following:

- **UPP** did not indicate timeliness quality checks were performed for claims/encounters originating from all of its subcontractors. **UPP** should enhance its timeliness quality checks by considering, among other actions, the implementation of regular timeliness audits, the adoption of automated monitoring systems capable of tracking submission dates and generating alerts or reports for delayed submissions, and periodic reviews and adjustments of timeliness quality checks based on performance data and any alterations in regulations or contractual requirements.
- **UPP** reported only conducting the field-level completeness and accuracy quality check for claims/encounters stored in its data warehouses. **UPP** should enhance its quality checks for claims and encounters collected and stored by **UPP** by considering the following, among other actions:
  - Implement timeliness checks to ensure that submissions comply with State or contractual deadlines.
  - Create a standardized process for checking claim volume submissions to confirm that they align with expected volumes.
  - Implement automated monitoring systems capable of tracking submission dates and generating alerts or reports for delayed submissions.
  - Periodically review and adjust timeliness quality checks based on performance data and any changes in regulations or contractual requirements.
- Although **UPP** submitted professional, institutional, and pharmacy encounters in a timely manner, **UPP** did not submit dental encounters timely. About 58 percent of dental encounters were submitted within 180 days of payment. **UPP** should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment.
- Although 100 percent of provider NPIs identified in the medical/dental data were identified in the provider data, approximately 91.3 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data. **UPP** should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.
- Although not required to be populated, 55.9 percent of professional encounters contained a billing provider NPI, and 2.4 percent contained a rendering provider NPI. **UPP** should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.



## 6. 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 does a monthly sub-contractor reconciliation (SOP 110-2014) that was not previously submitted to ensure encounter data that is accurate, complete, and timely.
  - 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 reviewed the untimely dental encounters and determined that when MDHHS sent the warehouse date to HSAG, the most current accepted version of adjusted claims was sent. On 10/21/22 our dental vendor submitted adjustments for most claims between 12/2021 and 9/2022 based on guidance from MDHHS in September of 2022, making it look like all these encounters were not submitted and accepted until October of 2022 when they had previously been submitted within 30 days of the paid date.
  - UPHP and our pharmacy vendor meet monthly to review provider data to ensure it aligns with MDHHS provider data.
  - UPHP passes all required key provider data elements on encounter submissions to MDHHS.
- 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:
  - None currently.

**HSAG Assessment:** HSAG has determined that **UPP** has partially addressed the prior year's recommendations. **UPP** implemented a monthly subcontractor reconciliation process and established a monitoring work plan that includes timeliness reviews, acceptance rates, and rejection outlier monitoring. These initiatives reflect progress in ensuring encounter data accuracy and timeliness. However, **UPP** has not fully demonstrated the use of automated systems for timeliness quality checks or regular audits to proactively identify systemic delays, as recommended by HSAG. For dental encounters, **UPP** clarified that delays noted in the prior review were due to MDHHS guidance and subsequent data adjustments, but there is no evidence of additional monitoring to prevent future issues.

Regarding provider data completeness, **UPP** meets MDHHS requirements and collaborates with its pharmacy vendor through monthly reviews to ensure alignment with MDHHS provider data. While progress is noted, gaps remain in rendering provider NPI completeness (e.g., only 2.4 percent of professional encounters contain rendering provider NPIs). No additional quality checks were reported to enhance rendering provider data accuracy.

In conclusion, **UPP** has made progress, particularly in establishing monitoring processes and improving collaboration with its pharmacy vendor. However, gaps remain in implementing systemic timeliness monitoring, automated solutions, and enhancing provider data quality. To strengthen compliance with HSAG's recommendations, **UPP** should:

## 6. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

- Develop and implement automated timeliness monitoring systems and conduct regular audits to address systemic delays proactively.
- Enhance quality checks to improve rendering provider NPI completeness and accuracy.
- Establish processes to ensure all data discrepancies are resolved promptly to prevent misinterpretation of submission timelines.

These steps will improve overall data quality, address identified gaps, and align more effectively with HSAG's recommendations.

## 7. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis

HSAG recommended the following:

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

**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 Upper Peninsula Health Plan (UPHP) conducts its own internal annual Home and Community Based Services (HCBS) Waiver Member Satisfaction Survey to measure members' experience with case management and the provision of their home-based services including satisfaction with timeliness and quality of service. The survey is conducted by a UPHP Community Health Worker and not the member's assigned Care Coordinator. Any member concerns or dissatisfaction is communicated back to the assigned UPHP Care Coordinator for follow up and resolution. To ensure member concerns or dissatisfaction are addressed timely, UPHP Care Coordinators also address member satisfaction through monthly care plan reviews which include assessing member satisfaction with amount, type, scope, and duration of each service identified in the members person-centered plan of care.
  - UPHP also receives updates from the Long-Term Services and Supports (LTSS) vendor of regular quarterly meetings the Area Agency on Aging (AAA) has with agency providers to address issues related to scheduling/hiring/member concerns, etc.

*HSAG recommends that UPHP develop innovative approaches to increase the number of members participating in future survey administrations.*

## 7. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis

- To increase member participation and to combat telemarketer/telephonic polling fatigue, UPHP Care Coordinators conduct outreach to members prior to the MDHHS CAHPS Survey and UPHPs internal Member Experience Survey, letting members know they can expect a call and to educate members on the importance of the survey and encourage their participation.

### b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- A total of 105 members met criteria for UPHP's internal HCBS Member Satisfaction Survey for 2024. Out of the 59 members who were able to be reached, 51 agreed to participate in the survey for a survey engagement rate of 86% (51/59).
- Analysis of the 51 survey responses for 2024 revealed that UPHP was able to achieve a satisfaction rate of 96% (49/51), meeting the UPHP goal of 96%, for overall satisfaction with the program. More granular data indicates 88% (45/51) Agreed or Strongly Agreed that they are happy with the quality of their in-home services. Another 94% (48/51) Agreed or Strongly Agreed that the in-home supports and services they requested were provided timely.
- In total, 92% (47/51) surveyed felt that by being in the UPHP HCBS C-Waiver program they had an improved quality of life. This is an increase in the perceived quality of life from CY2023 in which 87% of members felt their quality of life had improved. The survey results reflect UPHP's values of ensuring a member lives in the setting of their choice with all necessary supports in place to ensure their needs are met. No overarching program issues were identified and UPHP will continue to survey members and assess results annually.
- Conducting this internal survey allows UPHP staff to identify and address specific UPHP member concerns and address.

*HSAG recommends that UPHP develop innovative approaches to increase the number of members participating in future survey administrations.*

- UPHP will continue to conduct outreach notifying members that they may be getting a survey call related to satisfaction with their service provision. While current processes include one telephonic outreach to conduct the UPHP Member Satisfaction survey, a total of at least two outreach calls to conduct the survey if a member is unable to be reached will be built into the process for future surveys in an effort to increase participation rates.

### c. Identify any barriers to implementing initiatives:

*HSAG recommends that UPHP develop and implement interventions to improve member experience related to the Recommend Personal Assistance/Behavioral Health Staff and Planning Your Time and Activities measures.*

- Current barriers to this initiative include members who decline survey participation, are unable to be reached, or those who do not report dissatisfaction to their care coordinator.

*HSAG recommends that UPHP develop innovative approaches to increase the number of members participating in future survey administrations.*

- Barriers to increasing survey participation include: the survey not reaching certain areas due to limited cell coverage, member concerns about privacy or the potential for telemarketing calls, and length of the survey in which a member may have limited cell phone minutes.

**HSAG Assessment:** HSAG has determined that **UPP** addressed the prior year's recommendations. **UPP** reported implementing interventions to conduct its own member satisfaction survey and utilizing vendors. The SFY 2024 HCBS CAHPS activity demonstrated statistically significantly higher top-box scores compared to the 2024 HCBS CAHPS Database benchmarks for the MI Health Link program for *Rating of Personal Assistance and Behavioral Health Staff, Rating of Case Manager, Helpful Case Manager, Personal Safety and Respect, and Planning Your Time and Activities*. However, as the 2024 top-box score for *Planning Your Time*

**7. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis**

*and Activities* still demonstrated the lowest score of all HCBS CAHPS measures, HSAG recommends that **UPP** continue to monitor measures to continue any efforts to increase performance.

## 5. Integrated Care Organization Comparative Information

In addition to performing a comprehensive assessment of each ICO's performance, HSAG uses a step-by-step process methodology to compare the findings and conclusions established for each ICO to assess the MI Health Link program. Specifically, HSAG identifies any patterns and commonalities that exist across the six ICOs and the MI Health Link program, draws conclusions about the overall strengths and weaknesses of the program, and identifies areas in which MDHHS could leverage or modify MDHHS' CQS to promote improvement.

### Integrated Care Organization External Quality Review Activity Results

This section provides the summarized results for the mandatory and optional EQR activities across the ICOs.

## Validation of Quality Improvement Projects

For the SFY 2024 validation, the ICOs submitted Remeasurement 2 data for their ICO-specific QIP topic. HSAG’s validation evaluated the technical methods of the ICO’s QIPs (i.e., the QIP Implementation and Outcomes stages). Table 5-1 provides a comparison of the overall QIP validation ratings and the scores for the QIP Design (Steps 1 through 6), Implementation (Steps 7 and 8), and Outcomes (Step 9) stages, by ICO.

**Table 5-1—Comparison of Validation Ratings and Scores by ICO**

MHP	QIP 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>Comprehensive Diabetes Care—HbA1c Test: Decreasing the Disparity Between White (Non-Hispanic) and African American (Non-Hispanic) Members</i>	<i>High Confidence</i>	<i>Low Confidence</i>	100%	0%	0%	67%	0%	33%	Yes
AMI	<i>Transitions of Care, Medication Reconciliation Post-Discharge</i>	<i>High Confidence</i>	<i>No Confidence</i>	100%	0%	0%	33%	0%	67%	Yes



MHP	QIP 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	
HCS	Reducing Controlling High Blood Pressure Disparity Between Black/African American and White/ Caucasian Members	High Confidence	High Confidence	100%	0%	0%	100%	0%	0%	No
MER	Addressing Race and Ethnic Health Disparities: Statin Therapy for Patients With Diabetes	High Confidence	No Confidence	100%	0%	0%	33%	0%	67%	Yes
MOL	Addressing Disparities in Controlling Blood Pressure	High Confidence	High Confidence	100%	0%	0%	100%	0%	0%	No
UPP	Annual Dental Care	High Confidence	No Confidence	100%	0%	0%	33%	0%	67%	No

## Performance Measure Validation

The SFY 2024 PMV of Core Measure 9.3—*Minimizing Facility Length of Stay*, MI2.6—*Timely Transmission of Care Transition Record to Health Care Professional*, MI5.6—*Care for Adults—Medication Review*, and MI7.3—*Annual Dental Visit* resulted in all six ICOs receiving validation designations of *Reportable (R)* for all measures, indicating the measure data were compliant with the MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements.

Table 5-2 provides the validation designations for the MI Health Link program PMV of Core Measure 9.3, MI2.6, MI5.6, and MI7.3.

**Table 5-2—Comparison of Overall Validation Designations**

ICO	Core Measure 9.3	MI2.6	MI5.6	MI7.3
<b>AET</b>	REPORTABLE (R)	REPORTABLE (R)	REPORTABLE (R)	REPORTABLE (R)
<b>AMI</b>	REPORTABLE (R)	REPORTABLE (R)	REPORTABLE (R)	REPORTABLE (R)
<b>HCS</b>	REPORTABLE (R)	REPORTABLE (R)	REPORTABLE (R)	REPORTABLE (R)
<b>MER</b>	REPORTABLE (R)	REPORTABLE (R)	REPORTABLE (R)	REPORTABLE (R)
<b>MOL</b>	REPORTABLE (R)	REPORTABLE (R)	REPORTABLE (R)	REPORTABLE (R)
<b>UPP</b>	REPORTABLE (R)	REPORTABLE (R)	REPORTABLE (R)	REPORTABLE (R)

Table 5-3 provides the validated performance measure rates for the MI Health Link program PMV of Core Measure 9.3, MI2.6, MI5.6, and MI7.3 for SFY 2023 and SFY 2024 and provides an ICO-to-ICO comparison for SFY 2023 and SFY 2024.

**Table 5-3—Comparison of SFY 2023 and SFY 2024 Performance Measure Results**

Performance Measure Results						
Core Measure 9.3*						
	AET	AMI	HCS	MER	MOL	UPP
SFY 2023	1.07	0.62	1.35	1.51	1.07	1.35
SFY 2024	1.04	0.62	1.50	1.59	1.82	1.24
SFY 2023–SFY 2024 Comparison	-0.03	+/-0.00	+0.15	+0.08	+0.75	-0.11
MI2.6						
Performance Measure	AET	AMI	HCS	MER	MOL	UPP
SFY 2023	20.70%	22.60%	34.50%	23.10%	34.50%	69.10%
SFY 2024	35.00%	30.90%	25.80%	49.10%	49.50%	73.00%
SFY 2023–SFY 2024 Comparison	+14.30%	+8.30%	-8.70%	+26.00%	+15.00%	+3.90%

Performance Measure Results						
MI5.6						
Performance Measure	AET	AMI	HCS	MER	MOL	UPP
SFY 2023	87.80%	96.80%	68.60%	68.40%	80.50%	93.20%
SFY 2024	100%	95.40%	71.30%	91.70%	82.00%	93.70%
SFY 2023–SFY 2024 Comparison	+12.20%	-1.40%	+2.70%	+23.30%	+1.50%	+0.50%
MI7.3						
Performance Measure	AET	AMI	HCS	MER	MOL	UPP
SFY 2023	25.10%	16.10%	29.10%	25.40%	24.70%	34.30%
SFY 2024	26.90%	18.90%	31.50%	23.40%	28.70%	32.80%
SFY 2023–SFY 2024 Comparison	+1.80%	+2.80%	+2.40%	-2.00%	+4.00%	-1.50%

\*Please note for Core 9.3 that the SFY 2024 rates are reflective of the ICOs’ calculated ratio of observed to expected discharges (O/E ratio) rather than a calculated percentage rate, as is reflected for MI2.6, MI5.6, and MI7.3.

Best-performing ICOs’ rates are denoted in green font.

Worst-performing ICOs’ rates are denoted in red font.

Table 5-4 and Table 5-5 include the quality withhold analysis results for ICOs in the MI Health Link demonstration for Demonstration Year (DY) 8, which covers CY 2023. Table 5-4 provides the results for each CMS Core measure, and Table 5-5 provides the results for each state-specific measure. For each measure, the ICOs earn a “met” or “not met” designation depending on their achieved rate relative to the benchmark level or, where applicable, the gap closure target. Based on the percentage of measures with a “met” designation, the ICOs receive a quality withhold payment. Of note, measures that also utilize the gap closure target methodology are marked with an asterisk. For these measures, the ICOs can earn a “met” designation by meeting the benchmark or the gap closure target. For more information about the quality withhold methodology, measures, and benchmarks, refer to the Medicare-Medicaid Capitated Financial Alignment Model CMS Core Quality Withhold Technical Notes for DYs 2 through 12 and the Michigan Quality Withhold Technical Notes for DYs 2 through 10. These documents are available on the [MMP Quality Withhold Methodology & Technical Notes](#) webpage.

**Table 5-4—CMS Core Measure Quality Withhold Results**

ICO	CW6—Plan All-Cause Readmissions	CW7—Annual Flu Vaccine*	CW8—Follow-Up After Hospitalization for Mental Illness*	CW11—Controlling Blood Pressure*
	Benchmark: 1.00	Benchmark: 69%	Benchmark: 56%	Benchmark: 71%
AET	Not Met	Met	Not Met	Met
AMI	Not Met	Not Met	Not Met	Not Met
HCS	Not Met	Not Met	Met	Met

ICO	CW6—Plan All-Cause Readmissions	CW7—Annual Flu Vaccine*	CW8—Follow-Up After Hospitalization for Mental Illness*	CW11—Controlling Blood Pressure*
	Benchmark: 1.00	Benchmark: 69%	Benchmark: 56%	Benchmark: 71%
<b>MER</b>	Not Met	Not Met	Met	Not Met
<b>MOL</b>	Not Met	Met	Met	Met
<b>UPP</b>	Met	Met	Met	Met

\* Indicates measures that also utilize the gap closure target methodology.

**Table 5-5—Michigan State-Specific Measure Quality Withhold Results**

ICO	MIW4—Care Transition Record Transmitted to Health Care Professional*	MIW5—Medication Review—All Populations*	MIW8—Annual Dental Visit*	MIW9—Minimizing Facility Length of Stay	MIW10—Antidepressant Medication Management—Effective Acute Phase Treatment*	MIW11—Colorectal Cancer Screening*	MIW12—Medication Reconciliation Post-Discharge*
	Benchmark: 70%	Benchmark: 90%	Benchmark: 65%	Benchmark: 1.50	Benchmark: 71%	Benchmark: 72%	Benchmark: 65%
<b>AET</b>	Met	Met	Not Met	Not Met	Not Met	Met	Met
<b>AMI</b>	Met	Met	Not Met	Not Met	Not Met	Met	Met
<b>HCS</b>	Not Met	Met	Not Met	Met	Met	Met	Met
<b>MER</b>	Met	Met	Not Met	Met	Not Met	Met	Met
<b>MOL</b>	Met	Met	Met	Met	Met	Met	Met
<b>UPP</b>	Met	Met	Not Met	Not Met	Met	Met	Met

\* Indicates measures that also utilize the gap closure target methodology.

## Performance Measure Rates

Table 5-6 provides an ICO-to-ICO comparison with the statewide average for HEDIS MY 2023 performance data in 10 HEDIS measure domains. **Green** represents best ICO performance in comparison to the statewide average. **Red** represents worst ICO performance in comparison to the statewide average. Table 5-6 also provides a comparison of HEDIS MY 2022 and HEDIS MY 2023 statewide averages. Statewide averages in **bold** font and shaded in **orange** indicate the HEDIS MY 2023 statewide average demonstrated better performance than the HEDIS MY 2022 statewide average.

Table 5-6—ICO-to-ICO Comparison and Statewide Average

HEDIS Measure	HEDIS MY 2022 Statewide Average (%)	HEDIS MY 2023						
		Statewide Average (%)	AET (%)	AMI (%)	HCS (%)	MER (%)	MOL (%)	UPP (%)
<b>Prevention and Screening</b>								
BCS-E—Breast Cancer Screening	56.70	58.82	53.08	58.39	59.24	54.57	62.71	66.55
COL—Colorectal Cancer Screening <sup>1</sup>	57.59	60.82	54.59	52.92	60.48	60.05	66.11	65.76
COA—Care for Older Adults—Medication Review	80.41	90.90	100	97.27	73.47	91.97	86.97	94.65
COA—Care for Older Adults—Functional Status Assessment	62.71	70.13	66.42	76.67	70.41	58.64	75.00	79.32
COA—Care for Older Adults—Pain Assessment	78.04	83.50	78.10	78.06	82.40	79.08	88.03	93.92
<b>Respiratory Conditions</b>								
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	22.01	23.00	19.23	22.22	26.15	19.78	27.12	22.52
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	74.10	74.05	85.52	77.14	72.92	78.54	56.90	87.25
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	88.82	86.81	90.50	88.57	89.58	89.04	80.91	87.25
<b>Cardiovascular Conditions</b>								
CBP—Controlling High Blood Pressure	66.14	68.85	64.48	61.86	74.72	66.42	68.16	81.51
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack <sup>2</sup>	—	56.36	66.67	50.00	60.00	33.33	66.67	50.00
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy	80.90	85.02	83.81	87.60	84.26	86.85	84.08	85.71
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%	79.55	81.48	77.68	84.91	83.52	82.39	80.28	85.90
<b>Diabetes</b>								
HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)*	34.07	29.00	32.60	40.00	27.37	23.84	32.44	16.79

HEDIS Measure	HEDIS MY 2022 Statewide Average (%)	HEDIS MY 2023						
		Statewide Average (%)	AET (%)	AMI (%)	HCS (%)	MER (%)	MOL (%)	UPP (%)
<i>HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (&lt;8.0%)</i>	58.51	63.61	58.64	53.41	62.63	70.07	61.46	74.94
<i>EED—Eye Exam for Patients With Diabetes<sup>1</sup></i>	62.89	65.27	64.72	55.85	63.95	67.40	67.80	63.75
<i>BPD—Blood Pressure Control for Patients With Diabetes</i>	68.13	70.83	68.86	57.07	72.37	71.53	67.80	88.08
<i>SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy</i>	76.44	76.91	77.05	79.58	80.71	75.10	77.32	73.35
<i>SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%</i>	78.95	80.60	78.13	79.58	82.26	80.51	80.72	84.08
<b>Musculoskeletal Conditions</b>								
<i>OMW—Osteoporosis Management in Women Who Had a Fracture</i>	11.18	20.27	7.69	28.57	27.27	23.53	18.75	30.00
<b>Behavioral Health</b>								
<i>AMM—Antidepressant Medication Management—Effective Acute Phase Treatment<sup>1</sup></i>	73.66	70.76	67.05	67.31	75.26	66.98	72.21	77.89
<i>AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment<sup>1</sup></i>	57.94	54.20	51.70	53.85	61.11	46.70	57.40	56.84
<i>FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up</i>	32.79	31.03	21.94	14.04	22.86	39.62	34.02	44.78
<i>FUH—Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up</i>	58.91	58.83	53.55	35.09	58.57	60.38	60.31	77.61
<i>FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up</i>	32.06	29.44	41.80	33.33	22.45	32.62	22.75	22.22
<i>FUM—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up</i>	54.39	48.27	59.02	46.67	51.02	45.99	40.78	49.21
<b>Medication Management and Care Coordination</b>								
<i>TRC—Transitions of Care—Medication Reconciliation Post-Discharge</i>	47.59	56.17	79.08	60.10	58.88	43.31	37.96	75.18



HEDIS Measure	HEDIS MY 2022 Statewide Average (%)	HEDIS MY 2023						
		Statewide Average (%)	AET (%)	AMI (%)	HCS (%)	MER (%)	MOL (%)	UPP (%)
TRC—Transitions of Care—Notification of Inpatient Admission	16.53	24.53	17.27	26.03	39.90	25.55	11.92	52.07
TRC—Transitions of Care—Receipt of Discharge Information	15.38	19.48	15.09	13.38	27.01	23.11	9.73	42.58
TRC—Transitions of Care—Patient Engagement After Inpatient Discharge	77.74	79.78	77.86	74.21	80.05	78.59	79.08	90.27
<b>Overuse/Appropriateness</b>								
PSA—Non-Recommended PSA-Based Screening in Older Men*	26.71	27.99	24.71	22.30	32.58	24.73	34.23	23.16
DDE—Potentially Harmful Drug-Disease Interactions in Older Adults*	33.45	33.54	37.91	30.05	32.14	27.18	32.02	43.18
DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid*	18.16	17.57	17.43	10.11	20.65	13.41	19.34	22.04
DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis*	5.23	4.99	4.49	4.66	4.93	5.19	4.05	8.19
DAE—Use of High-Risk Medications in Older Adults—Total*	21.78	21.07	20.86	13.75	23.38	17.33	22.00	27.71
<b>Access/Availability of Care</b>								
AAP—Adults’ Access to Preventive/Ambulatory Health Services—20–44 Years	84.90	85.69	83.41	78.47	84.60	82.43	89.89	90.37
AAP—Adults’ Access to Preventive/Ambulatory Health Services—45–64 Years	93.83	93.71	92.61	90.84	92.80	92.08	96.11	95.16
AAP—Adults’ Access to Preventive/Ambulatory Health Services—65 Years and Older	91.69	91.79	90.52	87.83	91.14	89.72	93.87	95.45
AAP—Adults’ Access to Preventive/Ambulatory Health Services—Total	91.08	91.24	89.72	87.01	90.57	88.98	93.87	94.48
IET—Initiation and Engagement of Substance Use Disorder Treatment - Initiation of SUD Treatment—Total <sup>1</sup>	34.10	35.83	37.32	42.59	37.07	27.47	40.80	28.95
IET—Initiation and Engagement of Substance Use Disorder Treatment -	3.84	4.43	5.83	2.78	2.93	3.30	3.11	9.47

HEDIS Measure	HEDIS MY 2022 Statewide Average (%)	HEDIS MY 2023						
		Statewide Average (%)	AET (%)	AMI (%)	HCS (%)	MER (%)	MOL (%)	UPP (%)
<i>Engagement of Substance Use Disorder Treatment—Total<sup>1</sup></i>								
<b>Risk-Adjusted Utilization</b>								
<i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)*</i>	1.07	1.11	1.53	1.25	0.86	1.10	0.89	1.01
<i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)*</i>	1.21	1.21	1.47	1.33	1.25	0.97	1.22	0.99

\* Measures for which lower rates indicate better performance.

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

<sup>2</sup> Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between MY 2023 and prior years; therefore, the HEDIS MY 2022 statewide average will not be displayed for this measure.

Green represents best ICO performance in comparison to the statewide average. Red represents worst ICO performance in comparison to the statewide average.

When HEDIS MY 2022 and HEDIS MY 2023 are comparable, statewide averages in **bold** font and shaded in orange indicate the HEDIS MY 2023 statewide average demonstrated better performance than the HEDIS MY 2022 statewide average.

## Compliance Review

HSAG calculated the MI Health Link program’s performance in each of the 14 compliance review standards that were reviewed as part of the three-year compliance review cycle. Table 5-7 compares the ICOs’ compliance scores and the MI Health Link program aggregated score in each of the 14 compliance review standards.

**Table 5-7—Summary of Combined SFY 2022 and SFY 2023 Compliance Review Results**

Standard <sup>1,2</sup>	AET	AMI	HCS	MER	MOL	UPP	Statewide Aggregate
Standard I—Disenrollment: Requirements and Limitations	100%	100%	100%	100%	100%	89%	<b>97%</b>
Standard II—Member Rights and Member Information	65%	59%	61%	70%	70%	73%	<b>66%</b>
Standard III—Emergency and Poststabilization Services	100%	100%	100%	100%	100%	100%	<b>100%</b>
Standard IV—Availability of Services	92%	85%	100%	100%	100%	85%	<b>94%</b>
Standard V—Assurances of Adequate Capacity and Services	100%	100%	75%	75%	100%	75%	<b>88%</b>

Standard <sup>1,2</sup>	AET	AMI	HCS	MER	MOL	UPP	Statewide Aggregate
Standard VI—Coordination and Continuity of Care	73%	77%	80%	73%	80%	77%	<b>77%</b>
Standard VII—Coverage and Authorization of Services	89%	89%	86%	78%	85%	100%	<b>88%</b>
Standard VIII—Provider Selection	91%	91%	87%	87%	87%	87%	<b>88%</b>
Standard IX—Confidentiality	100%	73%	91%	91%	100%	64%	<b>86%</b>
Standard X—Grievance and Appeal Systems	78%	71%	78%	78%	71%	80%	<b>76%</b>
Standard XI—Subcontractual Relationships and Delegation	80%	80%	80%	80%	80%	60%	<b>77%</b>
Standard XII—Practice Guidelines	100%	100%	100%	83%	100%	83%	<b>94%</b>
Standard XIII—Health Information Systems <sup>3</sup>	89%	100%	100%	100%	100%	100%	<b>98%</b>
Standard XIV—Quality Assessment and Performance Improvement Program	90%	90%	90%	95%	81%	90%	<b>90%</b>
<b>Combined Total</b>	<b>85%</b>	<b>82%</b>	<b>84%</b>	<b>83%</b>	<b>84%</b>	<b>84%</b>	<b>84%</b>

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

Table 5-8 compares the number of total CAP elements, and the *Complete* and *Not Complete* elements across the ICOs and the MI Health Link program for the SFY 2024 CAP implementation review.

**Table 5-8—ICO and MI Health Link Program Summary of 2024 CAP Implementation**

ICO	Total CAP Elements	Number of CAP Elements Complete	Number of CAP Elements Not Complete	Percent Complete
<b>AET</b>	36	36	0	<b>100%</b>
<b>AMI</b>	42	40	2	<b>95%</b>
<b>HCS</b>	37	31	6	<b>84%</b>
<b>MER</b>	39	37	2	<b>95%</b>
<b>MOL</b>	38	30	8	<b>79%</b>
<b>UPP</b>	38	38	0	<b>100%</b>
<b>MI Health Link Total</b>	<b>230</b>	<b>212</b>	<b>18</b>	<b>92%</b>

## Network Adequacy Validation

### Network Adequacy Analysis

#### ISCA

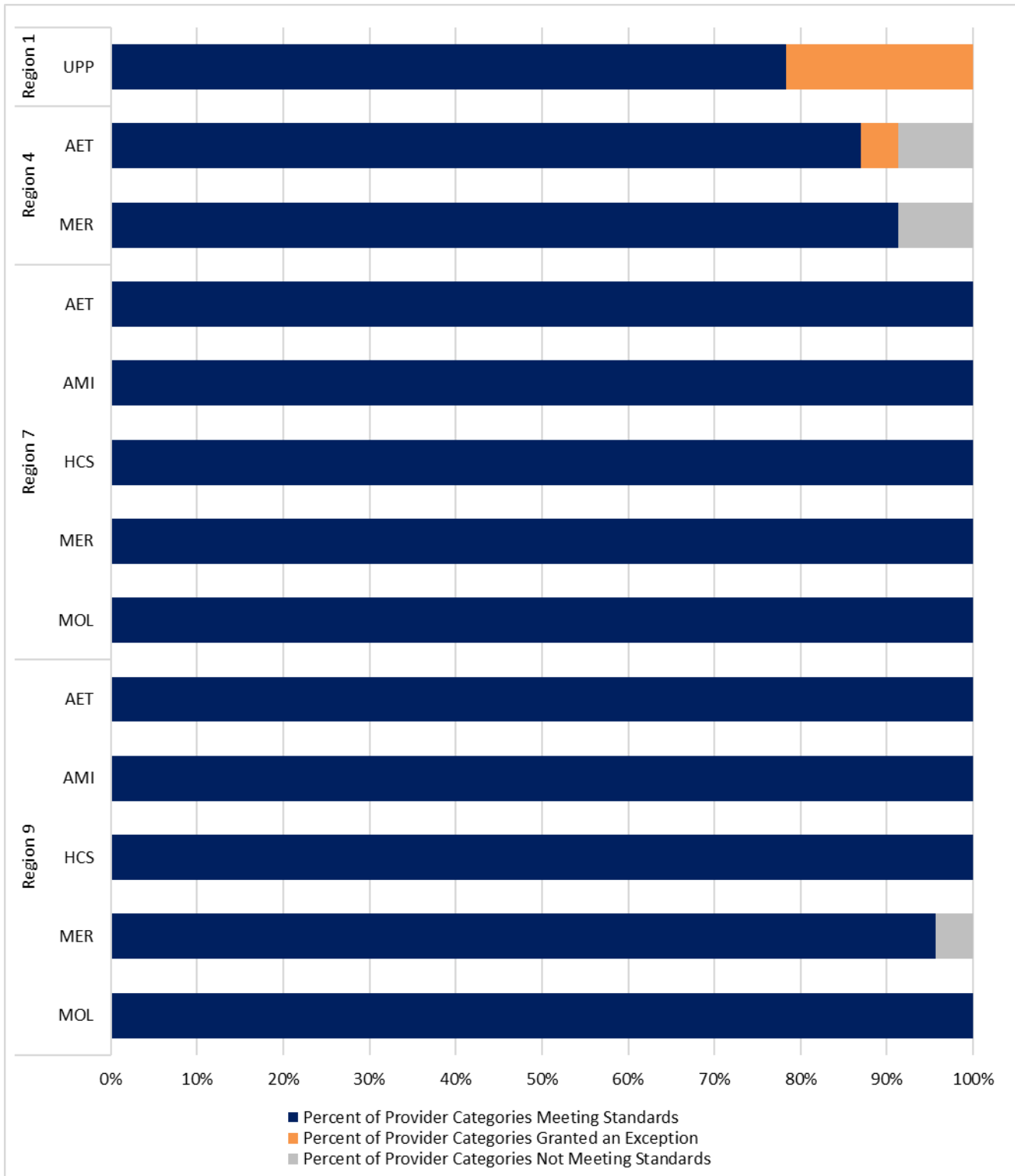
HSAG completed an ISCA for each of the six ICOs contracted to provide Medicaid and LTSS services in Michigan and in this report presents findings and validation ratings based on the ICOs' ISCA and live system demonstrations. For each of the ICOs assessed, HSAG identified no concerns regarding system data processing procedures, enrollment data systems, or provider data systems. Additionally, HSAG determined that each ICO's data collection procedures were acceptable. For the ICOs that used external delegated entities to complete network adequacy indicator reporting during the reporting period, no issues were identified.

Based on the results of the ISCA's combined with the detailed validation of each NAV indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and whether the ICOs' interpretation of data was accurate. All six of the ICOs received *High Confidence* for both provider capacity and time and distance indicators.

#### ***Time/Distance and Provide Capacity Analysis***

HSAG validated the adequacy of each ICO's provider network according to MI Health Link's minimum network requirements for 23 Medicaid and LTSS provider types. Figure 5-1 presents the ICOs' final region-specific NAV results (i.e., the percentage of the 23 Medicaid and LTSS provider types for which each ICO met the minimum network requirements, received an exception, or did not meet the minimum network requirements) using the most recent data submission and MDHHS' exception determinations.

**Figure 5-1—SFY 2024 Final NAV Results\* by Region and ICO**



\*All percentages reflect ICOs' region-specific adherence to network standards for 23 provider categories.

## Network Validation Survey

During March and May 2024, HSAG conducted a NVS among dental care providers contracted with one or more ICO that serve members enrolled in the MI Health Link program to ensure members have appropriate access to provider information. The NVS included a PDV and a secret shopper survey.

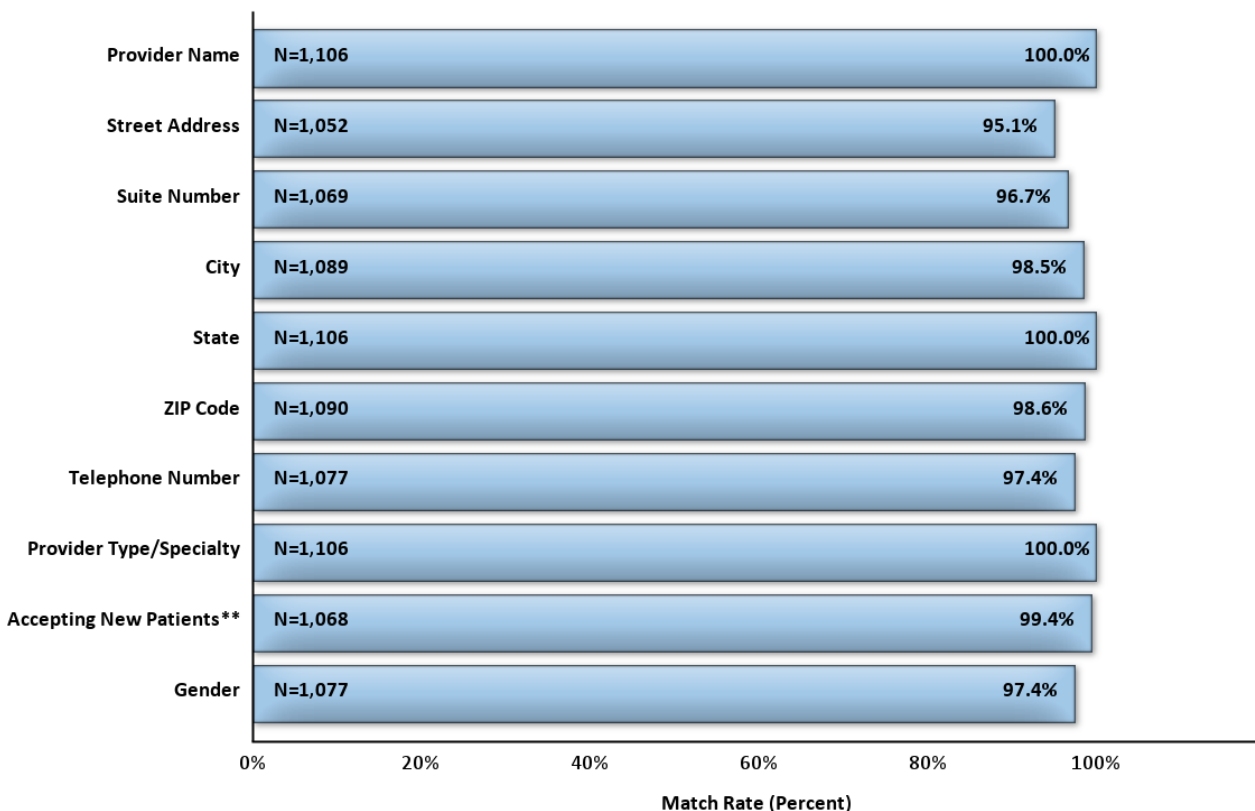
HSAG conducted provider directory reviews of 1,179 providers across all ICOs. HSAG was able to locate 93.8 percent of the dental providers in the ICOs’ online provider directories. Notably, **HCS** had the highest number of missing providers, resulting in only 87.0 percent of providers found in the directory. Among the located providers, all PDV study indicator match rates scored over 95.0 percent, indicating a high level of agreement between the ICOs’ provider data files and the online provider directory. Table 5-9 and Figure 5-2 display the percentage of providers found in the online directory, followed by the percentage of provider locations with matches between the ICOs’ data files and the online directory.

**Table 5-9—Providers Found in the Online Directory, by ICO**

ICO	Number of Sampled Providers	Providers Found in Directory	
		Count	Rate (%)
<b>AET</b>	215	211	98.1%
<b>AMI</b>	38	32	84.2%
<b>HCS</b>	332	289	87.0%
<b>MER</b>	386	370	95.9%
<b>MOL</b>	194	191	98.5%
<b>UPP</b>	14	13	92.9%
<b>ICO Total</b>	<b>1,179</b>	<b>1,106</b>	<b>93.8%</b>



**Figure 5-2—PDV Study Indicators Aggregate Match Rates\***



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

\*\*New patient information was not listed in the online directory for AmeriHealth and could only be confirmed by contacting the provider's office. Therefore, AmeriHealth was excluded from the new patient acceptance match rate. Additionally, the new patient acceptance match rate includes matches or not listed in the online directory for the remaining ICOs. Caution should be exercised when interpreting the new patient acceptance match rates.

HSAG included cases in the secret shopper survey only if those cases were found in the online directory and matched on eight key indicators in the PDV: name, address, city, state, ZIP Code, telephone number, provider type/specialty, and new patient acceptance.<sup>60</sup> PDV cases that did not match on these indicators were not included in the secret shopper survey. HSAG attempted to contact 1,068 sampled provider locations (i.e., “cases”), with an overall response rate of 88.5 percent among the ICOs. Of the responsive cases, 69.8 percent confirmed that the office accepted the requested insurance (i.e., DBA, ICO, or MI Health Link) and 68.3 percent reported accepting new patients, with 62.3 percent of cases offering an appointment date to the caller. Of the cases that offered an appointment, 83.5 percent of the appointments were compliant with the wait time standard for routine dental visits (i.e., within eight weeks or 56 calendar days). The overall median wait time for a routine dental care visit was 13 calendar days; however, the ICO in Region 1 (**UPP**) and those in Region 4 (**AET** and **MER**) had median wait

<sup>60</sup> New patient information was not listed in the online directory for **AMI** and could only be confirmed by contacting the provider's office. Therefore, HSAG did not use the new patient acceptance indicator when identifying **AMI** cases to be included in the secret shopper survey.

times well above the ICOs in Regions 7 and 9. This should be reviewed in the context of the limited number of sampled providers and appointments offered in Region 1 (14 providers and five appointments) and Region 4 (67 providers and 18 appointments), which may have impacted the median wait times. Table 5-10 and Table 5-11 display the rates for survey response and insurance acceptance, followed by new patient acceptance, appointment availability, and wait time compliance, as well as the median wait time, by ICO and region.

**Table 5-10—Overall Secret Shopper Survey Results, by ICO and Region**

ICO	Cases Reached <sup>1</sup>	Response Rate (%) <sup>2</sup>	Accepting Requested Insurance ICO <sup>3</sup> or MI Health Link Program	
			Count	Rate (%) <sup>4</sup>
Region 1				
UPP	9	69.2%	8	88.9%
Region 1 Total	9	69.2%	8	88.9%
Region 4				
AET	10	76.9%	4	40.0%
MER	40	80.0%	24	60.0%
Region 4 Total	50	79.4%	28	56.0%
Region 7				
AET	107	88.4%	90	84.1%
AMI	14	93.3%	11	78.6%
HCS	126	90.6%	99	78.6%
MER	144	91.7%	98	68.1%
MOL	101	84.2%	78	77.2%
Region 7 Total	492	89.1%	376	76.4%
Region 9				
AET	57	87.7%	43	75.4%
AMI	7	77.8%	5	71.4%
HCS	122	86.5%	83	68.0%
MER	150	92.6%	81	54.0%
MOL	58	92.1%	36	62.1%
Region 9 Total	394	89.5%	248	62.9%
ICO Total	945	88.5%	660	69.8%

<sup>1</sup> Cases reached includes cases that responded to the survey, confirmed the location, and offered the requested service.

<sup>2</sup> The denominator includes the total number of sampled 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). New patient information was not listed in the online directory for AmeriHealth and could only be confirmed by contacting the provider's office. Therefore, HSAG did not use the new patient acceptance indicator when identifying AmeriHealth cases to be included in the secret shopper survey.

<sup>3</sup> ICO acceptance results include offices that accepted the DBA.

<sup>4</sup> The denominator includes cases reached.

Table 5-11—Overall Appointment Availability and Wait Time Results, by ICO and Region

ICO	Rate of Cases Accepting New Patients <sup>1</sup>	Rate of Cases Offering an Appointment <sup>1</sup>	Rate of Appointments Within Standard <sup>2,3</sup>	Median Appointment Wait Time (Calendar Days)
<b>Region 1</b>				
<b>UPP</b>	77.8%	55.6%	0.0%	256
<b>Region 1 Total</b>	<b>77.8%</b>	<b>55.6%</b>	<b>0.0%</b>	<b>256</b>
<b>Region 4</b>				
<b>AET</b>	40.0%	20.0%	0.0%	152
<b>MER</b>	55.0%	40.0%	25.0%	175
<b>Region 4 Total</b>	<b>52.0%</b>	<b>36.0%</b>	<b>22.2%</b>	<b>175</b>
<b>Region 7</b>				
<b>AET</b>	83.2%	80.4%	90.7%	9
<b>AMI</b>	78.6%	64.3%	88.9%	7
<b>HCS</b>	77.0%	76.2%	86.5%	14
<b>MER</b>	65.3%	60.4%	81.6%	13
<b>MOL</b>	77.2%	66.3%	88.1%	12
<b>Region 7 Total</b>	<b>75.0%</b>	<b>70.1%</b>	<b>86.7%</b>	<b>12</b>
<b>Region 9</b>				
<b>AET</b>	73.7%	70.2%	75.0%	20
<b>AMI</b>	71.4%	42.9%	66.7%	28
<b>HCS</b>	68.0%	68.0%	86.7%	7
<b>MER</b>	52.7%	43.3%	89.2%	7
<b>MOL</b>	58.6%	51.7%	90.0%	23
<b>Region 9 Total</b>	<b>61.7%</b>	<b>56.1%</b>	<b>85.5%</b>	<b>12</b>
<b>ICO Total</b>	<b>68.3%</b>	<b>62.3%</b>	<b>83.5%</b>	<b>13</b>

<sup>1</sup> The denominator includes cases reached.

<sup>2</sup> The denominator includes cases that offered an appointment.

<sup>3</sup> Rate of Appointments Within Standard represents cases that offered an appointment that is compliant with MDHHS' standard for an initial dental appointment (i.e., appointments offered within eight weeks or 56 calendar days).

## Encounter Data Validation

Representatives from each ICO procured service records and IICSP documentation for sampled members from their contracted providers, based on the final sample lists provided by HSAG. These records included documentation of services rendered and the IICSP for the services during the review period and served as the primary sources for validating the completeness and accuracy of encounter data. The evaluation of the service records focused on key data elements, including *Date of Service*, *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Units*, as applicable to specific service categories, to identify discrepancies and ensure alignment between the service records and the encounter data submitted to MDHHS. Additionally, IICSP documents associated with personal care services were reviewed to ensure alignment with the member’s service records using authorization dates, scheduled services, units of service, and servicing providers.

Table 5-12 and Table 5-13 present the EDV service record review results for all ICOs, stratified by analytic review categories. The analysis categorized findings using three levels of concern: “✓” indicated no or minor concerns noted, “–” indicated moderate concerns noted, and “✗” indicated major concerns noted. By applying the evaluation criteria noted below, the service record review provides a comprehensive assessment of data integrity, allowing for targeted improvements in ICO data submission practices. For ICO-specific results, refer to Section 3.

## Service Record and PCSP Documentation Procurement Status

The *Service Record* and *IICSP Documentation Procurement Status* were assessed based on the following metrics: rates of 95 percent and above were assigned a “✓”, rates from 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 five key data elements (i.e., *Date of Service*, *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Units*), as applicable to specific service categories. 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 ensure a consistent standard for completeness evaluation.

**Table 5-12—EDV ICO Comparison: Procurement and Completeness**

ICOs	Service Category	Record/Documentation Procurement Status		Encounter Data Completeness	
		Service Record Procurement Rate	IICSP Document Procurement Rate	Service Record Omission Rate	Encounter Data Omission Rate
AET	Dental	✗	NA	✗	✓
	Hearing	✓	NA	–	–

ICOs	Service Category	Record/Documentation Procurement Status		Encounter Data Completeness	
		Service Record Procurement Rate	IICSP Document Procurement Rate	Service Record Omission Rate	Encounter Data Omission Rate
	Vision	✖	NA	–	✓
	NEMT	✖	NA	✖	✓
	Personal Care Service	✖	✓	✖	✓
AMI	Dental	–	NA	✓	✓
	Hearing	✓	NA	✓	✓
	Vision	–	NA	–	–
	NEMT	✖	NA	✖	✓
	Personal Care Service	✓	✓	✓	✓
HCS	Dental	✓	NA	✓	✓
	Hearing	✓	NA	✖	✓
	Vision	✓	NA	–	✓
	NEMT	✓	NA	✖	✓
	Personal Care Service	✓	✖	–	✓
MER	Dental	✖	NA	✖	–
	Hearing	✖	NA	✖	–
	Vision	✖	NA	✖	✓
	NEMT	–	NA	✖	–
	Personal Care Service	✓	✖	✖	✓
MOL	Dental	✖	NA	–	–
	Hearing	✖	NA	–	✖
	Vision	✖	NA	✖	✖
	NEMT	✓	NA	✓	✖
	Personal Care Service	✖	✓	✖	✓
UPP	Dental	✓	NA	✓	✓
	Hearing	✓	NA	✖	–
	Vision	✓	NA	✖	–
	NEMT	✓	NA	✓	–
	Personal Care Service	✓	✓	✓	✓

✓	No or minor concerns noted.
–	Moderate concerns noted.
✖	Major concerns noted.
NA	Not applicable for non-personal care services.

### Encounter Data Accuracy

For the accuracy rate assessment, the *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Units*, and *All-Element Accuracy Rates* were used as primary metrics. At the individual level, if all elements (i.e., *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, and *Units*) applicable to specific service categories 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 a “✗” was assigned. For the all-element accuracy, 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 determine the reliability of encounter data across ICOs and highlights areas where accuracy improvements may be necessary. It is important to note that the denominator for the element accuracy rate for each data element was defined differently than the denominator used for the all-element accuracy rate. Therefore, the all-element accuracy rate could not be derived from the individual data element accuracy rates. Using diagnosis code as an example, each diagnosis code was assigned to one of the four mutually exclusive categories: service 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 service records and encounter data, and the numerator is the total number of dates of service with the same values for all key data elements. Therefore, for each date of service, if any of the data elements were in the service record omission, encounter data omission, or inaccurate categories, the date of service was not counted in the numerator for the all-element accuracy rate.

### IICSP Document Review

The *IICSP Document Review* was assessed using several key indicators including: the validity of the IICSP document, the presence of an appropriate signature, the alignment of the selected date of service within the IICSP’s effective dates, documentation of the servicing provider, and whether the provider, procedures, and number of units documented in the member’s service records were supported by the IICSP documentation.

A “✓” was assigned if all indicators had a rate of at least 90 percent. A “–” was assigned if any single indicator had a rate below 90 percent. An “✗” was applied under any of the following conditions: if one indicator had a rate below 75 percent, if two indicators had rates below 80 percent, or if three indicators had rates below 85 percent. These thresholds help identify potential gaps in data submission and to maintain a consistent standard for completeness evaluation.



Table 5-13—EDV ICO Comparison: Element Accuracy and IICSP Document Review

ICOs	Service Category	Encounter Data Accuracy		IICSP Document Review
		Diagnosis Code, Procedure Code, Procedure Code Modifier, and Units Accuracy Rates	All-Element Accuracy Rates	
AET	Dental	✓	✓	NA
	Hearing	✓	✓	NA
	Vision	✓	✓	NA
	NEMT	✓	✓	NA
	Personal Care Service	✓	✓	✗
AMI	Dental	✓	✓	NA
	Hearing	✓	✓	NA
	Vision	✓	✓	NA
	NEMT	✗	✗	NA
	Personal Care Service	✓	✓	✗
HCS	Dental	✓	✓	NA
	Hearing	✓	✗	NA
	Vision	✓	–	NA
	NEMT	✗	✗	NA
	Personal Care Service	✓	–	✗
MER	Dental	✓	✓	NA
	Hearing	✓	✓	NA
	Vision	✓	✓	NA
	NEMT	✗	✗	NA
	Personal Care Service	✓	✓	✗
MOL	Dental	✓	✓	NA
	Hearing	✓	✓	NA
	Vision	✓	–	NA
	NEMT	✓	✓	NA
	Personal Care Service	✓	✗	✗
UPP	Dental	✓	✓	NA
	Hearing	✓	✓	NA
	Vision	✓	–	NA
	NEMT	✓	✗	NA
	Personal Care Service	✓	✓	✗

✓	No or minor concerns noted.
–	Moderate concerns noted.
✗	Major concerns noted.
NA	Not applicable for non-personal care services.

## Consumer Assessment of Healthcare Providers and Systems Analysis

HSAG administered the HCBS CAHPS Survey to eligible adult members enrolled in all six ICOs; however, due to the low number of respondents to the survey, individual plan results are unable to be presented or compared across the ICOs. Table 5-14 presents the 2022, 2023, and 2024 HCBS CAHPS top-box scores for the MI Health Link program. Top-box scores represent the percentage of eligible respondents who answered with the most positive response. For more detailed information regarding top-box scores, please refer to Appendix.

**Table 5-14—Summary of HCBS CAHPS Survey Top-Box Scores for the MI Health Link Program<sup>61,62</sup>**

	2022 Top-Box Score	2023 Top-Box Score	2024 Top-Box Score
<b>Global Ratings</b>			
<i>Rating of Personal Assistance and Behavioral Health Staff</i>	86.58%	89.96%	90.39% ↑
<i>Rating of Homemaker</i>	82.50%*	88.89%	82.35%*
<i>Rating of Case Manager</i>	87.18%	89.24%	87.55% ↑
<b>Composite Measures</b>			
<i>Reliable and Helpful Staff Composite</i>	81.40%	87.07%	84.51%
<i>Staff Listen and Communicate Well Composite</i>	86.80%*	89.43%	88.02%
<i>Helpful Case Manager Composite</i>	92.48%*	96.51%	96.06% ↑
<i>Choosing the Services that Matter to You Composite</i>	81.37%	82.87%	79.22%
<i>Transportation to Medical Appointments Composite</i>	80.12%	77.82%	77.77%
<i>Personal Safety and Respect Composite</i>	94.60% ▼	95.83%	97.01% ↑
<i>Planning Your Time and Activities Composite</i>	62.11%	63.70%	64.14% ↑
<b>Recommendation Measures</b>			
<i>Recommend Personal Assistance/Behavioral Health Staff</i>	86.75%	85.11%	87.16%
<i>Recommend Homemaker</i>	74.36%*	86.09%	75.00%*

<sup>61</sup> The 2024 HCBS CAHPS Database benchmarks represent survey data collected from January 1 to December 31, 2022. Caution should be exercised when comparing the 2024 HCBS CAHPS Database benchmarks to the MI Health Link Program 2024 results, which represent survey data collected from June 4 to July 30, 2024.

<sup>62</sup> HSAG recalculated the 2022 mean scores to top-box scores for HCBS CAHPS Database benchmark comparability; therefore, the 2022 results in this report will not match previous reports.

	2022 Top-Box Score	2023 Top-Box Score	2024 Top-Box Score
<i>Recommend Case Manager</i>	83.12%	83.18%	79.25%
<b>Unmet Need Measures</b>			
<i>No Unmet Need in Dressing/Bathing</i>	S	75.00%*	S
<i>No Unmet Need in Meal Preparation/Eating</i>	S	S	S
<i>No Unmet Need in Medication Administration</i>	S	71.43%*	78.95%*
<i>No Unmet Need in Toileting</i>	93.65%* ▼	98.04%	100%
<i>No Unmet Need with Household Tasks</i>	S	S	S
<b>Physical Safety Measure</b>			
<i>Not Hit or Hurt by Staff</i>	98.97%	100%	100%

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

“S” Indicates that there were fewer than 11 respondents for a measure; therefore, results were suppressed.

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

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

↑ Indicates the 2024 score is statistically significantly higher than the 2024 HCBS CAHPS Database benchmark.

↓ Indicates the 2024 score is statistically significantly lower than the 2024 HCBS CAHPS Database benchmark.

If no statistically significant differences were found, no triangle or arrow indicator is shown.

## 6. Programwide Conclusions and Recommendations

HSAG performed a comprehensive assessment of the performance of the ICOs and identified their strengths and weaknesses related to the provision of healthcare services. The aggregated findings from all EQR activities were thoroughly analyzed and reviewed across the continuum of program areas and the activities that comprise the MI Health Link program to identify programwide conclusions. The programwide conclusions are not intended to be inclusive of all EQR activity results; rather, only those results that had a substantial impact on a CQS goal. HSAG presents these programwide conclusions and corresponding recommendations to MDHHS to drive progress toward achieving the goals of the Michigan CQS and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid members. Table 6-1 displays each CQS goal and indicates whether the EQR activity results positively (✓), negatively (✗), or minimally (m) impacted the MI Health Link program's progress toward achieving the applicable goals and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to Medicaid members. A dash (–) is noted in Table 6-1 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 MI Health Link population.

**Table 6-1—Programwide Conclusions and Recommendations**

Performance Impact on Goals and Objectives <sup>63</sup>		Performance Domain
<b>Goal #1—Ensure high quality and high levels of access to care</b>		
m	<b>CQS Objective 1.1:</b> The MI Health Link program made minimal progress towards reaching the statewide 2026 performance target to achieve 65 percent for the <i>MI7.3 Annual Dental Visit</i> quality measure. While no ICOs reached the goal, four of the six ICOs demonstrated improvement from the prior year.	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
✓	<b>CQS Objective 1.1:</b> The MI Health Link program reached the statewide 2026 performance target to achieve 56 percent for the <i>FUH—Follow-Up After Hospitalization for Mental Illness (30 Days)</i> quality measure. The MI Health Link program rate was 58.83 percent.	
m	<b>CQS Objective 1.1:</b> The MI Health Link program made minimal progress towards reaching the statewide 2026 performance target to achieve 72 percent for the <i>COL—Colorectal Cancer Screening</i> quality measure. While the MI Health Link program rate was 68.85 percent, the rate increased in performance from the prior year.	
m	<b>CQS Objective 1.2:</b> The MI Health Link program made minimal progress towards reaching the statewide 2026 performance target to achieve 71 percent for the <i>CBP—Controlling High Blood Pressure</i> quality measure. While the MI Health Link program rate was 60.82 percent, the rate increased in performance from the prior year.	

<sup>63</sup> 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 <sup>63</sup>		Performance Domain
✗	<b>CQS Objective 1.2:</b> The MI Health Link program did not make progress towards reaching the statewide 2026 performance target to achieve 1.00 for the <i>PCR—Plan All-Cause Readmission</i> based on the results of the <i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)</i> performance measure demonstrating no improvement from the prior year.	
m	<b>CQS Objective 1.2:</b> The MI Health Link program made minimal progress towards reaching the statewide 2026 performance target to achieve 72 percent for the <i>COL—Colorectal Cancer Screening</i> quality measure. While the MI Health Link program rate was 68.85 percent, the rate increased in performance from the prior year.	
—	<b>CQS Objective 1.3:</b> The EQR activities do not produce data to assess the impact of the <i>Annual Flu Vaccine</i> quality measure under this objective.	
✓	<b>CQS Objective 1.3:</b> The MI Health Link program made progress towards reaching the statewide 2026 performance target to achieve 85 percent for the <i>MI5.6 Medication Review—All Populations</i> quality measure. Four of the six ICOs achieved the 85 percent target and five of the six ICOs demonstrated improvement from the prior year.	
m	<b>CQS Objective 1.3:</b> The MI Health Link program made minimal progress towards reaching the statewide 2026 performance target to achieve 65 percent for the <i>TRC - Transitions of Care—Medication Reconciliation Post-Discharge</i> quality measure. While the MI Health Link program rate was 56.17 percent, the rate increased in performance from the prior year.	
—	<b>CQS Objective 1.3:</b> The EQR activities do not produce data to assess the impact of the <i>PM13 Number and percent of enrollees whose IICSP addressed their assessed health and safety risks (HCBS C-Waiver population)</i> quality measure under this objective.	
—	<b>CQS Objective 1.3:</b> The EQR activities do not produce data to assess the impact of the <i>PM15 Number &amp; percent of enrollees with an individualized contingency/back-up plan addressing caregiver absences, severe weather, fire/other emergencies (HCBS C-Waiver population)</i> quality measure under this objective.	
—	<b>CQS Objective 1.3:</b> The EQR activities do not produce data to assess the impact of the <i>PM24 Number and percent of files that show enrollee/family/legal guardians (as appropriate) received information and education on how to report abuse, neglect, exploitation, and other critical incidents within 60 days of waiver enrollment</i> quality measure under this objective.	
✓	Based on the results of the ISCA's combined with the detailed validation of each NAV indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and whether the ICOs' interpretation of data was accurate. All six of the ICOs received <i>High Confidence</i> for both provider capacity and time and distance indicators. <sup>64</sup>	

<sup>64</sup> 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 <sup>63</sup>		Performance Domain
✓	The MI Health Link program met minimum network requirements, or an exception was granted, for all but one Medicaid and LTSS provider types. <sup>64</sup>	
✗	While the average wait time for an initial dental appointment was 13 calendar days and within MDHHS’ appointment wait time standard of eight weeks, only 83.5 percent of members were offered an appointment within the wait time standard. Further, only 68.3 percent of dental providers included in the secret shopper activity confirmed accepting new patients and only 62.3 percent offered an appointment. <sup>64</sup>	
✗	During the process of generating sample cases for the EDV review, HSAG encountered significant challenges with the completeness and accuracy of provider information within the MDHHS encounter data. Specifically, the data often lacked fully populated NPIs, which are crucial for accurately identifying providers that met the criteria for a specific service category. Additionally, the encounter data did not include detailed provider taxonomy codes that are vital for determining the eligibility of providers for specific services relevant for the review. The lack of detailed taxonomy information hindered HSAG’s ability to categorize and analyze data based on provider specialty and service type. <sup>64</sup>	
Goal #2—Strengthen person and family-centered approaches		
—	<b>CQS Objective 2.1:</b> The EQR activities do not produce data to assess the impact of the <i>MI2.3 Members with documented discussions of care goals</i> quality measures under this objective.	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
m	<b>CQS Objective 2.1:</b> The MI Health Link program made minimal progress towards reaching the statewide 2026 performance target to achieve 1.5 for the <i>Core 9.3 Minimizing Facility Length of Stay—Ratio of Observed to Expected Discharge Rates</i> quality measure. Five of the six ICOs achieved the target; however, three ICOs demonstrated a decrease in performance from the prior year.	
—	<b>CQS Objective 2.1:</b> The EQR activities do not produce data to assess the impact of the <i>PM17 Number and percent of enrollee IICSPs that are updated as the enrollee's needs change</i> quality measure under this objective.	
—	<b>CQS Objective 2.2:</b> The EQR activities do not produce data to assess the impact of the <i>SNS-E Social Needs Screening &amp; Intervention</i> quality measure under this objective.	
Goal #3—Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)		
✓	<b>CQS Objective 3.1:</b> The MI Health Link program reached the statewide 2026 performance target to achieve 56 percent for the <i>FUH—Follow-Up After Hospitalization for Mental Illness (30 Days)</i> quality measure. The MI Health Link program rate was 58.83 percent.	<input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
✓	<b>CQS Objective 3.2:</b> The MI Health Link program made progress towards reaching the statewide 2026 performance target to achieve 65 percent for the <i>MI2.6 Timely transmission of care transition record to health care professional</i> quality measure. One ICO achieved the target, while four additional ICOs demonstrated improvement from the prior year with rates increasing between 8 and 26 percentage points.	



Performance Impact on Goals and Objectives <sup>63</sup>		Performance Domain
<b>Goal #4—Reduce racial and ethnic disparities in healthcare and health outcomes</b>		
✓	<b>CQS Objective 4.1:</b> The MI Health Link program made progress towards reaching the statewide 2026 performance target to achieve a statistically significant reduction in disparity for the <i>Aetna—Comprehensive Diabetes Care—HbA1cTest: Decreasing the Disparity Between White and African American Members</i> quality measure. While the disparity was not eliminated, the ICO demonstrated statistically significant improvement over the baseline performance for the disparate population during second remeasurement period.	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access
✓	<b>CQS Objective 4.1:</b> The MI Health Link program made progress towards reaching the statewide 2026 performance target to achieve a statistically significant reduction in disparity for the <i>HCS—Reducing Controlling Blood Pressure Disparity Between Black/African American and White/Caucasian Members</i> quality measure. The disparate subgroup sustained statistically significant improvement over the baseline performance for the second remeasurement period and the state-specific goal of eliminating the existing disparity was achieved.	
✓	<b>CQS Objective 4.1:</b> The MI Health Link program made progress towards reaching the statewide 2026 performance target to achieve a statistically significant reduction in disparity for the <i>Molina—Addressing Disparities in Controlling High Blood Pressure Between Black/African American and White Members</i> quality measure. The ICO sustained statistically significant improvement over the baseline performance for both performance indicators during the second remeasurement period and eliminated the existing disparity between the two subgroups.	
✗	<b>CQS Objective 4.1:</b> The MI Health Link program made progress towards reaching the statewide 2026 performance target to achieve a statistically significant reduction in disparity for the <i>AmeriHealth—Transitions of Care, Medication Reconciliation Post-Discharge: Black/African American vs White</i> quality measure. The ICO did not eliminate the disparity and demonstrated statistically significant declines in performance as compared to the baseline rate for both the disparate and comparison populations.	
✗	<b>CQS Objective 4.1:</b> The MI Health Link program did not make progress towards reaching the statewide 2026 performance target to achieve a statistically significant reduction in disparity for the <i>Meridian—Statin Therapy for Patients with Diabetes—Decreasing the Disparity Between White and African American Members</i> quality measure. The ICO did not achieve the state-specific goal of eliminating the existing disparity between the two subgroups with the second remeasurement period, and the comparison subgroup demonstrated a decline in performance as compared to the baseline	

Performance Impact on Goals and Objectives <sup>63</sup>		Performance Domain
✗	<b>CQS Objective 4.1:</b> The MI Health Link program did not make progress towards reaching the statewide 2026 performance target to achieve a statistically significant reduction in disparity for the <i>UPHP—MI 7.3 Annual Dental Visit: AI/AN (American Indian/Alaskan Native) vs White</i> quality measure. The ICO did not achieve the state-specific goal of eliminating the existing disparity between the two subgroups with the second remeasurement period, and both subgroups demonstrated declines in performance as compared to the baseline.	
<b>Goal #5—Improve quality outcomes through value-based initiatives and payment reform</b>		
–	<b>CQS Objective 5.1:</b> The CQS does not include quality measures for the MI Health Link Program under Goal #5.	<input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access
<b>Recommendations</b>		
<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 access to healthcare services furnished to MI Health Link members:</p> <ul style="list-style-type: none"> <li>Comparing applicable data elements in the ICOs’ provider and member data against external data sources will help to ensure the quality of the ICOs’ data. Enhanced data verification processes may apply to future network analyses and/or NAV activities, including, but not limited to, the following: <ul style="list-style-type: none"> <li>MDHHS may consider further defining provider categories to ensure consistency between ICOs in aligning contracted providers with the Medicaid and LTSS provider categories. For example, MDHHS may define dental care providers based on taxonomy codes or other standardized provider category and specialty designations during the enrollment process.</li> <li>MDHHS may consider comparing ICOs’ provider data to external data sources to evaluate the accuracy of each ICO’s data values for NPIs, provider service locations, and provider categories. For example, ICOs’ NPI data could be compared to the NPPES database to determine whether the ICOs’ NPI values align with active providers.</li> <li>MDHHS may consider working with the ICOs and/or its EQRO to determine how ICOs identify non-participating providers that may be available to contract with the ICO. MDHHS may utilize internally available provider data to identify instances where an ICO is missing opportunities to contract with known providers that would allow them to meet network standards.</li> <li>MDHHS may consider providing ICO-specific technical assistance aimed at improving ICO understanding of reporting expectations and data submission requirements.</li> </ul> </li> <li>Accurate and complete encounter data are critical to the success of a managed care program. MDHHS relies on the quality of encounter data submissions from the ICOs to accurately and effectively monitor and improve the program’s quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information. To address the challenges identified during the EDV activity and improve the integrity of future data analyses, HSAG proposes the following strategic recommendations: <ul style="list-style-type: none"> <li>MDHHS should mandate the inclusion of complete NPI and provider taxonomy codes in all encounter data submissions.</li> </ul> </li> </ul>		

Performance Impact on Goals and Objectives <sup>63</sup>	Performance Domain
<ul style="list-style-type: none"> <li>– Introduce robust data verification processes at the point of entry. This step will help in early detection and rectification of incomplete or inaccurate provider data, maintaining the integrity of the database.</li> <li>– Develop a centralized, easily accessible repository for provider data that can be referenced and updated regularly. This will facilitate more efficient data linkage and retrieval, improving the ease and reliability of data analysis.</li> <li>– Implement a regular review and feedback system to monitor the improvements in data quality post-implementation of these changes. This will not only help in measuring the success of the implemented strategies but also in making continuous improvements.</li> <li>• As the MI Health Link program is ending and transitioning to the MI Coordinated Health (MICH) program through contracted highly integrated dual eligible specials needs plans (HIDE-SNPs) effective January 1, 2026, HSAG recommends that MDHHS consider the results of all EQR activities conducted for the MI Health Link program when initiating future EQR activities with the MICH program.</li> <li>• As the MI Health Link program transitions to the MICH program, HSAG recommends that MDHHS review the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) Medicaid and Children’s Health Insurance Program Managed Care Access, Finance, and Quality Final Rule (CMS-2439-F) and ensure its contract with the HIDE-SNPs meet all applicable future regulations (e.g., seven calendar day service authorization time frame, public reporting of prior authorization metrics, maximum appointment wait time standards).</li> </ul>	

## Appendix A. External Quality Review Activity Methodologies

### Methods for Conducting EQR Activities

#### *Validation of Quality Improvement Projects*

##### Activity Objectives

Validating QIPs is one of the mandatory EQR activities described at 42 CFR §438.330(b)(1).<sup>65</sup> In accordance with 42 CFR §438.330(d), ICOs are required to have a comprehensive QAPI program, which includes QIPs that focus on both clinical and nonclinical areas. Each QIP must involve:

- Measuring performance using objective quality indicators.
- Implementing system interventions to achieve quality improvement.
- Evaluating effectiveness of the interventions.
- Planning and initiating activities for increasing and sustaining improvement.

The EQR technical report must include information on the validation of QIPs required by the State and underway during the preceding 12 months.

The primary objective of QIP validation is to determine the ICO's compliance with the requirements of 42 CFR §438.330(d). HSAG's evaluation of the QIP includes two key components of the quality improvement process:

1. HSAG evaluates the technical structure of the QIP to ensure that the ICO designs, conducts, and reports the QIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the QIP design (e.g., study question, population, indicator[s], sampling techniques, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported QIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the QIP. Once designed, an ICO's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, identification of causes and barriers, and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the ICO improves its rates through implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results).

---

<sup>65</sup> MCEs that participate in Medicare and/or Medicaid are required by regulation to develop and implement QIPs/PIPs. Medicare plans are required to conduct and report on QIPs, and Medicaid plans are required to conduct and report on PIPs. Because both Medicare and Medicaid plans are referenced in this report, QIPs and PIPs will be referenced throughout the report.

The goal of HSAG's QIP validation is to ensure that MDHHS and key stakeholders can have confidence that the ICO executed a methodologically sound improvement project, and any reported improvement is related to and can be reasonably linked to the quality improvement strategies and activities conducted by the ICO during the QIP.

MDHHS requires that each ICO conduct one QIP that is validated by HSAG. For this year's SFY 2024 validation, the ICOs submitted Remeasurement 1 data for their ICO-specific QIP topics. HSAG conducted validation of the QIP Implementation (Steps 7 and 8) and Outcomes (Step 9) stages of the selected QIP topic for each ICO. The QIP topics chosen by the ICOs addressed CMS' requirements related to quality outcomes—specifically, quality and access to care and services. MDHHS requested that the ICOs implement QIPs that focus on eliminating disparities within their populations.

### Technical Methods of Data Collection and Analysis

In its QIP evaluation and validation, HSAG used the CMS EQR Protocol 1. Using this protocol, HSAG, in collaboration with MDHHS, developed the QIP Submission Form, which each ICO completed and submitted to HSAG for review and evaluation. The QIP Submission Form standardized the process for submitting information regarding QIPs and ensured all CMS EQR Protocol 1 requirements were addressed.

HSAG, with MDHHS' input and approval, developed a QIP Validation Tool to ensure uniform validation of QIPs. Using this tool, HSAG evaluated each of the QIPs according to the CMS EQR Protocol 1. The HSAG QIP review team consisted of, at a minimum, an analyst with expertise in statistics and QIP design and a clinician with expertise in quality improvement processes. The CMS EQR Protocol 1 identifies nine steps that should be validated for each QIP. For the SFY 2024 submissions, the ICOs reported Remeasurement 1 data and were validated for Steps 7 through 9 in the QIP Validation Tool.

The nine steps included in the QIP Validation Tool are listed below:

1. Review the Selected PIP Topic
2. Review the QIP 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 QIPs conducted by the ICOs to determine if a QIP is valid and to rate the percentage of compliance with CMS' protocol for conducting QIPs.

Each required step is evaluated on one or more elements that form a valid QIP. The HSAG 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 QIP process as “critical elements.” For a QIP to produce valid and reliable results, all critical elements must be *Met*.

In alignment with CMS Protocol 1, HSAG assigns two QIP validation ratings, summarizing overall QIP performance. One validation rating reflects HSAG’s confidence that the ICO adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of QIP 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 QIPs that have progressed to the Outcomes stage (Step 9) and reflects HSAG’s confidence that the QIP’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:

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 ICOs had the opportunity to receive initial QIP validation scores, request additional technical assistance from HSAG, make any necessary corrections, and resubmit the QIP for final validation. HSAG conducted a final validation for any resubmitted QIPs and documented the findings and recommendations for each QIP. Upon completion of the final validation, HSAG prepared a report of its findings and recommendations for each ICO. These reports, which complied with 42 CFR §438.364, were provided to MDHHS and the ICOs.

### Description of Data Obtained and Related Time Period

For SFY 2024, the ICOs submitted Remeasurement 2 data for their QIP topic. The performance indicator measurement period dates for the QIP are listed in Table A-1.

**Table A-1—Description of Data Obtained and Measurement Periods**

ICO	Data Obtained	Measurement Period	Period to Which the Data Applied
<b>AET</b>	Hybrid	Remeasurement 2	SFY 2024 (CY 2023)
<b>AMI</b>	Hybrid		
<b>HCS</b>	Hybrid		
<b>MER</b>	Administrative		
<b>MOL</b>	Administrative		
<b>UPP</b>	Administrative		

### Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each ICO provided to members, HSAG validated the QIPs to ensure they used a sound methodology in their design and QIP implementation. The process assesses the validation findings on the likely validity and reliability of the results by assigning a validation score of *High Confidence*, *Moderate Confidence*, *Low Confidence* or *No Confidence*. HSAG further analyzed the quantitative results (e.g., performance indicator results compared to baseline and QIP goals) and qualitative results (e.g., technical design of the QIP) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to ICO Medicaid members.

## Performance Measure Validation

### Activity Objectives

42 CFR §438.350(a) requires states that contract with ICOs to perform validation of performance measures as one of the mandatory EQR activities. The primary objectives of the PMV activities were to:

- Evaluate the accuracy of the performance measure data reported by the ICO.
- Determine the extent to which the specific performance measures reported by the ICO followed the State and federal specifications and reporting requirements.
- Identify overall strengths and areas for improvement in the PMV.

HSAG validated a set of performance measures that were selected by MDHHS for validation in SFY 2024. Table A-2 lists the performance measures calculated by the ICOs for CY 2023 (i.e., January 1, 2023, through December 31, 2023), along with the performance measure number. The performance measures are numbered as they appear in the *Medicare-Medicaid Capitated Financial Alignment Reporting Requirements*<sup>66</sup> and the *Medicare-Medicaid Capitated Financial Alignment Reporting Requirements: Michigan-Specific Reporting Requirements*<sup>67</sup> technical specification manuals.

**Table A-2—Performance Measures for Validation**

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

### Technical Methods of Data Collection and Analysis

HSAG developed the PMV protocol for ICOs in accordance with the CMS EQR Protocols. The CMS MMP Core Reporting Requirements (issued November 1, 2022, and effective as of January 1, 2023) and Michigan-Specific Reporting Requirements (issued February 29, 2024) documents provide the reporting specifications that ICOs were required to follow.

<sup>66</sup> The Centers for Medicare & Medicaid Services. *Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements*. Available at: <https://www.cms.gov/files/document/mmpcorereportingrequirements2023.pdf>. Accessed on: Mar 11, 2024.

<sup>67</sup> The Centers for Medicare & Medicaid Services. *Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Michigan-Specific Reporting Requirements*. Available at: <https://www.cms.gov/files/document/mireportingrequirements02292024.pdf>. Accessed on: Mar 11, 2024.

The CMS EQR Protocol 2 identifies key types of data that should be reviewed as part of the validation process. The list below indicates the type of data collected and how HSAG conducted an analysis of the data:

- **ISCAT**—The ICOs were required to submit a completed ISCAT that provided information on their IS; processes used for collecting, storing, and processing data; and processes used for performance measure reporting. Upon receipt by HSAG, the ISCAT(s) underwent a cursory review to ensure each section was complete and all applicable attachments were present. HSAG then thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- **Source code (programming language) for performance measures**—ICOs that reported the performance measures using computer programming language were required to submit source code for each performance measure being validated. HSAG completed line-by-line review on the supplied source code to ensure compliance with the state-defined performance measure specifications. HSAG identified areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any). ICOs that did not use computer programming language to report the performance measures were required to submit documentation describing the actions taken to report each measure.
- **Medical record documentation**—As applicable, the ICOs submitted the following documentation for review: medical record hybrid tools, training materials for MRR staff members, and policies and procedures outlining the processes for monitoring the accuracy of the reviews performed by the review staff members. HSAG did not request a convenience sample but conducted an over-read of approximately 30 records from the hybrid sample to ensure the accuracy of the hybrid data being abstracted by the ICOs. HSAG followed the CMS EQR Protocol 2 and NCQA guidelines to validate the integrity of the ICOs' MRRV processes and used the MRRV results to determine if the findings impacted the performance measure rates' audit results.
- **Performance measure reports**—HSAG also reviewed the ICOs' SFY 2023 performance measure reports. The previous year's reports were used along with the current reports to assess trending patterns and rate reasonability.
- **Supporting documentation**—The ICOs submitted documentation to HSAG that provided additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, with issues or clarifications flagged for follow-up. This additional documentation also included measure-level detail files provided for each measure for data verification.

### ***Performance Measure Activities***

HSAG conducted PMV virtually with each ICO. HSAG collected information using several methods including interviews, system demonstration, review of data output files, PSV, observation of data processing, and review of data reports. The virtual review activities are described as follows:

- **Opening session**—The opening session included introductions of the validation team and key ICO staff members involved in the PMV activities. Discussion during the session covered the review purpose, the required documentation, basic meeting logistics, and queries to be performed.
- **Evaluation of system compliance**—The evaluation included a review of the IS, focusing on the processing of enrollment and disenrollment data. Additionally, HSAG evaluated the processes used to collect and report the performance measures, including accurate numerator and denominator identification, and algorithmic compliance (which evaluated whether denominators were identified correctly, all data were combined appropriately, and numerator events were counted accurately). Based on the desk review of the ISCAT(s), HSAG conducted interviews with key ICO staff members familiar with the processing, monitoring, and reporting of the performance measures. HSAG used interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that written policies and procedures were used and followed in daily practice.
- **Overview of data integration and control procedures**—The overview included discussion and observation of source code logic, a review of how all data sources were combined, and how the analytic file used for reporting the performance measures was generated. HSAG performed PSV to further validate the output files. HSAG also reviewed any supporting documentation provided for data integration. This session addressed data control and security procedures as well.
- **PSV**—HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Each ICO provided HSAG with measure-level detail files which included the data the ICOs had reported to MDHHS. HSAG selected a random sample from the submitted data, then requested that the ICOs provide proof-of-service documents or system screen shots that allowed for validation against the source data in the system. During the pre-PMV and virtual review, these data were also reviewed for verification, both live and using screen shots in the ICOs' systems, which provided the ICOs an opportunity to explain processes regarding any exception processing or any unique, case-specific nuances that may not impact final measure reporting. Instances could exist in which a sample case is acceptable based on clarification during the virtual review and follow-up documentation provided by the ICOs. Using this technique, HSAG assessed the ICOs' processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across measures to verify that the ICOs have system documentation which supports that the measures appropriately include records for measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error and, as a result, no additional cases related to that issue may have been reviewed. In other scenarios, one case error detected may have resulted in the selection of additional cases to better examine the extent of the issue and its impact on reporting.
- **Closing conference**—The closing conference summarized preliminary findings based on the review of the ISCAT and the virtual meeting and reviewed the documentation requirements for any post-virtual review activities.

### Virtual Review Activities

- **Follow-up Documentation**—The ICOs had at least three business days after the virtual review to submit all follow-up items to HSAG. Follow-up documentation submitted by each ICO was reviewed by HSAG. This follow-up review was conducted to confirm information provided during the virtual review by the ICO. In instances when the follow-up documentation did not meet requirements to complete the validation process, additional documentation and questions were requested by HSAG, or an additional virtual review was recommended. In certain instances, ICOs had to provide multiple rounds of follow-up documentation when the prior submission failed to provide HSAG with the necessary information or data.

### Final Validation Results

Based on the validation activities described above, HSAG provided each ICO a validation designation for Core Measure 9.3, MI2.6, MI 5.6, and MI7.3. The ICO received a validation designation of either *Reportable (R)*, *Do Not Report (DNR)*, or *Not Applicable (NA)* for each performance measure. Table A-3 includes a definition of each validation designation.

**Table A-3—Measure-Specific Validation Designations**

Validation Designation	Definition
<b>REPORTABLE (R)</b>	Measure was compliant with State and federal specifications.
<b>DO NOT REPORT (DNR)</b>	ICO rate was materially biased and should not be reported.
<b>NOT APPLICABLE (NA)</b>	The ICO was not required to report the measure.

According to the protocol, the validation designation for each measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be not compliant based on the review findings. Consequently, an error for a single audit element may result in a designation of *DNR* because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, and the measure could be given a designation of *R*.

### Description of Data Obtained and Related Time Period

HSAG validated data submitted for the appropriate quarterly and CY reporting periods. The reporting periods and are specified in Table A-4.

Table A-4—Reporting Periods

Performance Measure	Reporting Period
Core Measure 9.3	CY 2023
MI2.6	CY 2023
MI5.6	CY 2023
MI7.3	CY 2023

### Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each ICO provided to members, HSAG determined results for each performance indicator and assigned each an indicator designation of *Reportable*, *Do Not Report*, or *Not Applicable*. HSAG further analyzed the qualitative results (e.g., data collection and reporting processes) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to ICO Medicaid members.

### Performance Measure Rates

#### Activity Objectives

HSAG completed a review of each ICO’s performance measure data that were audited by an organization licensed to conduct NCQA HEDIS Compliance Audits<sup>TM,68</sup> for 2023, as provided by MDHHS, for the SFY 2024 EQR.

#### Technical Methods of Data Collection and Analysis

MDHHS and CMS required each ICO to contract with an organization licensed by NCQA to conduct HEDIS Compliance Audits and undergo a full audit of its HEDIS reporting process. For this EQR technical report, HSAG reviewed HEDIS MY 2023 performance data for each ICO, as well as statewide comparison data, to assess performance in the areas of prevention and screening, respiratory conditions, cardiovascular conditions, diabetes, musculoskeletal conditions, behavioral health, medication management and care coordination, overuse/appropriateness, access/availability of care, and utilization. These data were compiled by a CMS vendor and provided to MDHHS, and subsequently to HSAG, for inclusion into this EQR.

<sup>68</sup> HEDIS Compliance Audit<sup>TM</sup> is a trademark of the National Committee for Quality Assurance (NCQA).



## Description of Data Obtained and Related Time Period

In accordance with the Three-Way Contract between CMS, MDHHS, and each ICO, HEDIS data must be reported consistent with Medicare requirements. The ICOs are required to report a combined set of core measures annually. For this EQR, HSAG reviewed HEDIS MY 2023 reported data.

## Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each ICO provided to members, HSAG analyzed the results of the ICO's HEDIS MY 2023 performance measure rates and 2023 performance levels based on comparisons to HEDIS MY 2022 performance levels and MY 2023 statewide averages to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality of, timeliness of, and access to care and services furnished to ICO Medicaid members.

## Compliance Review

### Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the ICOs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330. To complete this requirement, HSAG, through its EQRO contract with MDHHS, performed compliance reviews of the six ICOs contracted with MDHHS to deliver services to MI Health Link members.

MDHHS requires its ICOs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet federal requirements. The SFY 2024 compliance review is the third year of the three-year cycle of compliance reviews that commenced in SFY 2022. The review focuses on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance reviews for the Michigan ICOs consist of 14 program areas referred to as standards. MDHHS requested that HSAG conduct a review of the first seven standards in Year One (SFY 2022), and a review of the remaining seven standards in Year Two (SFY 2023). The Year Three (SFY 2024) review consisted of a review of the standards and elements that required a CAP during the Year One (SFY 2022) and Year Two (SFY 2023) compliance review activities. Table A-5, outlines the standards reviewed over the three-year review cycle.

Table A-5—Compliance Review Standards

Standard	Associated Federal Citation <sup>1</sup>	Year One (SFY 2022)	Year Two (SFY 2023)	Year Three (SFY 2024)
Standard I—Disenrollment: Requirements and Limitations	§438.56	✓		Comprehensive review of each element scored as <i>Not Met</i> during the SFY 2022 and SFY 2023 compliance reviews
Standard II—Member Rights and Member Information	§438.10 §438.100	✓		
Standard III—Emergency and Poststabilization Services	§438.114	✓		
Standard IV—Availability of Services	§438.206	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	✓		
Standard VI—Coordination and Continuity of Care	§438.208	✓		
Standard VII—Coverage and Authorization of Services	§438.210	✓		
Standard VIII—Provider Selection	§438.214		✓	
Standard IX—Confidentiality	§438.224		✓	
Standard X—Grievance and Appeal Systems	§438.228		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230		✓	
Standard XII—Practice Guidelines	§438.236		✓	
Standard XIII—Health Information Systems <sup>2</sup>	§438.242		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330		✓	

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

<sup>2</sup> This standard includes a comprehensive assessment of the ICO’s IS capabilities.

MDHHS and the individual ICOs use the information and findings from the compliance reviews to:

- Evaluate the quality, timeliness, and accessibility of healthcare services furnished by the ICOs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

## Technical Methods of Data Collection and Analysis

Prior to beginning the compliance review, HSAG developed data collection tools, referred to as compliance review tools, to document the review. The content of the compliance review tools was selected based on applicable federal and State regulations and laws, and the requirements set forth in the contract between MDHHS and the ICOs as they related to the scope of the review, which included a review of the ICO's implementation of its CAP for each element that received a deficiency during the SFY 2022 and SFY 2023 compliance reviews. The review processes used by HSAG to evaluate the ICOs' compliance were consistent with CMS EQR Protocol 3.

For each of the ICOs, HSAG's desk review consisted of the following activities:

### Pre-Site Review Activities:

- Collaborated with MDHHS to develop the scope of work, compliance review methodology, and compliance review tools (i.e., CAP review tool).
- Prepared and forwarded to the ICO a detailed timeline, description of the compliance review process, pre-site review information packet, a submission requirements checklist, and a post-site review documentation tracker.
- Scheduled the site review with the ICO.
- Hosted a pre-site review preparation session with all ICOs.
- Conducted a desk review of supporting documentation the ICO submitted to HSAG.
- Followed up with the ICO, as needed, based on the results of HSAG's preliminary desk review.
- Developed an agenda for the site review interview sessions and provided the agenda to the ICO to facilitate preparation for HSAG's review.

### Site Review Activities:

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- Interviewed ICO key program staff members.
- Conducted an IS review of the data systems that the ICO used in its operations, applicable to the standards under review.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

### Post-Site Review Activities:

- Conducted a review of additional documentation submitted by the ICO.
- Documented findings and assigned each element a score of *Complete* and *Not Complete* (as described below in the Data Aggregation and Analysis section) within the compliance review tool.

- Prepared an ICO-specific report detailing the findings of HSAG's review.
- Conducted a mandatory technical assistance meeting with the ICO to review any CAP element that received a score of *Not Complete*.

### Data Aggregation and Analysis:

HSAG used scores of *Complete* and *Not Complete* to indicate the degree to which the ICO's performance complied with the requirements. The scoring methodology is outlined below:

***Complete*** indicates full compliance defined as *all* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.
- Documentation, staff responses, case file documentation, and IS reviews confirm implementation of the requirement.

***Not Complete*** indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- Documentation, staff responses, case file documentation, and IS reviews do not demonstrate adequate implementation of the requirement.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any findings of *Not Complete* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

To draw conclusions about the quality, timeliness, and accessibility of care and services the ICO provided to members, HSAG aggregated and analyzed the data resulting from its desk and site review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the ICO's progress in achieving compliance with State and federal requirements.
- Scores assigned to the ICO's performance for each element that required a CAP.
- The total number of *Complete* CAPs and *Not Complete* CAPs for each standard.
- The overall number of *Complete* CAPs and *Not Complete* CAPs calculated across the standards.
- Whether the ICO was required to participate in a mandatory technical assistance meeting.
- Documented recommendations for program enhancement, when applicable.

## Corrective Action Plan Process:

HSAG created a CAP template that contained the findings and required actions for each element scored *Not Met*. When submitting its CAP to MDHHS and HSAG, the ICOs were required to use this template to propose its plan to bring all elements scored as *Not Met* into compliance with the applicable standard(s). The CAP process included the following activities:

- ICOs completed the CAP template describing the action plans to be implemented to remediate each deficient element.
- HSAG and MDHHS reviewed the ICOs’ action plans for each deficient element and assigned each element a designation of *Accepted*, *Accepted With Recommendations*, or *Not Accepted*.
- For any deficient element that received a designation of *Not Accepted*, the ICOs were required to revise the CAP until HSAG and MDHHS determined the action plan is sufficient to ensure compliance with the requirements of the element.

## Description of Data Obtained and Related Time Period

To assess the ICO’s compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the ICO, including, but not limited to:

- CAP workplans and timelines.
- Documentation supporting implementation of the CAPs (e.g., committee meeting agendas, minutes, and handouts; written policies and procedures; management/monitoring reports and audits; narrative and/or data reports across a broad range of performance and content areas).
- Examples of case file documentation for the applicable program areas and elements that required a CAP (e.g., care management, service authorization denials, grievances, appeals, credentialing, and/or delegated entities).
- IS review of the data systems that the ICO used in its operations applicable to the CAP elements under review.

HSAG obtained additional information for the compliance review through interactions, discussions, and interviews with the ICO’s key staff members. Table A-6 lists the major data sources HSAG used to determine the ICO’s performance in complying with requirements and the time period to which the data applied.

**Table A-6—Description of ICO Data Sources and Applicable Time Period**

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG’s desk review	Documentation available as of the ICO’s site review date
Information obtained through interviews	May 13, 2024, through May 20, 2024
Documentation submitted after the site review	Documentation available as of two business days after the ICO’s site review date

## Process for Drawing Conclusions

For the CAP review, to draw conclusions and provide an understanding of the strengths and weaknesses for each ICO individually, HSAG used the quantitative results (i.e., number of *Complete* and *Not Complete* elements) score calculated for each standard. As any element not achieving compliance required a formal action plan, HSAG determined each ICO's substantial strengths and weaknesses as follows:

- Strength—Any program area in which the ICO received a *Complete* score for all elements.
- Weakness—Any program area with one or more elements with a *Not Complete* 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 the ICO provided to members by determining whether each strength and weakness impacted one or more of the domains of quality, timeliness, and access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the ICO's Medicaid members.

## Network Adequacy Validation

### Activity Objectives

As guided by the CMS EQR Protocol 4, HSAG conducted the following tasks during the SFY 2024 NAV activity:

- **Defined the scope of the validation of the quantitative network adequacy standards:** HSAG obtained needed information from the State, identified and defined network adequacy indicators for validation, identified and defined provider categories subject to standards, and established a timeline for activities.<sup>69</sup>
- **Identified data sources for validation:** HSAG worked with the State and the ICOs to identify NAV-related data sources and to answer clarifying questions regarding the data sources.
- **Reviewed the information systems underlying network adequacy monitoring:** HSAG developed NAV study materials and an ISCAT, reviewed each ICO's ISCA, and assessed processes for collecting network adequacy data not addressed in the ISCA.
- **Validated network adequacy assessment data, methods, and results:** HSAG assessed the reliability and validity of each ICO's network adequacy data, methods, and results; calculated the validation ratings; and summarized the validation findings.

---

<sup>69</sup> MDHHS approved the SFY 2024 NAV workplan detailing specific tasks, responsible parties, and task deadlines in February 2024.



### ***Scope of Validation of Quantitative Network Adequacy Standards***

The purpose of the validation was to verify that the ICOs' contracted provider networks for state plan and MI Health Link waiver services (i.e., Medicaid and LTSS providers) meet MDHHS' network standards. Because the MI Health Link program serves members eligible for Medicare and Medicaid, CMS conducts NAV for MI Health Link services covered by Medicare (e.g., access to physical health providers and hospitals). HSAG's NAV was designed to complement the annual CMS validation without duplicating the provider categories validated by CMS.

HSAG's SFY 2024 NAV continued the existing annual MI Health Link NAV activities, in which each ICO submitted a region-specific electronic listing to HSAG of all providers and facilities with which the ICO had a signed contract to participate in MI Health Link.

### ***Travel Time and Distance Network Standards***

For each provider category subject to minimum time and distance network standards, HSAG assessed whether each ICO's region-specific network offered a choice of at least two providers to at least 90 percent of ICO members within a 30-mile radius<sup>70</sup> or for no more than 30 minutes based on driving under normal traffic conditions.<sup>71</sup>

HSAG used MI Health Link member data supplied by each ICO when calculating time and distance results. Member data were limited to only those individuals residing in a county covered by the ICO's MI Health Link region. To assess the network standard of a minimum of 90 percent of members within 30 miles or 30 minutes of a given provider category, HSAG calculated travel times and distances from residential addresses for each ICO's region-specific members to the service addresses for the ICO's network data for each of the following provider categories:

- Adult Day Program
- Dental (preventive and restorative)
- Eye Examinations
- Eye Wear (providers dispensing eyeglasses and contact lenses)
- Hearing Aids
- Hearing Examinations

---

<sup>70</sup> While the minimum network standards state that an ICO must ensure that members do not need to travel more than a 30-mile radius, MDHHS has instructed HSAG to assess ICOs' compliance with this standard using a standard for 30 miles of driving (roadway) distances.

<sup>71</sup> If a region does not contain an adequate number of providers to meet the travel time and distance standard, MDHHS allows the ICO to submit an exception request to HSAG. MDHHS will direct HSAG to deem the ICO compliant with the travel time and distance standard if the ICO's exception request documents that the ICO attempted to contract or hold contracts with all available providers in the region.

HSAG considered an ICO's region to have a network deficiency for these provider categories when fewer than 90 percent of the members residing in the region were within 30 miles of driving distance or 30 minutes from the nearest two providers.

### ***Capacity-Based Network Standards***

ICOs were not required to meet time and distance standards for the below provider categories, but MDHHS determined the providers still need to be within a reasonable traveling distance from members. For these provider categories, HSAG identified provider records (1) beyond a reasonable distance from region borders and (2) for which the distance to region borders could not be determined due to reporting PO Boxes in lieu of physical addresses. HSAG provided these records for MDHHS' information and applied exclusions on a case-by-case basis according to MDHHS' discretion. After MDHHS' review, HSAG assessed the ICOs' network adequacy in each region according to the established minimum network capacity standards (at least two providers located in each region for each ICO).

- Chore Services
- Environmental Modifications
- ECLS
- NEMT
- Non-Medical Transportation (waiver services only)
- Personal Care Services
- Preventive Nursing Services
- Private Duty Nursing
- Respite
- Skilled Nursing Home

For each of the following provider categories, services can be rendered from any location or can be delivered to the member from any location. Therefore, while ICOs are required to have at least two providers contracted to deliver services to MI Health Link members in each region, the contracted providers are not required to have a physical address within the region or within a reasonable distance from the region borders. HSAG proceeded with the NAV analyses, regardless of provider location, and assessed the ICOs' network adequacy in each region according to the established minimum network adequacy capacity standards (at least two providers contracted to serve members in each region for each ICO).

- Adaptive Medical Equipment and Supplies
- Assistive Technology—Devices
- Assistive Technology—Van Lifts and Tie Downs
- Fiscal Intermediary
- Home-Delivered Meals

- Medical Supplies
- Personal Emergency Response System

### Technical Methods of Data Collection

The CMS EQR Protocol 4 identifies key activities and data sources needed for NAV. The following describes the types of data collected and how HSAG conducted an analysis of these data.

#### ***Review Information Systems Underlying Network Adequacy Monitoring***

HSAG completed a desk review of the submitted ISCAT, followed by virtual interviews that included ICO network-related information systems demonstrations and discussion of data management processes described in the ISCAT submission.

HSAG conducted an ISCA using each ICO's completed ISCAT and relevant supplemental documentation to understand the processes for maintaining and updating provider data, including how the ICO tracks providers over time, across multiple office locations, and through changes in participation in the ICO's network. The ISCAT was used to assess the ability of the ICO's information systems to collect and report accurate data related to each network adequacy indicator. To do so, HSAG sought to understand the ICO's IT system architecture, file structure, information flow, data processing procedures, and completeness and accuracy of data related to current provider networks. HSAG thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.

#### ***Validate Network Adequacy Assessment Data, Methods, and Results***

##### **Validate Network Adequacy Data and Methods**

HSAG assessed data and documentation from each ICO including, but not limited to, network data files or directories, member enrollment data files, and/or provider and member handbooks. HSAG assessed all data files used for network adequacy calculation at the indicator level for validity and completeness. HSAG required each ICO to submit its methodology for calculating each indicator within the scope of the validation. HSAG identified whether the required variables were present and required each ICO to submit documentation describing the steps the ICO followed for indicator calculation.

##### **Validate Network Adequacy Results**

HSAG assessed each ICO's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its LTSS provider networks, and produce accurate results to support ICO network adequacy monitoring. HSAG validated network adequacy reporting against state-defined standards and against the most recent network monitoring reports to assess reasonability of reported indicator-level results. HSAG assessed whether the results were valid, accurate, and reliable, and whether the ICO's interpretation of the data was accurate.

HSAG conducted an independent review of the capacity-based network standards and the travel time and distance network standards. For the travel time and distance network standards, HSAG calculated the percentage of members with required access according to standards using Quest Analytics Suite software to calculate the travel time and driving distance between the addresses of specific members and the addresses of their nearest two providers for all applicable provider categories identified in the analysis. For the capacity-based network standards, HSAG calculated the number of providers that were contracted to serve members in each respective geographical area. All study results were stratified by ICO and region. HSAG's results were compared to ICO-submitted results.

### **Provide Validation Ratings for Network Adequacy Results Submitted by the ICO**

HSAG used the CMS EQR Protocol 4 Worksheet 4.6 as a guide to systematic assessment of the quality of ICO network adequacy data, methods, and results. The worksheet was completed for each network adequacy indicator for each ICO. The worksheet consisted of 10 questions regarding data collection procedures, 16 questions regarding network adequacy methods, and four questions regarding results. For each question, a "Yes" response indicated that the ICO met quality expectations, a "No" response indicated that the ICO fully or partially failed to meet expectations, and an "N/A" response indicated that the question did not apply to the ICO or the specific indicator. For each indicator, HSAG calculated a validation score equal to the number of "Yes" responses divided by the total number of "Yes" and "No" responses. Based on where the score fell within ranges defined by CMS, the ICO received a rating for the indicator of *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*.

### **Description of Data Obtained and Related Time Period**

HSAG identified the data sources needed for NAV, which included the following data and documentation from the ICOs: (1) provider and member data from the ICOs, (2) annual network monitoring reports and exception requests submitted by the ICOs, (3) ICO-submitted ISCATs and documentation, and (4) information gathered in subsequent communication and interviews with the ICOs.

### **ICO Data Request**

Following MDHHS' approval of the data requirements materials, HSAG distributed the NAV\_Data Submission Template and NAV Network Monitoring and Exception Request Template Microsoft Excel files for the ICOs' use in data compilation and submission. HSAG also supplied the ICOs with the *ICO Data Requirements* Microsoft Word document that contained instructions for the ICOs' use in preparing data files for the region-specific Medicaid and LTSS networks and members for the MI Health Link program.

### **Processing and Reviewing ICO Data Submissions**

Using an MDHHS-approved ICO Document Request and MI Health Link NAV Microsoft Excel template, each ICO submitted a region-specific electronic listing to HSAG and MDHHS of all providers and facilities that had a signed contract with the ICO to participate in MI Health Link. Each ICO also

submitted an electronic listing of all members assigned to the ICO for the specified MI Health Link region.

Upon receipt of the ICOs' region-specific provider and member data files, HSAG reviewed the files to ensure that all spreadsheet tabs were populated. HSAG collaborated with MDHHS to identify data validation checks that HSAG applied to assess the ICOs' fidelity to the data submission instructions, and potential data anomalies (e.g., invalid NPI or provider taxonomy code values).

Following the data validation checks, HSAG communicated via email with each ICO to address any questions regarding the data file that may have affected the NAV calculations (e.g., use of an incorrect data template, missing provider types, or unexpected data values) and requested a resubmission of data to meet the needs of the NAV activity, if needed.

HSAG used Quest Analytics Suite software to review addresses to ensure they could be geocoded to exact geographic locations (i.e., latitude and longitude). To facilitate geocoding, HSAG standardized member and provider address data to align with the United States Postal Service Coding Accuracy Support System (USPS CASS) to ensure consistent address formatting across data files. Geocoded member and provider addresses were assembled into datasets that were then loaded into SAS®<sup>72</sup> for deduplication and cleaning. For each ICO's records within the region and provider category, deduplication ensured that only one unique practitioner/facility combination was listed. Additionally, facilities with multiple practitioners at one physical address were counted as multiple provider choices available for the ICO's members in the region.

## Member Data

The ICOs supplied HSAG with data that listed all MI Health Link members assigned to the ICO as of March 1, 2024. These data were used to conduct geospatial analyses specific to the ICO and MI Health Link region. Key data elements included, but were not limited to, the following:

- Medicaid ID and demographic characteristics
- Residential address

All address information was required to pertain to the member's place of residence (i.e., no PO Boxes or mailing addresses).

Prior to calculating the travel time and distance results, HSAG collaborated with MDHHS to determine the extent to which the ICOs' member records were excluded from network calculations. HSAG sought MDHHS' confirmation to exclude records meeting the following criteria:

- Members not enrolled in the ICO as of March 1, 2024, or with missing enrollment start dates.

---

<sup>72</sup> 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.

- Members residing in a county not covered by the ICO's MI Health Link region.
- Member records listing PO Boxes in lieu of physical addresses.

### Provider Data

The ICOs supplied HSAG with data reflecting the 23 Medicaid and LTSS provider categories for all providers and facilities that had a signed contract with the ICO to participate in the MI Health Link program as of March 1, 2024, through at least April 1, 2024. Also, if a provider had more than one physical service location, ICOs were instructed to submit a record for each location on a separate line in the Microsoft Excel template spreadsheet.

Prior to calculating the network capacity and travel time and distance results, HSAG collaborated with MDHHS to determine the extent to which the ICOs' provider records were excluded from network calculations. HSAG sought MDHHS' confirmation to exclude records meeting the following criteria:

- For provider categories subject to travel time and distance standards, providers with service locations outside the region or state and not within a reasonable traveling distance (e.g., 30 miles).
- Provider records for select provider categories listing PO Boxes in lieu of physical addresses.
- Provider records listing a contract start date after March 1, 2024, or an end date prior to April 1, 2024.
- Provider records missing contract start and/or end dates.

### ICO-Submitted Results and Exception Requests

If an ICO's network failed to meet the minimum network standards<sup>73</sup> following the June 26, 2024, data resubmissions, HSAG worked with MDHHS to evaluate the ICOs' most recent exception requests. MDHHS provided its final exception request determinations for SFY 2024 by August 2024 for instances in which an adequate number of providers were not available to contract with the ICO in the specific region. ICOs were able to request an exception under the following circumstances:

- If no potential providers of that service type were available within the network standard
- If there was only one potential provider and the provider would not contract with the ICO
- If a potential provider did not contract with Medicare-Medicaid Plans
- If potential providers did not meet the qualifications to contract with the ICO
- If the only provider of a specific type was sanctioned and therefore ineligible to contract with the ICO
- If there was only one provider and there is no choice available

---

<sup>73</sup> For each provider type with minimum time and distance network standards, an ICO's network was deemed "deficient" if it did not provide at least 90 percent of members with a choice of at least two providers within a 30-mile radius or within 30-minutes based on driving under normal traffic conditions. For each provider type with minimum network capacity standards, an ICO's network was deemed "deficient" if it did not ensure a choice of at least two providers.



- If the ICO offered to contract with a provider/facility but the provider/facility declined or rejected the contract
  - If the ICO identified geographic limitations contributing to the network deficiency, the request was required to include the ICO's explanation regarding the nature of the limitations.

### ***ISCAT and Document Request Packet***

HSAG collaborated with MDHHS to develop an ISCAT for collecting information on and evaluating the capabilities of the ICOs' information systems infrastructure to monitor network standards in accordance with the requirements of the CMS EQR Protocol 4. The ISCAT included a list of supplemental documentation requested, such as policies and procedures and provider mapping documents.

HSAG performed an ISCA of the MI Health Link ICOs in connection with its validation of performance measure reporting and received completed ISCATs and extensive documentation from the ICOs. HSAG also conducted virtual site visits to assess data systems and methodologies. Some additional information was required to conduct the NAV activities as HSAG sent some additional questions and requests for documentation, and conducted limited additional interviews. HSAG avoided duplicating requests and submitted for MDHHS' review any additional items required for collecting information on and evaluating the capabilities of the ICOs' information systems infrastructure related to network adequacy standards. ICOs were asked to identify any additional data sources used in their assessment of network adequacy, and to provide supplemental documentation such as policies and procedures and provider mapping documents used in their assessment of network adequacy.

### **Process for Drawing Conclusions**

HSAG calculated region-specific time and distance results and capacity results for each provider category and ICO. HSAG then compared these analytic results to MDHHS' minimum network standards and identified the ICOs that failed to meet the minimum network standards. HSAG determined each ICO's substantial strengths and weaknesses by considering the degree to which the ICO met minimum network standards for its regional geographical area(s) and the exceptions or extensions determined by MDHHS.

Additionally, HSAG evaluated each ICO's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support the ICO's and MDHHS' network adequacy monitoring efforts.

HSAG used the CMS EQR Protocol 4 indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that the ICO used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators. HSAG calculated each network adequacy indicator's validation score by identifying the number of *Met* and *Not Met* elements recorded in HSAG's CMS EQR Protocol 4 Worksheet 4.6, noted in Table A-7.

Table A-7—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of <i>Met</i> elements
B. Total number of <i>Not Met</i> elements
Validation Score = $A / (A + B) \times 100\%$
Number of <i>Not Met</i> elements determined to have significant bias on the results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and whether the ICO’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. 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-8, and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table A-8—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>

If applicable, significant bias was determined based on the magnitude of errors detected and not solely based on the number of elements *Met* or *Not Met*. HSAG determined that a *Not Met* element had significant bias on the results by:

- Requesting that the ICO provide a root cause analysis of the finding.
- Working with the ICO to quantify the estimated impact of an error, omission, or other finding on the indicator calculation.
- Reviewing the root cause, proposed corrective action, timeline for corrections, and estimated impact, within HSAG’s NAV Oversight Review Committee, to determine the degree of bias.
- Finalizing a bias determination within HSAG’s NAV Oversight Review Committee based on the following threshold:

The impact biased the reported network adequacy indicator result by more than 5 percentage points; the impact resulted in a change in network adequacy compliance (i.e., the indicator result changed from

compliant to noncompliant or changed from noncompliant to compliant); or, the impact was unable to be quantified and therefore was determined to have the potential for significant bias.

## Network Validation Survey

### Activity Objectives

During March and May 2024, HSAG conducted a NVS among dental care providers contracted with one or more ICO that serve members enrolled in the MI Health Link program to ensure members have appropriate access to provider information. The NVS included a PDV and a secret shopper survey. The primary purpose of the SFY 2024 NVS was to assess the accuracy of the network information supplied to members enrolled in the MI Health Link program by comparing data obtained from three sources: the ICOs' provider data files, the ICOs' online provider directories, and telephone survey calls to sampled provider locations. As a secondary survey objective, HSAG collected appointment availability information for preventive dental visits among new patients enrolled in an ICO under the MI Health Link program. Specific survey objectives included the following:

- Determine whether dental service locations accept patients enrolled in the requested ICO and the degree to which ICO acceptance aligns with the ICO's provider data.
- Determine whether dental service locations accepting the requested ICO accept new patients and the degree to which new patient acceptance aligns with the ICO's provider data.
- Determine appointment availability at the sampled dental service locations for routine dental care visits.

### Technical Methods of Data Collection and Analysis

To address the survey objectives, HSAG conducted a secret shopper telephone survey of dental provider offices contracted with ICOs serving Regions 1, 4, 7, and 9. The secret shopper approach allows for objective data collection from healthcare providers while minimizing potential bias introduced by revealing the surveyor's identity. Secret shopper callers inquired about appointment availability for routine dental visits for Medicaid managed care members served by at least one of the participating ICOs.

Each ICO submitted dental provider data to HSAG, reflecting individual practitioners<sup>74</sup> actively enrolled with the ICO to serve members in the MI Health Link program at the time the data file was created. Out-of-state dental practitioners located in Indiana, Ohio, or Wisconsin were included in the study if they were adjacent to the demonstration region and located within a reasonable distance (i.e., within 30 minutes or 30 miles). Dental practitioners specializing in endodontics, orthodontics, oral surgery,

---

<sup>74</sup> HSAG identified dental practitioners from the ICOs' data based on provider type, specialty, and taxonomy code. Provider types and specialties indicating that the provider was a general dentist, pediatric dentist, or hygienist were included unless the corresponding taxonomy code was that of a student or dental specialist.

periodontics, or prosthodontics were excluded from the study. HSAG randomly selected survey cases by ICO from a de-duplicated list of unique provider locations.<sup>75</sup>

During the survey, HSAG's callers used an MDHHS-approved script to complete survey calls to all sampled provider locations, recording survey responses in an electronic data collection tool.

Several limitations and analytic considerations must be noted when reviewing secret shopper telephone survey results:

- The provider data submitted by the ICOs in February 2024 may have changed and subsequently been updated in the ICOs' data systems and/or online provider directories prior to HSAG's PDV reviews and secret shopper survey calls between March and May 2024.
- Reviewers conducted the directory reviews using desktop computers with high-speed Internet connections. Reviewers did not attempt to access or navigate the ICOs' online provider directories from mobile devices or using accessibility tools (e.g., software that reads the website content for users with limited eyesight). The current study cannot speak to whether the results are maintained across the different types of devices that members may use to access provider directories.
- HSAG included cases in the secret shopper survey only if those cases were found in the online directory and matched on eight key indicators in the PDV: name, address, city, state, ZIP code, telephone number, provider type/specialty, and new patient acceptance.<sup>76</sup> PDV cases that did not match on these indicators were not included in the secret shopper survey. It is unknown whether the secret shopper survey results would have been better, similar, or worse among the PDV cases that did not match on the eight key indicators described. Since this is the first year of implementation for PDV, the 2024 survey results are not comparable to previous years. Caution should be exercised when comparing the 2022 and 2023 results with the 2024 results.
- In previous years, the program and insurance questions were asked separately. If the office did not accept MI Health Link, the survey would end. For 2024, HSAG updated the script so that it would continue if the office confirmed acceptance of the ICO or MI Health Link. Due to the shift in methodology, caution should be exercised when comparing the 2022 and 2023 results with the 2024 results.
- 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 MI Health Link 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

---

<sup>75</sup> To minimize the number of repeat phone calls to providers, HSAG identified locations based on unique phone numbers. If a phone number was associated with multiple regions or addresses within a plan, HSAG randomly assigned the number to a single region, plan, and standardized address, prioritizing assignment to the least represented plans and regions.

<sup>76</sup> New patient information was not listed in the online directory for **AMI** and could only be confirmed by contacting the provider's office. Therefore, HSAG did not use the new patient acceptance indicator when identifying **AMI** cases to be included in the secret shopper survey.

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 MI Health Link 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 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).
- ICOs are responsible for ensuring that MI Health Link members have access to a provider location within MDHHS' contract standards rather than requiring that each individual provider or location offer an appointment within the specified time frame. As such, extended appointment wait times from individual provider locations should be considered within the context of the ICO's processes for assisting MI Health Link members who require timely appointments.
- ICOs may contract the provision of dental services for their MI Health Link members with a DBA, a vendor that maintains the dental provider network, processes payments, and provides member support. The ICOs are responsible for the oversight of vendors such as DBAs. Actions by an ICO's DBA may impact the timeliness and quality of dental provider data, and the ICOs' adherence to MDHHS' network standards. HSAG continued the survey if the location confirmed acceptance of the ICO or the affiliated DBA.

**MDHHS CAP Requirements**—Based on the survey's findings, the ICOs were required to develop and implement remediations for all identified PDV and secret shopper survey deficiencies and/or the offered appointment's wait time exceeded the contractual Appointment and Timely Access to Care Standard for a new patient routine appointment (Three-Way Contract: 2.7.1.7 Exhibit 4). The ICOs were required to review the case-level analytic data file provided by MDHHS. At a minimum, the remediation plan was expected to include the following:

- The ICO must identify a plan and remediation steps to ensure all provider information will be accurate in the provider directory.
- The ICO must correct provider data deficiencies identified during the survey (e.g., incorrect or disconnected telephone number, incorrect address, listing non-medical facility, medical facility that does not provide dental services, etc.).
- The ICO must evaluate the effectiveness of previous remediations and make appropriate modifications to the interventions in a 2024 CAP:
  - The ICO must review previous CAPs and identify whether the cases/locations found deficient previously received remediations during any of the previous CAP cycles. If the location was found to be deficient previously, enter Yes in that Column. As part of the root cause analysis, evaluate why the previous intervention was not effective.

- The interventions must be based on root causes of the deficiency specific to each case/location. Specific root causes identified during the investigation of each location’s deficiency must be listed. The interventions taken to remediate the deficiency must be listed and the ICO must make sure that the intervention is appropriate to address the specific non-compliance.
- Many locations did not offer an appointment during the secret shopper survey, which limits MDHHS’ understanding of the true median wait time. During the CAP process, the ICO must collect wait times for routine appointments for a new ICO/MI Health Link member for ALL locations that did not offer an appointment during the survey or that offered a wait time exceeding the Appointment and Timely Access to Care Standards. The ICO must calculate and enter the number of calendar days between when the information was collected and when the appointment was offered.
- ICO must provide MDHHS with evidence of training offered to dental providers’ offices regarding the ICO plan name, MI Health Link program, and benefit coverage.
  - Evidence should demonstrate that all office staff scheduling appointments have been educated on the ICO name and benefit coverage and the offices have a plan in place for educating new staff in the event of staff turnover.
- If the ICO delegates the CAP to its DBA, the ICO must assign a staff member to oversee the CAP, including review of any documents submitted to MDHHS for completeness and accuracy as well as appropriateness of the intervention(s) to remediate the deficiency based on the specific root cause for each case/location.

The CAP implementation involved the completion of the CAP report, which was due by November 19, 2024.

### Description of Data Obtained and Related Time Period

HSAG completed the survey calls during March and May 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 ICO provided to members, HSAG analyzed the results of the activity to determine each ICO’s substantial strengths and weaknesses by assessing (1) which dental service locations accepted patients enrolled with the requested ICO for the MI Health Link program and the degree to which ICO and MI Health Link acceptance aligned with the ICOs’ provider data, (2) whether dental service locations accepting MI Health Link for the requested ICO accepted new patients and the degree to which new patient acceptance aligned with the ICOs’ provider data, and (3) appointment availability with the sampled dental service locations for preventive dental visits.



## Encounter Data Validation

### Activity Objectives

Accurate and complete encounter data are critical to the success of a managed care program. State Medicaid agencies rely on the quality of encounter data submissions from contracted 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 six MI Health Link ICOs:

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

The study aimed to verify whether key data elements in the encounter data were supported by the information found in the service records and IICSP documents. The goal was to answer the following questions:

- Are the data elements in the encounters complete and accurate compared to the information in the service records?
- Are the services documented in the IICSP supported by the service records, including authorization dates, scheduled services, units of service, and service providers?

### Technical Methods of Data Collection and Analysis

The technical methodology for data collection and analysis for the EDV activity involved several key components:

- **Service Records and IICSP Documentation:** MDHHS identified key service categories for review ensuring the accuracy of encounter data through comparisons with provider-documented service records. For members receiving personal care services, IICSP documents were reviewed to validate authorization dates, scheduled services, and providers.

Table A-9 outlines these service categories along with associated provider-documented information, providing support for the information reported within the encounter data.

**Table A-9—Service Categories and Supporting Documentation**

Supporting Documentation	Dental	Hearing and Vision	Non-Emergency Medical Transportation (NEMT)	Personal Care Services
Medical record		✓		
Dental record	✓			
Service record				✓
Transportation record			✓	
IICSP				✓

Table A-10 outlines the key data elements evaluated during the review of supporting documentation associated with each service category.

**Table A-10—Key Data Elements for Service Record Review**

Key Data Element	Dental	Hearing and Vision	NEMT	Personal Care Services
Date of Service	✓	✓	✓	✓
Diagnosis Code		✓		✓
Current Dental Terminology (CDT)/Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) Code(s)	✓	✓	✓	✓
Procedure Code Modifier		✓	✓	✓
Units			✓	

- Eligible Population Identification and Sampling:** HSAG identified eligible members continuously enrolled in the ICO during the review period and generated a sample of members based on this eligibility. A two-stage sampling technique was employed to ensure each member's record was selected only once and to ensure proportional representation of targeted service categories. HSAG first identified eligible members and then randomly selected 411 members per ICO using the SURVEYSELECT procedure in SAS®. For each sampled member, one Medicaid-covered service category visit during the review period (October 1, 2022, to September 30, 2023) was selected. Additionally, for all service categories, except for members selected for personal care services, HSAG reviewed a second date of service, if applicable.
- Service Record and IICSP Document Procurement:** Each ICO procured service records from contracted providers and submitted associated IICSP documents to HSAG through a secure data

exchange platform. To improve procurement rates, HSAG conducted a technical assistance session to guide the ICOs 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 service record. For any discrepancies, reviewers documented omissions or inaccuracies. The reviewers also compared the services reported in the encounter data to the IICSP documents to evaluate support by the plans of care.
- **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-11 displays the review indicators that were used to report the service record review results. In addition to the service-related review indicators, based on reviews of the IICSP documents, findings that included an evaluation of whether the services documented for the selected dates of service were supported by the plans of care were presented.

**Table A-11—Service Record Review Indicators**

Review Indicator	Denominator	Numerator
<b>Record Procurement Rate:</b> Percentage of service records submitted. Additionally, the reasons for missing service records were presented.	Total number of requested sample cases.	Number of requested sample cases with service records submitted for either the sampled date of service or the second date of service.
<b>Second Date of Service Submission Rate:</b> Percentage of sample cases with a second date of service submitted in the service records.	Number of sample cases with service records submitted.	Number of sample cases with a second date of service submitted in the service records.
<b>Record/Documentation Omission Rate:</b> Percentage of data elements (e.g., <i>Date of Service</i> ) identified in MDHHS’ data warehouse that are not found in the members’ service records. HSAG calculated the review indicator for each data element listed in Table A-10.	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 service records.

Review Indicator	Denominator	Numerator
<b>Encounter Data Omission Rate:</b> Percentage of data elements (e.g., <i>Date of Service</i> ) identified in members' service records, but not found in MDHHS' data warehouse. HSAG calculated the review indicator for each data element listed in Table A-10.	Total number of data elements (e.g., <i>Date of Service</i> ) identified in members' service records (i.e., based on the service 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.
<b>Diagnosis Code Accuracy:</b> Percentage of diagnosis codes supported by the service 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"> <li>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 service records.</li> <li>Diagnosis codes present for both MDHHS' encounter data and the service records.</li> </ul>	Number of diagnosis codes supported by the service records.
<b>Procedure Code Accuracy:</b> Percentage of procedure codes supported by the service 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"> <li>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 service records.</li> <li>Procedure codes present for both MDHHS' encounter data and the service records.</li> </ul>	Number of procedure codes supported by the service records.
<b>Procedure Code Modifier Accuracy:</b> Percentage of procedure code modifiers supported by the service records.	Total number of procedure code modifiers that met the following two criteria: <ul style="list-style-type: none"> <li>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 service records.</li> <li>Procedure code modifiers present for both MDHHS' encounter data and the service records.</li> </ul>	Number of procedure code modifiers supported by the service records.

Review Indicator	Denominator	Numerator
<b>Units Accuracy</b>	<p>Total number of units that met the following two criteria:</p> <ul style="list-style-type: none"> <li>For dates of service (i.e., including both sample dates of service and the second dates of service) that exist in both MDHHS' encounter data and the service records.</li> <li>Units present for both MDHHS' encounter data and the service records.</li> </ul>	Number of units supported by the service records.
<b>All-Element Accuracy Rate:</b> Percentage of dates of service present in both MDHHS' encounter data and the service records, with the same values for all data elements listed in Table A-10.	<p>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 service records.</p>	<p>The number of dates of service in the denominator with the same diagnosis codes, procedure codes, procedure code modifiers, and units for a given date of service.</p>

### 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 ICOs included:

- Service records for services rendered from October 1, 2022, through September 30, 2023.
- IICSP documentation associated with the sampled member for the review period, October 1, 2022, through September 30, 2023.

## Process for Drawing Conclusions

To draw conclusions about the encounter data completeness and accuracy between each ICO's service records, IICSP documentation, and the 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, service records, and IICSP documentation. This approach provided a comparative framework that enabled a thorough assessment of each ICO's performance. HSAG determined each ICO'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 ICOs.
- **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 goal of the HCBS CAHPS Survey is to gather direct feedback from MI Health Link HCBS C-waiver program members receiving HCBS about their experiences and the quality of the LTSS they receive. The survey provides state Medicaid agencies with standard individual experience metrics for HCBS programs that are applicable to all populations served by these programs, including frail elderly and people with one or more disabilities, such as physical disabilities, cognitive disabilities, intellectual impairments, or disabilities due to mental illness.

### Technical Methods of Data Collection and Analysis

The technical method of data collection was through administration of the HCBS CAHPS Survey. The method of data collection for the surveys was via computer-assisted telephone interviewing (CATI). Members could complete the survey over the telephone in either English or Spanish. Prior to survey administration, a pre-notification letter was sent out to members alerting them to expect a telephone call to complete the survey, and assured members that the survey was sponsored by the federal government and endorsed by MDHHS. For the HCBS CAHPS Survey, HSAG sampled MI Health Link adult



members who were enrolled in the HCBS C-waiver program at any time during the measurement period (i.e., November 18, 2023, to March 17, 2024) and receiving at least one qualifying service.<sup>77</sup>

The survey questions were categorized into various measures of member experience. The survey included 96 core questions that yielded 19 measures. These measures included three global ratings, seven composite measures, three recommendation measures, five unmet need measures, and one physical safety measure. The global ratings reflect overall member experience with the personal assistance and behavioral health staff, homemaker, and case manager. The composite measures are sets of questions grouped together to address different aspects of care (e.g., *Helpful Case Manager* or *Personal Safety and Respect*). The recommendation measures evaluate whether a member would recommend their personal assistance and behavioral health staff, homemaker, or case manager to family and friends. The unmet need measures assess whether certain needs are not being met due to lack of staff. The physical safety measure evaluates whether any staff hit or hurt the member.

### Description of Data Obtained and Related Time Period

The survey was administered to eligible adult members in the MI Health Link ICOs from June to July 2024.

### Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each ICO provided to members, HSAG evaluated the top-box scores for each measure assigned to one or more of these three domains depicted in Table A-12.<sup>78</sup>

Top-box scores represent the percentage of eligible respondents who answered with the most positive response. Top-box responses were defined as follows:

- “9” or “10” for the standard global rating response or “Excellent” for the alternative response option.
- “Always,” “Yes,” or “All” for the standard composite rating response, or “Mostly yes” for the alternative response option.
- “Definitely yes” for the standard recommendation rating response.
- “Yes” for Question 27 in the *No Unmet Need in Toileting* measure.

---

<sup>77</sup> The eligible criteria for the 2022 surveys were different than the 2023 and 2024 surveys. In 2022, the eligible population included all MI Health Link program members receiving at least one qualifying personal care service or enrolled in the MI Health Link HCBS C-waiver program. In 2023 and 2024, the eligible population was limited to only the MI Health Link HCBS C-waiver program members receiving qualifying services. Caution should be exercised when comparing 2022 results to the 2023 and 2024 results.

<sup>78</sup> HSAG recalculated the 2022 mean scores to top-box scores for HCBS CAHPS Database benchmark comparability; therefore, the 2022 results in this report will not match previous reports.

For reverse coded response options, the top-box responses were defined as follows:

- “No” for the standard physical safety rating response and standard unmet need measures response, Question 65 and Question 68 in the *Personal Safety and Respect* composite measure, and Question 79 in the *Planning Your Time and Activities* composite measure.
- “Never” or “Mostly no” for Question 29 and Question 42 in the *Staff Listen and Communicate Well* composite measure.

HSAG performed significance testing to determine whether results in 2024 were statistically significantly different from results in 2023 and 2022, and the 2024 HCBS CAHPS Database benchmarks.<sup>79</sup>

**Table A-12—Assignment of HCBS CAHPS Measures to the Quality, Timeliness, and Access Domains**

HCBS CAHPS Measure	Quality	Timeliness	Access
<b>Global Ratings</b>			
<i>Rating of Personal Assistance and Behavioral Health Staff</i>	✓		
<i>Rating of Homemaker</i>	✓		
<i>Rating of Case Manager</i>	✓		
<b>Composite Measures</b>			
<i>Reliable and Helpful Staff</i>	✓	✓	
<i>Staff Listen and Communicate Well</i>	✓		
<i>Helpful Case Manager</i>	✓		
<i>Choosing the Services that Matter to You</i>	✓		✓
<i>Transportation to Medical Appointments</i>	✓	✓	✓
<i>Personal Safety and Respect</i>	✓		
<i>Planning Your Time and Activities</i>			✓
<b>Recommendation Measures</b>			
<i>Recommend Personal Assistance/Behavioral Health Staff</i>	✓		
<i>Recommend Homemaker</i>	✓		
<i>Recommend Case Manager</i>	✓		
<b>Unmet Need Measures</b>			
<i>No Unmet Need in Dressing/Bathing</i>	✓		✓
<i>No Unmet Need in Meal Preparation/Eating</i>	✓		✓
<i>No Unmet Need in Medication Administration</i>	✓	✓	✓

<sup>79</sup> The 2024 HCBS CAHPS Database benchmarks represent survey data collected from January 1 to December 31, 2022. Caution should be exercised when comparing the 2024 HCBS CAHPS Database benchmarks to the MI Health Link Program 2024 results, which represent survey data collected from June 4 to July 30, 2024.

HCBS CAHPS Measure	Quality	Timeliness	Access
<i>No Unmet Need in Toileting</i>	✓		✓
<i>No Unmet Need with Household Tasks</i>	✓		✓
<b>Physical Safety Measure</b>			
<i>Not Hit or Hurt by Staff</i>	✓		

## MI SFY 2024 Technical Report: Erratum Notice Integrated Care Organizations (ICOs)

### 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 Integrated Care Organization Performance**
  - Table 3-21—EDV Results for **Aetna Better Health Premier Plan (AET)**
  - Table 3-101—EDV Results for **Upper Peninsula Health Plan MI Health Link (UPP)**
- **Section 5: Integrated Care Organization Comparative Information**
  - Table 5-12—EDV ICO Comparison: Procurement and Completeness
  - Table 5-13—EDV ICO Comparison: Element Accuracy and IICSP Document Review

The following replacement tables reflect updated values based on a revised review of the service record and corresponding encounter data. The corrections do not impact the overall conclusions of the report.

Replacement Table 3-21—EDV Results for AET

Analysis	Key Findings
<b>Record Procurement Status</b>	
Service Record Procurement Rate	<ul style="list-style-type: none"> <li>The overall service record procurement rate was notably low at <b>77.4 percent</b>, indicating that more than 20 percent of the requested records were not procured and submitted.</li> <li>Of the service records not submitted, <b>77.4 percent</b> were not submitted due to non-responsive providers or provider did not respond in a timely manner.</li> <li>Submission rates varied across different service categories within <b>AET</b>, ranging from <b>64.9 percent</b> (i.e., Dental) to <b>100 percent</b> (i.e., Hearing).</li> </ul>
Second Date of Service Submission Rate	<ul style="list-style-type: none"> <li>Among the procured service records, <b>32.7 percent</b> included a corresponding second date of service. The submission rates for a second date of service varied across different service categories within <b>AET</b>, ranging from <b>0 percent</b> (i.e., NEMT) to <b>68.7 percent</b> (i.e., Dental).</li> </ul>
IICSP Document Procurement Rate	<ul style="list-style-type: none"> <li>All requested IICSP documents (<b>100 percent</b>) were submitted for review.</li> </ul>
<b>Encounter Data Completeness</b>	
Service Record Omission Rate	<ul style="list-style-type: none"> <li>The overall service record omission rate for <i>Date of Service</i> was high at <b>20.3 percent</b>. Rates varied by service category, ranging from <b>0 percent</b> (i.e., Hearing) to <b>28.2 percent</b> (i.e., Dental).</li> <li>The overall service record omission rate for <i>Diagnosis Code</i> was moderately high at <b>11.9 percent</b>, with variations across service categories, ranging from <b>0 percent</b> (i.e., Hearing) to <b>14.3 percent</b> (i.e., Personal Care Service).</li> <li>The overall service record omission rate for <i>Procedure Code</i> was high at <b>19.6<sup>+</sup> percent</b>. Rate varied by service category, ranging from <b>5.3 percent</b> (i.e., Vision) to <b>33.3 percent</b> (i.e., NEMT).</li> <li>The overall service record omission rate for <i>Procedure Code Modifier</i> was <b>7.7 percent</b>. Rate varied by service category, ranging from <b>4.3 percent</b> (i.e., Vision) to <b>33.3 percent</b> (i.e., NEMT).</li> <li>The service record omission rate for <i>Units</i> was high at <b>33.3 percent</b> for NEMT; however, the denominator for this data element was small, indicating limited data points that may affect interpretation.</li> <li>Higher rates of service record omission suggest that the data elements in the encounter data were not adequately supported by the members' service records.</li> </ul>

Analysis	Key Findings
Encounter Data Omission Rate	<ul style="list-style-type: none"> <li>Across all key data elements, encounter data omission rates were generally low, with the <i>Date of Service</i> having the highest encounter data omission rate at <b>6.2 percent</b>.</li> </ul>
<b>Encounter Data Accuracy</b>	
Diagnosis Code Rate	<ul style="list-style-type: none"> <li>The <i>Diagnosis Codes</i> were accurate in <b>100 percent</b> of instances where <i>Diagnosis Codes</i> were present in both the service records and encounter data.</li> </ul>
Procedure Code Rate	<ul style="list-style-type: none"> <li>The <i>Procedure Codes</i> were accurate in <b>99.2 percent</b> of instances where <i>Procedure Codes</i> were present in both the service records and encounter data.</li> <li>The accuracy rate for Dental was at <b>98.1 percent</b>, while all other service categories reached <b>100 percent</b> accuracy for <i>Procedure Codes</i>.</li> </ul>
Procedure Code Modifier Rate	<ul style="list-style-type: none"> <li>The <i>Procedure Code Modifiers</i> were accurate in <b>100 percent</b> of instances where <i>Procedure Code Modifiers</i> were present in both the service records and encounter data.</li> </ul>
Units Rate	<ul style="list-style-type: none"> <li>The <i>Units</i> were accurate in <b>100 percent</b> of instances where <i>Units</i> were present in both the service records and encounter data.</li> </ul>
All-Element Rate	<ul style="list-style-type: none"> <li>Dates of service with accurate values for all key data elements relevant to their respective service categories (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, <i>Procedure Code Modifier</i>, and <i>Units</i>) were observed in <b>89.5<sup>+</sup> percent</b> of the dates of service present in both data sources (i.e., encounter data and service records).</li> </ul>
<b>IICSP Review</b>	
Document Review	<ul style="list-style-type: none"> <li>The percentage of valid IICSP documents with proper signatures was very low at <b>14.3 percent</b>, which largely prevented the assessment of subsequent items requiring signature verification.</li> </ul>

Note: Rates in green font<sup>+</sup> indicate a change in the calculated rate.



Replacement Table 3-101—EDV Results for UPP

Analysis	Key Findings
<b>Record Procurement Status</b>	
Service Record Procurement Rate	<ul style="list-style-type: none"> <li>The overall service record procurement rate was at <b>97.8 percent</b>, indicating that most of the requested records were procured and submitted.</li> <li>Of the service records not submitted, <b>66.7 percent</b> were not submitted due to non-responsive providers or provider did not respond in a timely manner.</li> <li>Submission rates varied across different service categories within <b>UPP</b>, ranging from <b>96.7 percent</b> (i.e., Vision) to <b>100 percent</b> (i.e., Hearing and NEMT).</li> </ul>
Second Date of Service Submission Rate	<ul style="list-style-type: none"> <li>Among the procured service records, <b>48.4 percent</b> included a corresponding second date of service. The submission rates for a second date of service varied across different service categories within <b>UPP</b>, ranging from <b>29.3 percent</b> (i.e., Vision) to <b>58.6 percent</b> (i.e., Hearing).</li> </ul>
IICSP Document Procurement Rate	<ul style="list-style-type: none"> <li>A total of <b>98.3 percent</b> of the requested IICSP documents were successfully submitted for review.</li> </ul>
<b>Encounter Data Completeness</b>	
Service Record Omission Rate	<ul style="list-style-type: none"> <li>The overall service record omission rate for <i>Date of Service</i> was low at <b>2.7 percent</b>. Rates varied by service category, ranging from <b>0.0 percent</b> (i.e., NEMT) to <b>10.9 percent</b> (i.e., Vision).</li> <li>The overall service record omission rate for <i>Diagnosis Code</i> was moderately high at <b>13.5 percent</b>, with variations across service categories, ranging from <b>0.0 percent</b> (i.e., Hearing) to <b>17.2 percent</b> (i.e., Vision).</li> <li>The overall service record omission rate for <i>Procedure Code</i> was at <b>5.9+ percent</b>. Rates varied by service category, ranging from <b>0.0 percent</b> (i.e., NEMT) to <b>15.5 percent</b> (i.e., Hearing).</li> <li>The overall service record omission rate for <i>Procedure Code Modifier</i> was moderately high at <b>12.5 percent</b>. Rates varied by service category, ranging from <b>3.2 percent</b> (i.e., NEMT) to <b>27.3 percent</b> (i.e., Hearing).</li> <li>The service record omission rate for <i>Units</i> was at <b>0.0 percent</b> for NEMT.</li> <li>High rates of service record omission suggest that the data elements in the encounter data were not adequately supported by the members' service records.</li> </ul>

Analysis	Key Findings
Encounter Data Omission Rate	<ul style="list-style-type: none"> <li>The overall encounter data omission rates for <i>Date of Service</i>, <i>Procedure Code</i>, <i>Procedure Code Modifier</i>, and <i>Units</i> data elements were relatively low with rates at or below 8.1 percent.</li> <li>The overall encounter data omission rate for <i>Diagnosis Code</i> was slightly elevated at <b>10.6 percent</b>, with variations across service categories ranging from <b>0.0 percent</b> (i.e., Personal Care Service) to <b>15.2 percent</b> (i.e., Hearing).</li> </ul>
<b>Encounter Data Accuracy</b>	
Diagnosis Code Rate	<ul style="list-style-type: none"> <li>The <i>Diagnosis Codes</i> were accurate in <b>100 percent</b> of instances where diagnosis codes were present in both the service records and encounter data, with all errors attributed to inaccurate coding.</li> </ul>
Procedure Code Rate	<ul style="list-style-type: none"> <li>The <i>Procedure Codes</i> were accurate in <b>99.6 percent</b> of instances where procedure codes were present in both the service records and encounter data.</li> <li>The accuracy rates for Dental and Vision were at <b>99.6 percent</b>, and <b>99.1 percent</b>, respectively, while all other service categories reached <b>100 percent</b> accuracy for procedure codes.</li> </ul>
Procedure Code Modifier Rate	<ul style="list-style-type: none"> <li>The <i>Procedure Code Modifiers</i> were accurate in <b>98.4 percent</b> of instances where procedure code modifiers were present in both the service records and encounter data.</li> </ul>
Units Rate	<ul style="list-style-type: none"> <li>The <i>Units</i> were accurate in <b>100 percent</b> of instances where units were present in both the service records and encounter data.</li> </ul>
All-Element Rate	<ul style="list-style-type: none"> <li>Dates of service with accurate values for all key data elements relevant to their respective service categories (i.e., <i>Diagnosis Code</i>, <i>Procedure Code</i>, <i>Procedure Code Modifier</i>, and <i>Units</i>) were observed in <b>91.0<sup>+</sup> percent</b> of the dates of service present in both data sources (i.e., encounter data and service records).</li> </ul>
<b>IICSP Review</b>	
Document Review	<ul style="list-style-type: none"> <li>The percentage of valid IICSP documents with proper signatures was low at <b>5.3 percent</b>, which largely prevented the assessment of subsequent items requiring signature verification.</li> </ul>

Note: Rates in green font<sup>+</sup> indicate a change in the calculated rate.

Replacement Table 5-12—EDV ICO Comparison: Procurement and Completeness

ICOs	Service Category	Record/Documentation Procurement Status		Encounter Data Completeness	
		Service Record Procurement Rate	IICSP Document Procurement Rate	Service Record Omission Rate	Encounter Data Omission Rate
AET	Dental	✗	NA	✗	✓
	Hearing	✓	NA	–	–
	Vision	✗	NA	–	✓
	NEMT	✗	NA	✗	✓
	Personal Care Service	✗	✓	✗	✓
AMI	Dental	–	NA	✓	✓
	Hearing	✓	NA	✓	✓
	Vision	–	NA	–	–
	NEMT	✗	NA	✗	✓
	Personal Care Service	✓	✓	✓	✓
HCS	Dental	✓	NA	✓	✓
	Hearing	✓	NA	✗	✓
	Vision	✓	NA	–	✓
	NEMT	✓	NA	✗	✓
	Personal Care Service	✓	✗	–	✓
MER	Dental	✗	NA	✗	–
	Hearing	✗	NA	✗	–
	Vision	✗	NA	✗	✓
	NEMT	–	NA	✗	–
	Personal Care Service	✓	✗	✗	✓
MOL	Dental	✗	NA	–	–
	Hearing	✗	NA	–	✗
	Vision	✗	NA	✗	✗
	NEMT	✓	NA	✓	✗
	Personal Care Service	✗	✓	✗	✓

ICOs	Service Category	Record/Documentation Procurement Status		Encounter Data Completeness	
		Service Record Procurement Rate	IICSP Document Procurement Rate	Service Record Omission Rate	Encounter Data Omission Rate
UPP	Dental	✓	NA	✓	✓
	Hearing	✓	NA	✗	–
	Vision	✓	NA	– <sup>+</sup>	–
	NEMT	✓	NA	✓	–
	Personal Care Service	✓	✓	✓	✓

Note: Symbols in green<sup>+</sup> indicate a change in the assessment.

✓	No or minor concerns noted.
–	Moderate concerns noted.
✗	Major concerns noted.
NA	Not applicable for non-personal care services.

Replacement Table 5-13—EDV ICO Comparison: Element Accuracy and IICSP Document Review

ICOs	Service Category	Encounter Data Accuracy		IICSP Document Review
		Diagnosis Code, Procedure Code, Procedure Code Modifier, and Units Accuracy Rates	All-Element Accuracy Rates	
AET	Dental	✓	✓	NA
	Hearing	✓	✓	NA
	Vision	✓	✓	NA
	NEMT	✓	✓	NA
	Personal Care Service	✓	✓	✗
AMI	Dental	✓	✓	NA
	Hearing	✓	✓	NA
	Vision	✓	✓	NA
	NEMT	✗	✗	NA
	Personal Care Service	✓	✓	✗

ICOs	Service Category	Encounter Data Accuracy		IICSP Document Review
		Diagnosis Code, Procedure Code, Procedure Code Modifier, and Units Accuracy Rates	All-Element Accuracy Rates	
HCS	Dental	✓	✓	NA
	Hearing	✓	✗	NA
	Vision	✓	–	NA
	NEMT	✗	✗	NA
	Personal Care Service	✓	–	✗
MER	Dental	✓	✓	NA
	Hearing	✓	✓	NA
	Vision	✓	✓	NA
	NEMT	✗	✗	NA
	Personal Care Service	✓	✓	✗
MOL	Dental	✓	✓	NA
	Hearing	✓	✓	NA
	Vision	✓	–	NA
	NEMT	✓	✓	NA
	Personal Care Service	✓	✗	✗
UPP	Dental	✓	✓	NA
	Hearing	✓	✓	NA
	Vision	✓	✓ <sup>+</sup>	NA
	NEMT	✓	✗	NA
	Personal Care Service	✓	✓	✗

Note: Symbols in green<sup>+</sup> indicate a change in the assessment.

✓	No or minor concerns noted.
–	Moderate concerns noted.
✗	Major concerns noted.
NA	Not applicable for non-personal care services.