

Michigan Department of Health and Human Services

Comprehensive Quality Strategy

2023 – 2026

Final October 2023

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The MDHHS 2023-2026 CQS was submitted to CMS in October 2023.

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Executive Summary

The Michigan Department of Health and Human Services (MDHHS) is committed to improving the health and well-being of Michigan residents. Michigan Medicaid has chosen to forge a path toward population health improvement on behalf of the individuals they serve.

Michigan has a longstanding history of implementing Medicaid managed care programs. The first managed care programs were instituted in 1996 after Michigan received a Section 1915(b) waiver to adopt full-risk capitated managed care for the majority of Medicaid beneficiaries. Under this first Section 1915 (b) waiver, Medicaid services were provided through contracted Medicaid Health Plans (MHPs) and the Comprehensive Health Care Program (CHCP) was implemented in July 1997. The program was based on a value purchasing approach driven by accountability. Since then, numerous Medicaid managed care programs and waivers have been implemented to provide high quality of care and services to Medicaid beneficiaries. In addition, many populations that were formerly voluntary or excluded are now mandatorily enrolled in managed care.

Michigan's 2023-2026 Comprehensive Quality Strategy (CQS) provides a summary of the work being done to assess and improve the quality of care and services provided and reimbursed by Michigan's Medicaid managed care programs, in accordance with State and Federal laws and regulations which follow the principles of quality measurement, monitoring, and improvement. The CQS provides the framework to accomplish the overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality across all Michigan Medicaid managed care programs.

During the last three years, MDHHS and the managed care programs have initiated processes to align program operations and strategies related to quality of care and services, data driven outcomes measurement, and address social determinants of health, health equity and disparities. The updated 2023-2026 CQS establishes a new three-year vision to further integrate managed care program priorities to implement quality monitoring and improvement strategies to ensure Medicaid beneficiary experience of care is positive, appropriate, and timely. The CQS also strives to align with the 2022 Centers for Medicare and Medicaid Services (CMS) National Quality Strategy and MDHHS Strategic Priorities Fiscal Years 2023-2027.

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.

2023-2026 CQS Goals:

- Goal #1: Ensure high quality and high levels of access to care.
- Goal #2: Strengthen person and family-centered approaches.
- Goal #3: Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external).
- Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes.
- Goal #5: Improve quality outcomes through value-based initiatives and payment reform.

During 2020-2023, Michigan's managed care programs made significant progress toward implementing strategies to improve the access, quality of care and services to Medicaid beneficiaries.

Key improvements described in the *2020-2023 CQS Effectiveness Evaluation* include:

1. Alignment of CQS Goals & Objectives with the CMS National Quality Strategy and MDHHS Strategic Priorities
2. Inclusion of Baseline Data and Target-Setting for Performance Metrics
3. Alignment of CQS Quality Goals to Measurable Objectives
4. Increased Focus on Reducing Health Disparities
5. Alignment with Michigan's 2022-2024 Social Determinants of Health (SDOH) Strategy

In response to CMS feedback on the MDHHS 2020-2023 CQS and after review of the June 2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit, the MDHHS CQS Core Team spent considerable time assessing and revising the CQS Objectives with a goal of meeting CMS quality strategy expectations and requirements. As a result, the 2020-2023 CQS Objectives were revised, and relevant performance measures were identified for each CQS Objective. **Table 2** in the **MDHHS 2020-2023 Comprehensive Quality Strategy Effectiveness Evaluation** outlines the MDHHS 2020-2023 and revised 2023-2026 CQS Goals and Objectives (Appendix B).

The successful alignment of CQS goals and objectives with established performance measures and targets reflects a new process among the Michigan Medicaid managed care programs. MDHHS and the managed care programs continue to work toward implementing data-driven approaches to identify and address racial and ethnic disparities. Challenges moving forward will include review of measurement data and trends, and the identification of opportunities for continuous quality improvement and implementation of evidence-based strategies and interventions.

MDHHS is committed to further development and integration of the Medicaid managed care programs to positively impact the care and services provided to all Medicaid populations.

Section I: INTRODUCTION AND OVERVIEW

Introduction

Michigan's 2023-2026 Comprehensive Quality Strategy (CQS) provides a summary of the work being done to assess and improve the quality of care and services provided and reimbursed by Michigan's Medicaid managed care programs, in accordance with State and Federal laws and regulations which follow the principles of quality measurement, monitoring, and improvement. The CQS provides the framework to accomplish the overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality across all Michigan Medicaid managed care programs.

Michigan's 2020-2023 CQS initiated a new process of integrating traditionally separate quality improvement goals and objectives into a common set of overarching quality strategies that encompassed all Medicaid managed care programs within the MDHHS. As a part of this process, 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 eliminate disparate outcomes.

2020-2023 CQS Goals:

- Goal #1: Ensure high quality and high levels of access to care.
- Goal #2: Strengthen person and family-centered approaches.
- Goal #3: Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external).
- Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes.
- Goal #5: Improve quality outcomes and disparity reduction through value-based initiatives and payment reform.

During the last three years, MDHHS and the managed care programs have initiated processes to align program operations and strategies related to quality of care and services, data driven outcomes measurement, and address social determinants of health, health equity and disparities. The 2023-2026 CQS establishes a new three-year vision to further integrate managed care program priorities to implement quality monitoring and improvement strategies to ensure Medicaid beneficiary experience of care is positive, appropriate, and timely.

Purpose

MDHHS developed this Comprehensive Quality Strategy (CQS) in accordance with Title 42 of the Code of Federal Regulations (42 C.F.R. 438.340(a) and 42 CFR 457.1240(e)) which outlines federal requirements to develop and maintain a Medicaid Managed Care and Children's Health Insurance Program (CHIP) comprehensive quality strategy to assess and improve the quality of health care and services provided by managed care programs in Michigan. The quality strategy's purpose, goals, objectives, assessment of performance, interventions, and annual effectiveness evaluation are detailed in this CQS.

In accordance with State and Federal laws and regulations, the CQS follows the principles of quality measurement, monitoring, and improvement which functionally aligns with MDHHS's commitment to data-driven and evidence-based quality improvement.

Vision and Strategic Priorities

MDHHS is united by a common desire to improve the health and welfare of the people of the State of Michigan and address the health-related challenges facing the state.

Michigan's CQS represents a data-driven endeavor by all Medicaid managed care programs to monitor, prioritize, and implement improvement processes that ensure timely access to high-quality services for all members across the continuum of care, including traditionally marginalized populations, regardless of managed care delivery system. The CQS defines measurable goals to assess, track and trend quality improvement efforts and outcomes for the Medicaid managed care programs while adhering to managed care regulatory requirements.

The 2023-2026 CQS incorporates each managed care program's individual accountability, population characteristics, provider network, and prescribed authorities into a common strategy with the intent of guiding the programs toward aligned goals that address equitable, quality health care and services.

Michigan's CQS emphasizes:

- health equity and Michigan Medicaid's commitment to reduce health disparities;
- quality, safety, and coordination of care delivered to special populations;
- enhanced health delivery models (e.g., patient centered medical homes, integration of medical and behavioral health and payment transformation);
- patient and community engagement; and
- effective population health management to improve prevention and treatment of chronic conditions and the leading causes of mortality.

In addition, Michigan is utilizing three foundational principles to guide implementation of the CQS to improve the quality of care and services. These principles are:

- A focus on health equity and decreasing racial and ethnic disparities;
- Addressing social determinants of health; and
- Using an integrated data-driven approach to identify quality improvement opportunities and improve outcomes.

MDHHS aligns wherever applicable with the National Quality Strategy (NQS) mandated by the Affordable Care Act of 2010, to improve the delivery of health care services, patient health outcomes, and population health. The 2020-2023 CQS was organized around the NQS three aims (better care, healthy people and communities, and affordable care) and six priorities (making care safer/reducing harm, ensuring that people and families are engaged as partners in care, promoting effective communication/coordination, promoting the most effective treatment practices, working with communities to use best practices to enable healthy living, and making care more affordable by spreading new care delivery models).^{1,2}

The MDHHS 2023-2026 CQS aligns with the 2022 CMS National Quality Strategy's eight goals which aim to promote the highest quality outcomes and safest care for all individuals and focuses on a person-centric approach as individuals' journey across the continuum of care.³

CMS 2022 National Quality Strategy Goals:⁴

1. Embed Quality into the Care Journey
2. Advance Health Equity
3. Promote Safety
4. Foster Engagement between Individuals and their Care Teams
5. Strengthen Resilience in the Health Care System
6. Embrace the Digital Age

7. Incentivize Innovation & Technology
8. Increase Alignment of Performance Metrics, Programs, Policy, and Payment

The 2023-2026 CQS also aligns with the newly developed 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.

MDHHS Strategic Priorities Fiscal Years 2023-2027:⁵

1. Public health investment
2. Racial equity
3. Address food & nutrition, housing, and other social determinants of health (SDOH)
4. Improve the behavioral health service system for children & families
5. Improve maternal-infant health & reduce outcome disparities
6. Reduce lead exposure for children
7. Reduce child maltreatment & improve rate of permanency within 12 months
8. Fully implement the Families First Preservation Services Act (FFPSA) state plan
9. Expand & simplify safety net access
10. Reduce opioid & drug related deaths
11. Ensure all administrations are managing to outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances

Table 1 outlines the 2023-2026 Comprehensive Quality Strategy Goals and Objectives.

Table 1: 2023-2026 Comprehensive Quality Strategy Goals and Objectives

MDHHS CQS Goal	MDHHS 2023-2026 CQS Objectives
1. Ensure high quality and high levels of access to care.	1.1 Monitor, track and trend the quality, timeliness and availability of care and services. 1.2 Promote prevention, treatment, services and supports to address acute and chronic conditions in at-risk populations. 1.3 Ensure services are delivered to maximize beneficiaries' health and safety.
2. Strengthen person and family-centered approaches.	2.1 Facilitate an environment where individuals and their families are empowered to make healthcare decisions that suit their unique needs and goals. 2.2 Ensure referrals are made to community resources to address SDOH needs.
3. Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external).	3.1 Support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations. 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.
4. Reduce racial and ethnic disparities in healthcare and health outcomes.	4.1 Use evidence-informed approaches to address racial and ethnic disparities and health inequity.
5. Improve quality outcomes through value-based initiatives and payment reform.	5.1 Promote value-based models that improve quality of care.

Table 2 depicts MDHHS CQS 2023-2026 Goals and Objectives alignment with the 2022 CMS National Quality Strategy and the 2023-2027 MDHHS Strategic Priorities.

Table 2: CQS Alignment with 2022 CMS National Quality Strategy & 2023-2017 MDHHS Strategic Priorities ^{3,5}

MI Medicaid CQS Goals	MDHHS 2023-2027 Strategic Priorities	CQS Objectives
Goal #1: Ensure high quality and high levels of access to care		
2022 CMS National Quality Strategy: Goal 1: Embed Quality into the Care Journey Goal 2: Advance Health Equity Goal 3: Promote Safety	<ul style="list-style-type: none">Public health investmentRacial equityAddress food and nutrition, housing, and other social determinants of health (SDOH)Improve the behavioral health service system for children and familiesImprove maternal-infant health and reduce outcome disparitiesReduce lead exposure for childrenReduce child maltreatment and improve rate of permanency within 12 monthsExpand and simplify safety net accessReduce opioid and drug related deaths	Objective 1.1: Monitor, track and trend the quality, timeliness and availability of care and services.
		Objective 1.2: Promote prevention, treatment, services and supports to address acute and chronic conditions in at-risk populations.
		Objective 1.3: Ensure services are delivered to maximize beneficiaries' health and safety.
Goal #2: Strengthen person and family-centered approaches		
2022 CMS National Quality Strategy: Goal 1: Embed Quality into the Care Journey Goal 2: Advance Health Equity Goal 4: Foster Engagement	<ul style="list-style-type: none">Racial equityAddress food and nutrition, housing, and other social determinants of healthImprove the behavioral health service system for children and familiesEnsure all administrations are managing to outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances	Objective 2.1: Facilitate an environment where individuals and their families are empowered to make healthcare decisions that suit their unique needs and goals.
		Objective 2.2: Ensure referrals are made to community resources to address social determinant of health needs.
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)		
2022 National Quality Strategy: Goal 4: Foster Engagement Goal 5: Strengthen Resiliency Goal 6: Embrace the Digital Age	<ul style="list-style-type: none">Expand and simplify safety net accessAddress food and nutrition, housing, and other social determinants of healthIntegrate services, including physical and behavioral health, and medical care with long-term support servicesFully implement the Families First Preservation Services Act (FFPSA) state planEnsure all administrations are managing to outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances	Objective 3.1: Support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations.
		Objective 3.2: Promote the use and adoption of health information technology and health information exchange to connect providers, payers, and programs to optimize patient outcomes.
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes		
2022 CMS National Quality Strategy: Goal 2: Advance Health Equity Goal 4: Foster Engagement	<ul style="list-style-type: none">Public health investmentRacial equityAddress food and nutrition, housing, and other social determinants of health (SDOH)Improve the behavioral health service system for children and familiesImprove maternal-infant health and reduce outcome disparitiesReduce lead exposure for children	Objective 4.1: Use evidence-informed approaches to address racial and ethnic disparities and health inequity.

<p>Goal 5: Strengthen Resiliency</p> <p>Goal 7: Incentivize Innovation and Technology Adoption to Drive Care Improvements</p>	<ul style="list-style-type: none"> • Reduce child maltreatment and improve rate of permanency • Fully implement the Families First Preservation Services Act (FFPSA) state plan • Expand and simplify safety net access • Reduce opioid and drug related deaths • Ensure all administrations are managing to outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances 	
Goal #5: Improve quality outcomes through value-based initiatives and payment reform.		
<p>CMS 2022 National Quality Strategy:</p> <p>Goal 7: Incentivize Innovation and Technology Adoption to Drive Care Improvements</p> <p>Goal 8: Increasing Alignment</p>	<p>Ensure all administrations are managing to outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances</p>	<p>Objective 5.1: Promote value-based payment models that improve quality of care.</p>

SCOPE

The Comprehensive Quality Strategy is applicable to all Michigan Medicaid and CHIP managed care members in all demographic groups and service areas for which the MCOs, PAHPs, and PIHPs are approved to provide Medicaid and CHIP managed care services.

Managed Care in Michigan

Michigan has a longstanding history of implementing Medicaid managed care programs. The first managed care programs were instituted in 1996 after conducting an analysis confirming increasing Medicaid expenditures were outpacing available state revenue. It was further noted that there was a lack of provider accountability for both health care delivery and medical utilization, and an absence of reliable data to measure program impact on health care quality and access. As a result, Michigan pursued and received a Section 1915(b) waiver to adopt full risk capitated managed care for the majority of Medicaid beneficiaries. Under this first Section 1915 (b)waiver, Medicaid services were provided through contracted Medicaid Health Plans (MHPs) and the Comprehensive Health Care Program (CHCP) was implemented in July 1997. The program was based on a value purchasing approach driven by accountability. Implementation activities included developing Medicaid policies to meet federal rules, creating a competitive bidding process, contracting with Medicaid managed care plans, designating a beneficiary enrollment agency, and developing processes for oversight and reporting.

Since that time, numerous Medicaid managed care programs and waivers have been implemented to provide high quality of care and services to Medicaid beneficiaries. In addition, many populations that were formerly voluntary or excluded are now mandatorily enrolled in managed care (e.g., pregnant individuals, most categories of foster children, Children’s Special Health Care Services).

As of 6/1/2023, Medicaid covers approximately 3.2 million Michigan residents. Seventy-five percent (75%) of Medicaid beneficiaries are enrolled with managed care entities.

Historically, managed care programs in Michigan were administered by the MDHHS, Medical Services Administration (MSA) and the Behavioral Health and Developmental Disabilities Administration (BHDDA). The MSA administered the Medicaid program, providing health care services to eligible Michigan residents. MSA also included the Bureau of Medicaid Long Term Care Services and Supports (LTSS) and exercised administrative discretion in the administration and supervision of the MI Choice Waiver, MI Health Link and PACE including all related policies, rules, and regulations. The BHDDA administered Medicaid Waivers for people with intellectual/developmental disabilities, mental illness, serious emotional disturbance, and it administered prevention and treatment services for substance use disorders.

Effective March 2022, MDHHS created the new Behavioral and Physical Health and Aging Services Administration (BPHASA) which combines Michigan's Medicaid office, services for aging adults and community-based services for adults with intellectual and developmental disabilities, serious mental illness, and substance use disorders under one umbrella within MDHHS. BPHASA is also the designated State Unit on Aging. The new structure integrates MDHHS teams that focus on aging and long-term care issues and allows BPHASA to develop innovative policies that benefit our state and its residents. The restructure also builds upon the administration's existing efforts to deliver services to adults with mild to moderate mental illness.⁶

In addition, the Bureau of Children's Coordinated Health Policy and Supports (BCCHPS) was created to improve and build upon the coordination and oversight of specialty behavioral health services provided to children and families.⁶ BCCHPS works in collaboration with other MDHHS administrations to improve and build upon the coordination and oversight of children's behavioral health services and policies. BCCHPS consists of three divisions to support the development and implementation of a system of care for children, youth, and their families in the public mental health system: the Office of the Advocate for Children, Youth, and Families; the Program and Grant Development and Quality Monitoring Division; and the Access Standards, Service Array, and Policy Division.⁷

Table 3 outlines the Medicaid managed care programs administered by the MDHHS and included in this Comprehensive Quality Strategy. **Appendix A** includes a complete listing and brief description of the Michigan Medicaid managed care programs.

Table 3: Michigan Medicaid Managed Care Programs

Medicaid Managed Care Program	MCP Type	Managed Care Authority (e.g., 1915b/1115)	Date Initiated	Populations Served
Comprehensive Health Care Program (CHCP)				
Medicaid Health Plans (MHPs)	MCO	1915b	July 1997	MHPs provide comprehensive health care services to low-income adults and children.
<ul style="list-style-type: none"> MICHild: Michigan's Children's Health Insurance Program (CHIP) 		1915b	January 2016	MICHild is a Medicaid program for low-income uninsured children under the age of 19.
<ul style="list-style-type: none"> Children's Special Health Care Services (CSHCS) 		Michigan Medicaid State Plan <small>CSHCS is mandated by the Michigan Public Health Code, Public Act 368 of 1978, Part 58, children and youth with special health care needs (MCL 333.5801 – 333.5879), in cooperation with the federal government under Title</small>	October 2012	CSHCS is a program within MDHHS for children and some adults with special health care needs and their families.

		V of the Social Security Act, Sec.501. [42 U.S.C. 701] (a) 1 (D) and the annual Michigan Department of Health and Human Services (MDHHS) Appropriations Act.		
<ul style="list-style-type: none"> Foster Children 		1915b	November 2010	
<ul style="list-style-type: none"> Pregnant Individuals 		1915b	October 2008	
Healthy Michigan Plan (Medicaid Expansion)	MCO	1115 Demonstration	April 2014	HMP establishes eligibility for Michigan citizens up to 133% of the federal poverty level who are otherwise not eligible for Medicaid at the time of enrollment.
Flint Medicaid Expansion (FME) Waiver	MCO	1115 Demonstration	March 2016	The waiver provides Medicaid coverage and benefits to individuals affected by the Flint Water Crisis.
MI Health Link Demonstration (Integrated Care Organizations, ICOs)	ICO	1915b & 1915c	March 2015	Persons fully eligible and enrolled in both Medicare and Medicaid who are over the age of 21 and reside in one of the four regions where the program is available.
MI Choice Waiver Program (Prepaid Ambulatory Health Plans, PAHPs)	PAHP	1915 (c) since 1992 1915 (b) since 2012	1992 (available in all counties October 1998)	The elderly or disabled adults (aged 18+) who meet the nursing facility level of care
Dental Health Programs				
<ul style="list-style-type: none"> Healthy Kids Dental (Pre-paid Ambulatory Health Plan, PAHP) 	PAHP	1915b	October 2016	The Healthy Kids Dental program provides dental services to beneficiaries under age 21.
<ul style="list-style-type: none"> Adult Dental (Medicaid Health Plans, MHPs) 	MCO	1915b	April 2023	Medicaid beneficiaries aged 21 years and older, including HMP beneficiaries and pregnant individuals who are enrolled in a Medicaid Health Plan, Integrated Care Organization or Program of All-Inclusive Care for the Elderly receive dental benefits through their Medicaid health plan.
Behavioral Health Managed Care				
Children's Behavioral Health - Bureau of Children's Coordinated Health Policy & Supports (BCCHPS)				
Adult Behavioral Health- Bureau of Specialty Behavioral Health Services (SBHS)				
<ul style="list-style-type: none"> Pre-Paid Inpatient Health Plans (PIHPs) /Community Mental Health Service Programs (CMHSPs) 	PIHP	Behavioral Health 1115 Demonstration Waiver 1915(i) SPA	April 2019 (Approval Date); October 2019 (Effective Date) September 2019 (Approval Date); October 2022 (Effective Date) April 2014	Individuals with IDD/SMI/SED/SUD

		1115 Healthy Michigan Plan	May 2016	
		Flint 1115 Waiver or Community Block Grant		
		1915(c) Habilitation Supports Waiver (HSW), Children's Waiver Program (CWP), and Children's Serious Emotional Disturbance Waiver (SEDW)	October 2019	

Additional Medicaid Populations and Programs

The CQS reflects overarching goals and aligned priorities for all managed care programs in Michigan taking into consideration each program's individual accountability, population characteristics, provider network, and prescribed authorities.

Medicaid Fee-for Service

While most of Michigan's Medicaid populations are enrolled in managed care programs, approximately twenty-five percent (25%) of the beneficiaries receive care through fee-for-service. Certain populations may voluntarily enroll (e.g., Migrants, Native Americans) or are excluded from enrollment in managed care (e.g., persons authorized to receive private duty nursing services or who are incarcerated in a city, county, state, or federal correctional facility). The BPHASA is responsible for the oversight of the fee-for-service populations.

Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) is a capitated benefit authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing for frail, elderly individuals that meet Nursing Facility Level of Care criteria. For most PACE participants (enrollees), the comprehensive service package permits them to continue living at home while receiving services rather than being institutionalized. The PACE model is centered on the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible.

In general, eligibility criteria require that individuals be age and medically qualified, meet Medicaid's Nursing Facility Level of Care eligibility criteria, live within the approved geographic area of the PACE organization, be able to live safely in the community (not residing in a nursing facility) at the time of enrollment, and not be concurrently enrolled in the MI Choice waiver program, MI Health Link, or a Health Maintenance Organization (HMO). In Michigan, services are provided through PACE organizations who operate twenty-four (24) centers in lower Michigan. (Note: PACE is not a statewide service.) The PACE service package includes all Medicare and Medicaid covered services, and other services as determined necessary by the interdisciplinary team.

Mandatory and Special Health Care Needs Populations

Since 2008, the following populations, formerly voluntary or excluded are mandatorily enrolled in managed care: pregnant individuals (effective October 1, 2008), most categories of foster children

(effective November 1, 2010), and Children's Special Health Care Services (CSHCS) (effective October 1, 2012). As of January 1, 2016, Michigan's Title XXI Children's Health Insurance Program (CHIP) population is enrolled in the Comprehensive Health Care Program (CHCP). MDHHS utilizes MIBridges data to determine program eligibility and enrollment. MIBridges is an online system where individuals can explore potential eligibility for assistance and benefits.

Defining Children and Youth with Special Health Care Needs (42 CFR §438.208 and §438.340) Children and youth with special health care needs (CYSHCN) are a diverse group of children, ranging from children with chronic conditions to those with more medically complex health issues, to children with behavioral or emotional conditions. The Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau defines the population as children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. The Children's Special Health Care Services (CSHCS) population is a subset of the CYSHCN population and includes children and some adults who are medically eligible for CSHCS. The MDHHS CSHCS Program relies on a list of specified diagnosis codes to identify persons eligible for the program. CSHCS provides coverage for medical/physical conditions, and typically does not cover behavioral or developmental conditions. The Children's Special Health Care Services (CSHCS) population has been enrolled in managed care since October 2012.

Defining Disability Status

Individuals who qualify for Medicaid must meet the designation for disability as defined by Social Security Administration (SSA) for the Supplemental Security Income (SSI) program. MDHHS defines disability as the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months.⁸

Long Term Services and Supports (LTSS)

Long Term Services and Supports (LTSS) include a variety of services and supports that help elderly individuals and individuals with disabilities meet their daily needs and improve the quality of their lives. Examples include assistance with bathing, dressing and other activities of daily living, as well as support for everyday tasks such as medication management, laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

The State authorizes the use of standardized functional assessments by approved entities to evaluate beneficiaries. Based on the results of the functional assessments, beneficiaries are provided information about LTSS programs available to them. They are then provided the opportunity to choose which LTSS program best meets their needs.

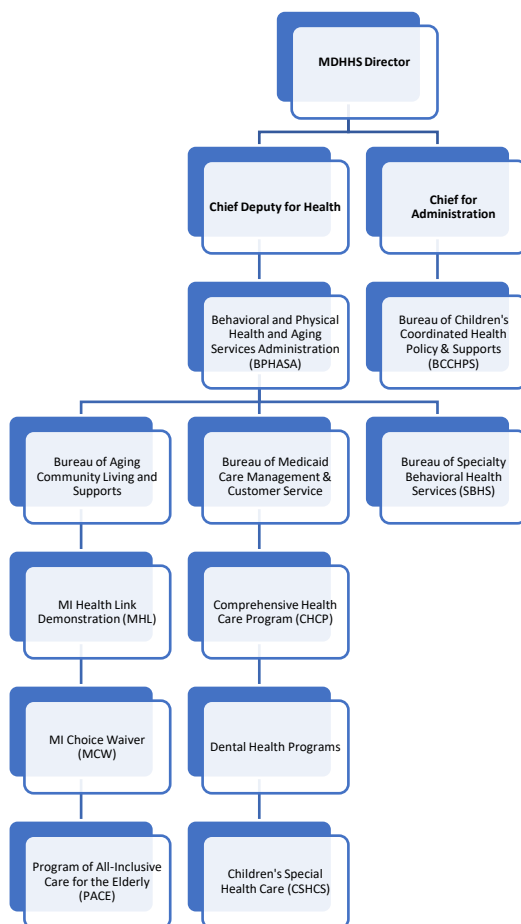
Individuals seeking Medicaid reimbursed long-term services and supports from a Medicaid-certified nursing facility, the Program of All-Inclusive Care for the Elderly (PACE), the MI Choice Waiver Program, or MI Health Link must meet the Medicaid State Agency's definition of Nursing Facility (NF) Level of Care (LOC). The criteria that determine NF LOC is outlined in the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD).⁹

MDHHS Quality Management and Organizational Structure

Managed care programs in Michigan are administered by the MDHHS, Behavioral and Physical Health and Aging Services Administration (BPHASA) which combines Michigan's Medicaid office, services for aging adults and community-based services for adults with intellectual and developmental

disabilities, serious mental illness, and substance use disorders under one umbrella within MDHHS. BPHASA is also the designated State Unit on Aging. BPHASA and the State Hospital Administration are under the direction of the Chief Deputy Director for Health who directly reports to the MDHHS Director. The Bureau of Children's Coordinated Health Policy and Supports (BCCHPS) falls under the direction of the Chief for Administration, under the MDHHS Director. Refer to Figure 1.

Figure 1: MDHHS Organizational Structure¹⁰



Medicaid managed care programs are responsible for quality improvement, program development and plan management (including contract management and compliance) with contracting agencies/organizations for providing services and care to Medicaid beneficiaries.

Stakeholder and Member Engagement

Promoting effective communication among managed care programs, providers, and stakeholders, is an essential component of Michigan's Comprehensive Quality Strategy (**CQS Goal #3**). Internal communication helps align MDHHS managed care program goals and the commitment to quality improvement processes. External stakeholder engagement provides insight into the needs of Michigan residents/beneficiaries and serves as a crucial source of information to guide the quality improvement process and provides direction for the development of quality priorities, strategies, and initiatives that positively impact health outcomes. The Medicaid beneficiary's perspective informs the Medicaid managed care programs and the CQS.

Michigan requires the CHCP Medicaid Health Plans (MHPs) to include beneficiary membership either on the organization governance board or a consumer advisory council. MHPs have indicated that members often have opportunities to comment on quality initiatives through these venues.

The MI Kids Now MDHHS initiative, directed by BCCHPS, aims to provide adequate behavioral health services and support to Early and Periodic Screening, Diagnostic and Treatment (EPSDT). The initiative will include an outreach campaign to garner parent/caregiver and youth feedback for children's specialty behavioral health services.

SBHS offers an opportunity for members to voice satisfaction through the Quality Improvement Committee (QIC), the Developmental Disability Practice Improvement Committee (DDPIT), the National Core Indicators (NCI) survey, and Consumer and Family interviews.

MI Choice uses a leadership group composed of participants and advocates and waiver agency staff to known as the MI Choice Quality Management Collaboration (QMC). The QMC provides a venue where participants, advocates and providers can review quality outcomes, identify areas that need improvement, develop strategies for remediation of service delivery, and recommend improvements. Waiver agencies are required to maintain their own local quality collaborative group and hold meetings quarterly at a minimum. Participant representatives from each waiver agency's QMC participate in the statewide QMC.

MDHHS has established committees to provide direction and oversight for the managed care programs structure and operations. Committee membership is comprised of medical and/or quality improvement representatives from contracted organization/entities (e.g., MHPs, ICOs, PIHPs, Community Mental Health Programs, LTSS providers) and senior leadership from both MDHHS and the organization/entity. In addition, membership includes health plan participants (enrollees), families, health care providers, community organizations, payors, and consumer advocates. Refer to **Table 4** for a listing of managed care program committees.

Michigan's Medicaid managed care programs are also integrated with other state operational units and programs that serve the Medicaid population, including but not limited to Medicaid Policy, MDHHS Division of Maternal and Child Health, MDHHS Housing and Homeless Services Division, the Office of Equity and Minority Health (OEMH), Department of Human Services, Michigan Department of Education/Part C/Early On, and Public Health.

Key areas of focus with active stakeholder engagement include health disparities and health equity, member experience, social determinants of health, and integration of physician and behavioral health, and long-term services and supports.

Table 4: Medicaid Managed Care Program Committees

Committee Name	Purpose/Target Population	Membership	Meeting Schedule
Comprehensive Health Care Program (CHCP)			
Medical Care Advisory Council (MCAC)	The purpose of the MCAC is to advise the MDHHS on policy issues related to Medicaid. In addition, the Council is involved with the issues of access to care, quality of care, and service delivery for managed care and fee for service programs.	The MCAC consists of members who represent consumers and consumer advocates, health care providers, and the community.	Quarterly
Medicaid Health Plan-Clinical	The MHP-CAC oversees the development and implementation of the	The MHP-CAC is comprised of medical or quality improvement	Quarterly

Advisory Committee (MHP-CAC)	Medicaid quality improvement program and serves as the primary point of prioritization and integration of quality improvement activities (e.g., HEDIS®, CAHPS®, EQR, performance bonus, performance improvement projects, and monitoring standards). The MHP-CAC assists in developing quantifiable, performance-driven objectives and performance goals addressing quality improvement priorities and addresses common areas of clinical and service delivery.	directors from each of the contracted health plans and senior leadership from both MDHHS and the plan. MDHHS representatives attend these meetings to ensure ongoing communication and interaction around Medicaid quality improvement priorities.	
Managed Care Plan Division (Medicaid Health Plans, Healthy Michigan Plan, Managed Care Dental Programs)	The Medicaid Managed Care Plan Division, MSA facilitates multiple meetings with the MHPs and dental programs including the MHP/MDHHS Operations Workgroup, Quality Improvement Directors, Care Management Directors, APM Workgroup, Enrollment Workgroup, Pharmacy Directors, and dental program workgroups. The purpose of these meetings is to address internal and external quality improvement program activities related to Medicaid contractual requirements.	Managed Care Division meetings/workgroups are comprised of MDHHS staff and representatives from the MHPs and the Michigan Association of Health Plans (MAHP).	Meeting schedules are held bi-weekly, monthly or quarterly
Children's Special Health Care Services			
CSHCS Advisory Committee (CAC)	The CAC makes recommendations and provides guidance to the CSHCS Division on program policy, effectiveness, operations, and awareness to assure that services reflect the voice of consumers, family members, and stakeholders in the system of care for CYSHCN.	CAC membership is comprised of consumers, family members, Local Health Department and health system representatives, CSHCS staff and MSA, Office of Medical Affairs (OMA) physician consultants.	Meeting schedules vary from quarterly to bi-monthly
CSHCS Local Advisory Council (CLAC)	The CLAC provides a venue for Local Health Departments (LHDs) to provide input to develop, implement, evaluate and revise components of the CSHCS program.	CLAC is comprised of Local Health Department (LHD) representatives and State CSHCS staff. The members represent various geographic areas of the state, as well as rural, urban, small and large health departments.	
MI Choice			
Statewide MI Choice Quality Management Collaborative (QMC)	The purpose of the QMC is to develop and review MI Choice quality management activities. The QMC reviews quality outcomes, identifies areas that need improvement, develops strategies for remediation of service delivery, and recommends improvements. The QMP focuses on meeting CMS assurances and requirements for protecting health and welfare of waiver participants, MDHHS contractual requirements, and targeted participant outcome improvement goals.	The QMC is comprised of MI Choice participants, family members, and advocates, along with waiver agency and MI Choice Program staff.	Meeting schedules are monthly, bi-monthly or quarterly
MI Choice Local Consumer Advisory Teams	The Consumer Advisory Teams are workgroups at local waiver agencies and at the statewide level who meet throughout the year to discuss	The Local Consumer Advisory Teams are comprised of participants and waiver agencies.	

	opportunities and program improvement.		
MI Choice Steering Committee	The Steering Committee establishes the agenda and work of the QMC. The Steering committee is charged with developing the agenda, finding presenters, conducting additional research on topics of interest, and discussing the quality indicators selected for the MI Choice Quality Strategy for the QMC meetings.	The Steering Committee includes a Chair, Vice Chair, and members from both the QMC and Local Consumer Advisory Teams.	
MI Health Link			
MI Health Link Consumer Advisory Committee	The MI Health Link Consumer Advisory Committee provides a structured mechanism for enrollees/families, stakeholders and service partners and organizations to provide input on Program implementation, quality improvement, and evaluation.	MI Health Link State Advisory Committee includes program beneficiaries and family members.	Meeting schedules may be monthly, bi-monthly or quarterly
Quality Sub-workgroup	The Quality Sub-workgroup provides opportunity for collaboration and information sharing among MDHHS, ICOs and PIHPs. The two main goals of this group are to add clarity to existing program quality metrics and to share promising practices for improving quality measure performance.	The Quality Management Workgroup comprised of BPHSA, ICOs and PIHPs provides opportunity for collaboration and information sharing among MDHHS, ICOs and PIHPs.	
Internal Data Quality Workgroup	The Internal Data Quality Workgroup examines the quality, integrity and completeness of MI Health Link program data. This workgroup helps ensure that quality measurement and assessment can be performed accurately.	The Internal Data Quality Workgroup is comprised of several sections within BPHSA.	
Program for All-Inclusive Care for the Elderly (PACE)			
PACE Directors Meetings	PACE Program oversight is conducted by both CMS and MDHHS. In 2023, PACE Directors implemented a “Best Practice” agenda item for each meeting. The sharing of best practices will assist PACE programs improve the quality and services to PACE participants.	The PACE Directors meetings include MDHHS PACE program staff and representatives from the 13 PACE organizations. PACE Contract Managers have regular contact with PACE organizations. CMS Region 5 Account Managers meet with Michigan PACE organizations which include MDHHS PACE program staff.	Meeting frequency varies from monthly, bi-monthly or quarterly
Local PACE Committees	Local PACE organizations establish committees, with community input, to: (a) Evaluate data collected pertaining to quality outcome measures. (b) Address the implementation of, and results from, the quality improvement plan. (c) Provide input related to ethical decision-making, including end-of-life issues and implement the Patient Self-Determination Act.	Local PACE organizations establish one or more committees, with community input. Participants include representatives from each PACE organization.	

Participant Advisory Committee	The PACE Participant Advisory Committee (PAC) is required by federal regulation. The PAC provides advice to the PACE governing body on matters of concern to participants. The identified concerns are shared at PACE Board meetings and discussed during scheduled CMS/State/PACE program meetings. PAC activities are monitored via CMS and State audits through a review of PAC minutes and PACE Board meeting agendas.	The Participant Advisory Committee includes participants and representatives of participants; these individuals must constitute a majority of the membership of this committee. A PACE Board member must also participate in the PAC meetings.	
Long Term Supports & Services (LTSS)			
Olmstead Coalition	The Olmstead Coalition represents all LTSS programs with a focus on improving programs and assuring beneficiaries are in the least restrictive setting of their choice.	Membership includes advocates, Waiver agencies, Area Agency on Aging (AAAs), Centers for Independent Living, Michigan Disability Rights Coalition, beneficiaries, State Long Term Care (LTC) Ombudsman, MICPOP Ombudsman and more.	Monthly
Children's Behavioral Health - Bureau of Children's Coordinated Health Policy & Supports (BCCHPS) Adult Behavioral Health- Bureau of Specialty Behavioral Health Services (SBHS)			
Quality Improvement Council (QIC)	The Quality Improvement Council directs the development and implementation of the behavioral health managed care programs and serves as the primary point of prioritization and integration of quality improvement activities.	The Quality Improvement Council includes quality and administrative staff representatives from MDHHS, the PIHPs, CMHSPs, provider organizations, quality vendors and advocacy members.	Meeting schedules may be monthly, bi-monthly or quarterly
Developmental Disability Practice Improvement Committee (DD-PIT)	The purpose of the Developmental Disabilities Practice Improvement Team (DD-PIT) is to advise MDHHS and make policy recommendations guided by promising and emerging practices that empower people with Developmental Disabilities (DD) and their families across the state of Michigan with a focus on person centered planning, self-determination, and family and youth guided principles.	Represents people served with IDD and their families. Members must be of the DD community, behavioral health system partners, people with lived experience and/or their family members.	Monthly
MI Kids Now Community Reintegration Process Interagency Team	Develop proposals to address program needs, resource development, and new initiatives to expand community-based supports.	Membership includes representation from BCCHPS, BPHASA, Field Operations Administration, Children's Services Administration, State Hospital Administration, and the Center for Health Care Strategies.	The interagency team will meet at least every other week during the initial implementation period.
MI Kids Now Community Behavioral Health Treatment and Placement Options Interagency Team	Develop proposals on new and/or expanded community treatment options for the child welfare population.	Membership includes representation from BCCHPS, BPHASA, Children's Services Administration, Financial Operations Administration, and the Center for Health Care Strategies.	The interagency team will meet at least every other week during the initial implementation period.

MI Kids Now Care Coordination Interagency Team	<p>Develop a proposal and related implementation plan for providing Care Coordination to children, youth, and families.</p> <p>Develop a plan for redesigning and expanding access to wraparound services.</p>	Membership includes representation from BCCHPS, BPHASA, Children's Services Administration, Chief Deputy for Health, State Hospital Administration, Financial Operations Administration, Policy, Planning, and Operational Support Administration, and the Center for Health Care Strategies.	The interagency team will meet weekly during the initial implementation period.
MI Kids Now Workforce Development Interagency Team	<p>Develop a proposal for the expansion of Student Loan Repayment Program for children's behavioral health providers.</p> <p>Develop a proposal for creation of internship stipend program for children's behavioral health providers.</p>	Membership includes representation from BCCHPS, BPHASA, Financial Operations Administration, Policy, Planning, and Operational Support Administration, and the Center for Health Care Strategies.	The interagency team will meet at least every other week during the initial implementation period.
MI Kids Now Intensive Crisis Stabilization Services (ICSS) Interagency Team	Develop a proposal for the implementation and monitoring of an expanded ICSS model for children, youth, and families.	Membership includes representation from BCCHPS, BPHASA, the Medical Director of Mental Health Services, Children's Services Administration, Financial Operations Administration, Policy, Planning, and Operational Support Administration, Program Management Office, and the Center for Health Care Strategies.	The interagency team will meet at least every other week during the initial implementation period.
MI Kids Now CANS (Child and Adolescent Needs and Strengths) Interagency Team	Develop the suite of MichiCANS tools and determine how they will be used across the state.	Membership includes representation from BCCHPS, Children's Services Administration, BPHASA, State Hospital Administration, Financial Operations Administration, and the Center for Health Care Strategies.	The interagency team will meet at least every other week during the initial implementation period.

Quality Assessment and Performance Improvement

MDHHS utilizes a continuous quality improvement (QI) process to monitor access to care, timeliness and quality of care, identify opportunities for improvement, and to identify and implement intervention strategies to improve outcomes and performance. The QI process follows the Institute for Healthcare Improvement Plan-Do-Study-Act (PDSA) cycle which includes evaluating the effectiveness of interventions and reassessment of performance using qualitative and quantitative data.

Figure 2: Quality Improvement Plan-Do-Study-Act (PDSA) Cycle¹¹



Comprehensive Quality Strategy Updates

MDHHS intends to review and update the CQS as needed, but no less than every three years. The review and revision process will include a formal comprehensive assessment of performance against CQS performance objectives and progress toward meeting established performance goals. In addition, the CQS will be reviewed and revised, as appropriate when “significant changes” occur. MDHHS defines a “significant change” as adding or removing CQS goals and objectives; CQS changes that trigger public comment, tribal consultation, and input from the state’s Medical Care Advisory Committee; changes in Federal Managed Care regulations; and substantive changes to the state’s managed care quality laws, regulations, Medicaid Programs, or Medicaid policy.

Quality Strategy Effectiveness Review and Evaluation

As required under 42 CFR 438.340 (c)(2) MDHHS conducted an initial Effectiveness Evaluation of the 2020-2023 Medicaid Comprehensive Quality Strategy during FY2023. **The 2020-2023 CQS Effectiveness Evaluation is appended to this 2023-2026 CQS document (Appendix B).** The Effectiveness Evaluation findings are driving program activities and priorities for the MDHHS 2023-2026 CQS.

MDHHS intends to conduct a formal comprehensive assessment of performance against CQS performance objectives annually and update the CQS as needed.

To support ongoing collaboration and continued integration of the CQS goals and objectives across the Michigan Medicaid managed care programs, an internal team of program staff under the direction of MDHHS leadership was established. The internal CQS team meets monthly to continue the visioning and integration process, and to identify opportunities for improvement and collaboration across programs. The CQS team assesses overall and individual program progress toward meeting the CQS goals and objectives against established performance goals and benchmarks based on interim program data at a plan, state, and federal level.

When evaluating the effectiveness of the CQS, MDHHS considers the recommendations provided by the state’s External Quality Review Organization (EQRO) and includes recommendations for improving the quality of health care services furnished by each MCO, PIHP, and PAHP entity. The revision process will include an assessment of CQS program target goals and objectives to support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries and describe how the CQS was updated to address the EQR findings and recommendations.

Public Comment

In compliance with federal and state public comment requirements, MDHHS follows all applicable processes for public comment across managed care programs. The Michigan Medicaid CQS is developed collaboratively with input from health care providers, stakeholders, advocates, and multiple state agencies with an interest in improving access, clinical quality, and service quality received by Medicaid enrollees. After stakeholder’s input is obtained, the CQS is presented to the Medical Care Advisory Committee (MCAC) and Michigan tribal representatives to obtain their input and comments prior to submission to CMS.

Comprehensive Quality Strategy Performance Metrics and Targets

As previously stated, development of the MDHHS 2020-2023 CQS initiated a new process of integrating traditionally separate quality improvement goals and objectives into a common set of overarching Medicaid managed care quality strategies that encompass all MDHHS managed care programs. While the programs collaboratively identified and agreed upon 2020-2023 CQS goals and

objectives, specific performance metrics for each CQS objective were not identified for the first iteration of Michigan's CQS. Consequently, individual program performance measures and standards were outlined in the Appendices attached to the 2020-2023 CQS document.

In response to CMS feedback and after review of the June 2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit, the MDHHS CQS team spent considerable time reviewing the 2020-2023 CQS goals and objectives to establish measurable objectives for each CQS goal.^{12,13} As a result of this work and in accordance with 42 CFR 438.340(b)(3) and 457.1240(e), each CQS objective is tied to one or more quality measures that will be used to assess progress toward meeting established goals across Michigan's Medicaid managed care programs.

Managed care programs in Michigan monitor a wide range of process, outcome, and satisfaction measures, and all programs contractually require plans to track and submit performance data. The measure selection process included the identification of national quality organization endorsed measures including but not limited to the CMS Child, Adult and Behavioral Health Core Sets; CMS Managed Long Term Services and Supports (MLTSS) metrics; the National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS); and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys. In addition, state specific MDHHS program data were considered for inclusion. External Quality Review (EQR) Technical reports were also used to identify opportunities to improve performance related to the quality of, timeliness of, and access to care and services provided by Michigan's managed care plans.

As required by 42 CFR 438.340(b)(3)(i) and 42 CFR 457.1240(e), long-term services and supports (LTSS) performance measures related to quality of life, rebalancing and community integration activities for individuals receiving LTSS through managed care (e.g., the MI Choice Waiver, MI Health Link and PACE programs) have been incorporated into the MDHHS 2023-2026 CQS Goals and Objectives Performance Measures.

MDHHS 2023-2026 CQS Goals & Objectives Measures (Appendix C) outlines a crosswalk of the MDHHS 2023-2026 CQS Goals and Objectives with corresponding measures.

Section II: ASSESSMENT

Assessment of Quality and Appropriateness of Care

Michigan Medicaid has a strong and well-established process to monitor and evaluate managed care performance and employs a broad range of mechanisms to assess the quality of healthcare services delivered to beneficiaries. Managed care contracts include robust requirements to ensure plans meet or exceed minimum performance standards and contractual requirements. These standards are described throughout this document and include requirements related to beneficiary access to care, availability of services, network adequacy, assurances of adequate capacity and services, coordination and continuity of care, transitions in care, and coverage and authorization of services. In addition, contracts outline requirements for structure and operations to ensure the provision of high-quality care that include provider selection requirements, practice guidelines, beneficiary information, enrollment and disenrollment processes, confidentiality, appeals and grievance systems, sub-contractual relationships, payment reform and information technology.

MDHHS has established infrastructure to oversee the development, prioritization, implementation, and measurement of the Medicaid managed care program quality improvement efforts. Oversight mechanisms are in place to review, track and trend data; and multiple committees serve as the point of integration for quality improvement activities (**Table 4**). Managed care programs are also integrated with other state programs and departments including but not limited to the Public Health Administration, MI Children’s Services Agency, the Division of Maternal & Infant Health, Child and Adolescent Health Center Program, the Housing and Homeless Services Division, and the Department of Corrections.

MDHHS operates a formal, comprehensive system to ensure that the waiver programs meet the assurances and other requirements contained within CMS-approved waiver applications. Components include an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by providing administrative oversight of and monitoring level of care determinations, individual plans and services delivery, provider qualifications, etc. MDHHS further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem.

In addition, a combination of program, state and national performance measures are used to assess the impact of quality improvement initiatives related to care and services provided to Medicaid managed care beneficiaries.

The methods by which the quality of care and services of managed care programs are evaluated are outlined in **Table 5**. Defined metrics and applicable performance goals are established by each managed care program. **The 2023-2026 CQS outlines performance measures for each CQS Objective which are described in Appendix C.**

Table 5: MDHHS Managed Care Program Oversight and Assessment Methods

Medicaid Managed Care Program	Assessment Methods						
	HEDIS®	EQR	CAHPS®/ Member Surveys	PIPs	Monitoring Standards	Performance Bonus	Site Reviews
Comprehensive Health Care Program (CHCP)	X	X	X	X	X	X	X
Children's Special Health Care Services *	X	X	X	X	X	X	X
Healthy Michigan Plan (Medicaid Expansion)	X	X	X	X	X	X	X
Flint Medicaid Expansion (FME) Waiver	X	-	X		X	-	-
MI Health Link Demonstration	X	X	X	X	X	X	X
MI Choice Waiver Program	-	X	X	X	X	X	X
Program of All-Inclusive Care for the Elderly (PACE)	-	X	X	X	X	X	X
Dental Managed Care	X	X	X***	X	X	X	X
Behavioral Health Managed Care (PIHPs)	X**	X	X	X	X	X	X

* CSHCS may be included in CHCP assessment methods as a subset of the population.

Subset of HEDIS® measures. *HKD and Adult Dental

Detailed descriptions of Medicaid managed care program quality assessment and evaluation methods are outlined below.

Special Health Care Needs Populations

To assess the quality of care and services for special populations, MDHHS conducts periodic stratified analyses based on program-specific enrollment. Data sources may include Medicaid claims and encounters (including pharmacy and behavioral health, validated health plan HEDIS® submissions, enrollment files, and vital records). Stratified analyses of relevant quality measures are also conducted.

Health Disparities Reduction

MDHHS is committed to addressing health equity and reducing racial and ethnic disparities in the health care services provided to Medicaid beneficiaries. The requirement to reduce disparities is codified in federal and state law.¹³ As required by 42 CFR 438.340(b)(6) and applicable to CHIP managed care programs per 42 CFR 457.1240(e), the state must include its plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status.

Michigan Medicaid is required to monitor the quality and appropriateness of the healthcare services delivered by participating Medicaid health plans. In addition, Federal regulations require that managed care plans provide services “in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.” On a state level, Michigan Public Act 653 of 2006 directs MDHHS to develop strategies to reduce racial and ethnic disparities, including the compilation of racial and ethnic specific data including, but not limited to, morbidity and mortality.¹³

Michigan’s Medicaid managed care programs collect race/ethnicity, language, gender identity and sexual orientation data using methods such as Health Risk Assessments to assess for disparities, focus quality improvement efforts, and decrease health care disparities. Although the Michigan Medicaid programs have been implementing health equity reporting and monitoring processes for varying periods of time, MDHHS and the managed care programs are committed to improving the access, care and services provided to Medicaid beneficiaries with the goal of reducing health disparities. This commitment supports the MDHHS’s vision to deliver health and opportunity to all Michiganders, reducing intergenerational poverty and promoting health equity. It also aligns with CMS 2022 National Quality Strategy which pursues “a resilient, high-value health care system that promotes quality outcomes, safety, equity, and accessibility for all individuals, especially for people in historically underserved and under-resourced communities.”¹⁴

The CQS pursues an integrated framework for population health improvement and a commitment to eliminating disparate outcomes within Medicaid managed care populations. While all the 2023-2026 CQS Goals & Objectives incorporate the concept of health equity and health disparities, Goal #4 specifically describes the intent to “Reduce racial and ethnic disparities in healthcare and health outcomes.” MDHHS and the managed care programs continue to work toward strengthening processes to improve quality of care and services; implementing data driven outcomes measurement; pursuing efforts to identify and address social determinants of health (SDOH), health equity and disparities; and advancing payment methodologies.

The Comprehensive Health Care Program (CHCP) developed the Medicaid Health Equity Project in early 2010 and the Medicaid Health Plans (MHPs) began submitting data in 2011 (Year 1). Data reporting on 14 measures across four health domains has been tracked over time. The MHP Health Equity Project published its tenth Annual report in 2023. The Year 10 report includes measurement year 2019 data for 13 HEDIS® measures. Comparisons were made based on a reference population and differences between each racial/ethnic population included in the analysis. In 2022, Children's Special Health Care Services (CSHCS), MI Health Link (MHL), and MI Choice Waiver (MCW) initiated health equity projects to assess disparities in their respective populations. The goal of the

health equity projects is to identify and eliminate racial and ethnic disparities in healthcare and health outcomes by focusing on key vulnerable populations.

In January 2022, MDHHS received a 2-year grant from the Michigan Health Endowment Fund (MHEF) which allows the MI Health Link, MI Choice, Home Help, Home Health, and PACE programs to identify barriers to and increase the use of home and community-based services (HCBS). In addition, MDHHS is evaluating disparity in oral health for children and adults through performance measure monitoring and reporting of the plan performance based on gaps found in racial/ethnic stratifications. The PIHPs also initiated efforts to understand potential target areas, such as disparities in Substance Use & Substance Use Disorders (SUD) care and has a quality withhold program that targets racial disparities. The Prepaid Inpatient Health Plans (PIHPs) collect data by race on response rates to the National Core Indicators and use HEDIS® specifications for quality reporting on some of Michigan's Mission-Based Performance Indicator System (MMBPIS). An initiative to review race data on SUD service access began in 2020; and a process to use encounter data to calculate HEDIS-like measures for behavioral health related conditions was undertaken in March 2021.

The Medicaid program health equity projects are described in further detail in the 2020-2023 CQS Effectiveness Evaluation.

Initiatives to Address Social Determinants of Health

MDHHS and the Medicaid managed care programs acknowledge that an individual's health is profoundly shaped by life circumstances that fall outside the traditional purview of the health care system. Conditions in the places where people live, learn, work, and play, affect a wide range of health risks and outcomes. Education, nutrition, transportation, and other dynamics are examples of social determinants of health (SDOH) that collectively influence health outcomes. Michigan's population health model recognizes that health management is built upon a detailed understanding of the distribution of social, economic, familial, cultural, and physical environment factors. These factors impact health outcomes among different geographic locations and groups; the distribution of health conditions; and health-related behaviors and outcomes including but not limited to physical, dental, behavioral, and social needs. As a result, managed care programs are incorporating SDOH into quality assessment and improvement processes. The goal is to address health disparities, improve community collaboration and enhance care coordination, case management, targeted interventions, and complex care management services for enrollees.

Analysis of SDOH utilizes data available from information sources such as claims, pharmacy, and laboratory results which is supplemented with utilization data, health risk assessment (HRA) results and eligibility status (e.g., children in foster care, CSHCS, persons receiving LTSS). Demographic data is shared with the plans (MCO, PIHP or PAHP) at the time of enrollment. Age and gender indicators are included in all enrollment files, along with race, ethnicity, primary language, and the basis for eligibility which includes disability status.

Target populations may include those experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level. Populations may include individuals with poor health outcomes or access issues based on factors such as race, ethnicity, gender, age, primary language, disability, geographic location, or income level. Health plans collaborate with primary care and specialty practices to develop, promote, and implement targeted evidence-based strategies. Interventions may include in-person support services such as Community Health Workers (CHW), patient navigators, home visiting programs, or health promotion or preventions programs delivered by community-based organizations (e.g., adult/family shelters, schools, foster homes). Managed care programs have also initiated contractual requirements to incorporate SDOH into processes for analyzing data to support population health management.

To the extent that Community Health Innovation Regions (CHIRs) are available in the plan's service area, the plan should collaborate with CHIRs to develop, promote, and implement these targeted evidence-based interventions. Plans evaluate and report on the effectiveness of its evidence-based interventions to reduce health disparities by considering such measures as number of enrollees experiencing a disparate level of social needs (e.g., transportation, housing, food access) and the number enrollees participating in additional in-person support services.

Culturally and Linguistically Appropriate Services

Michigan Medicaid programs support and contractually require the provision of culturally and linguistically appropriate services (CLAS) and the collection of race/ethnicity, language, gender identity and sexual orientation data using standardized methods to focus quality improvement efforts and improve the provision of culturally and linguistically appropriate services.

Managed care plans are contractually required to make available to all enrollees appropriate, culturally responsive educational materials to promote health, mitigate the risks for specific conditions, and manage existing conditions. Plans are also required to provide information to enrollees in a manner and format that may be easily understood and is readily accessible as required in 42 CFR 438.10; as well as provide oral and written assistance to all Limited English Proficient (LEP) individuals and arrange for translated materials to be accessible or make such information available orally through bilingual staff or the use of interpreters.

Member handbooks must be written at no higher than a 6.9 grade reading level and be available in Alternative Formats for enrollees with special needs. Member handbooks must be available in a Prevalent Language when more than 5% of the enrollees speak a Prevalent Language, as defined by MDHHS policy. Finally, plans must provide a mechanism for Enrollees who are blind or deaf and hard of hearing or who speak a Prevalent Language to obtain member materials and a mechanism for Enrollees to obtain assistance with interpretation. Reasonable accommodations for enrollees with hearing and/or vision impairments (e.g., signing video for deaf and hard of hearing) must also be made. Managed care plans are also to designate member services staff to assist CSHCS enrollees to accommodate their needs.

National Performance Measures

Section 1139B of the Patient Protection and Affordable Care Act requires the Secretary of the Department of Health and Human Services to identify and publish a core set of health quality measures for adult Medicaid enrollees. Child core set measures are outlined in Section 401 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009.

Michigan began voluntarily reporting the national Child and Adult Core Set Measures in 2013. The Medicaid managed care programs continue to successfully extract, stratify, and report administrative data for the Core Set Measures. Programs coordinate these efforts with their respective health equity projects and reporting, where applicable. The MI Health Link Integrated Health Organizations (ICOs) collect and submit timely data for Core Measures developed by CMS for health plans participating in the Financial Alignment Demonstration along with Michigan-Specific reporting requirements. MI Choice waiver agencies are monitored using established performance measures in six waiver assurances and requirements in the areas of service adequacy, access, provider network training, person centered service plans, satisfaction and quality of life, and critical incidents. PACE organizations must report aggregate and individual PACE quality data to CMS along with any root cause analysis conducted. The behavioral health managed care programs (PIHPs) are also held accountable to federal requirements for the following: sentinel events, unexpected deaths, reporting of critical incident and

risk events, and behavior treatment reviews. MDHHS continues to strengthen internal capacity to generate and report the Child and Adult Core Set Measures.

Monitoring and Compliance

Michigan's Medicaid managed care programs have established methods and processes to **assess compliance of access, structure, and operations**. Monitoring and assessment mechanisms include member and provider surveys, the Healthcare Effectiveness Data and Information Set (HEDIS®), mandatory performance monitoring standards, annual performance bonus templates, performance improvement projects (PIPs), and the External Quality Review (EQR).

Health plans must address identification of persons with special health care needs and activities to ensure the quality of care and access for individuals in targeted groups and vulnerable populations. For example, managed care programs annually monitor provider networks and continually evaluate oversight of vulnerable populations to identify opportunities for improving the oversight of healthcare services and outcomes. MDHHS continues to work with the programs to develop uniform methods for targeted monitoring of vulnerable people.

The following is a discussion of procedures and methods used by MDHHS to monitor and evaluate plan compliance with access, structure, and operational contractual requirements.

Member Satisfaction

Medicaid managed care programs contractually require or conduct beneficiary satisfaction surveys for their respective populations using tools such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys, the National Core Indicators (NCI) survey, and the Integrated Satisfaction Measurement for PACE (I-SAT™) Survey. The survey results are an important component of Medicaid program management and oversight. Beneficiary feedback may also be obtained through focus groups, interviews and through community partner organizations such as town halls. **Table 6** outlines the survey methods programs utilize to garner satisfaction information from beneficiaries.

Table 6: Medicaid Managed Care Program Beneficiary Satisfaction Survey Methods

Medicaid Managed Care Program	Population	Survey Instrument	Report Year
Comprehensive Health Care Program (CHCP)	Adult and Child members in an MHP or FFS	Standardized CAHPS® 5.1H Adult Medicaid Health Plan Survey Standardized Child Medicaid Health Plan Survey (without the children with chronic conditions measurement set)	2022 Adult Medicaid Health Plan CAHPS® Report, August 2022 2022 Child Medicaid Health Plan CAHPS® Report, July 2022
Healthy Michigan Plan (HMP)	Adult HMP members	Standardized CAHPS® 5.1 Adult Medicaid Health Plan Survey with the HEDIS® supplemental item set	2022 Healthy Michigan Plan CAHPS® Report, October 2022
Children's Special Health Care Services (CSHCS)	CSHCS Fee-for-Service (FFS) and	Modified version CAHPS®5.1 Child Medicaid Health Plan Survey with the HEDIS® supplemental item set and the Children with Chronic Conditions (CCC) measurement set	2022 Children's Special Health Care Services Program Member

	Medicaid Health Plan		Experience Report, December 2022
Dental Programs	Healthy Kids Dental (HKD); and Healthy Michigan Plan (HMP) Dental	<p>FY20 was the first year the CAHPS® Dental Plan Survey was administered for the HKD and HMP Dental programs.</p> <p>The standardized survey instrument selected for the Adult Healthy Michigan Plan (HMP) was the Dental Consumer Assessment of Healthcare Providers and Systems (CAHPS®).</p> <p>The CAHPS® Adult Dental Survey was modified for the HKD Dental program Child Dental Survey.</p>	<p>2022 Healthy Kids Dental Survey Report, July 2022</p> <p>Healthy Michigan Plan CAHPS® Dental Survey Report, June 2020)</p>
MI Choice	MI Choice participants	CAHPS® Home and Community-Based Services (HCBS) Survey	<p>2022 Michigan MI Choice Enrollee Satisfaction Report</p> <p>Consumer Assessment of Healthcare Providers and Systems Survey</p> <p>Home and Community-Based Services</p>
MI Health Link	Adult Medicare/Medicaid members	Medicare Advantage Prescription Drug CAHPS® with 10 supplemental questions (added by RTI)	2020 & 2021 Reports are not publicly available.
	2022 HCBS CAHPS® results of adult members that received a qualifying personal care service or were currently enrolled in the MI Health Link HCBS waiver.	<p>CAHPS® 5.0 Adult Medicaid Health Plan Survey with HEDIS® supplemental item set</p> <p>CAHPS® Home and Community-Based Services (HCBS) survey without the Supplemental Employment Module</p>	<p>2020 Integrated Care Organization CAHPS® Report, August 2020</p> <p>2022 Michigan Home and Community-Based Services (HCBS) Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Member Experience Report, October 2022</p>
PACE	Adult Medicare/	Integrated Satisfaction Measurement for PACE (I-SAT™) Survey	2021 & 2022 Reports are not publicly available.

	Medicaid members	CMS administers the Medicare Health Outcomes Survey-Modified (HOS-M) to PACE enrollees. The HOS-M is a modified version of the Medicare Health Outcomes Survey (HOS).	
Adult and Children's Behavioral Health	Intellectual or Developmental Disability (IDD) Adults	National Core Indicators (NCI) Adult Consumer Survey	National Core Indicators® – Intellectual and Developmental Disabilities (NCI-IDD) 2020-2021 Michigan Adult In-Person Survey Final Report (pdf)

CAHPS® survey results are used to identify quality improvement activities related to member satisfaction with the plan and contracted physicians. The goal of the surveys is to provide performance feedback that is actionable and supports improving members' overall experiences. Survey findings are tracked, trended, and compared to aggregate statewide results and to national Medicaid data, where appropriate. In addition, the Health Services Advisory Group (HSAG), Michigan's CAHPS® vendor, compares scores for each measure to the National Committee for Quality Assurance's (NCQA's) Quality Compass Benchmarks and Compare Quality Data to derive the overall member experience ratings (i.e., star ratings) for use in the reporting process. Where applicable, survey findings are included in managed care program External Quality Review (EQR) technical reports. CAHPS® data also comprise a portion of the annual Comprehensive Health Care Program (CHCP), Medicaid Health Plan Performance Bonus and are used to promote informed consumer choice through publication in Michigan's annual Medicaid consumer guide, "A Guide to Michigan Medicaid Health Plans" to support informed consumer choices of health care services.¹⁴ Other managed care programs conduct member satisfaction surveys using a similar CAHPS® survey format including the Flint Waiver evaluation.

The National Core Indicators® (NCI®) survey, which measures and tracks performance of public services for people with intellectual or developmental disabilities, provides comprehensive and statistically reliable information based on a random sample of adult service recipients. The behavioral health programs use the information to help focus oversight activities and to guide quality improvement priorities and collaborative efforts that occur in partnership with the PIHPs and CMHSP providers. NCI findings are also used in the behavioral health managed care performance dashboard.¹⁵

PACE centers are required to conduct a yearly participant satisfaction survey. Although a specific survey is not required, multiple PACE organizations utilize the Integrated Satisfaction Measurement for PACE (I-SAT™) survey. CMS also administers the Medicare Health Outcomes Survey-Modified (HOS-M) to PACE enrollees that is based on a randomly selected sample of individuals from each participating PACE organization, measures the physical and mental health functioning of beneficiaries at a single point in time.¹⁶ PACE centers utilize survey data to guide their quality assurance and performance improvement processes and Quality Plan development.

Medicaid Health Plan Performance Reports

Healthcare Effectiveness Data and Information Set (HEDIS®)

Michigan Medicaid uses the HEDIS® set of performance measures to assess the quality of care and services provided to beneficiaries. MDHHS contracts with Health Services Advisory Group, Inc. (HSAG) to objectively analyze managed care program HEDIS® results and evaluate managed care entity (MCE) performance relative to national Medicaid percentiles.

MDHHS requires MCEs to have electronic health systems sufficient to report health care claims, membership and provider files, and hardware/software management tools to facilitate accurate and reliable HEDIS® reporting. MDHHS establishes performance levels that are specific, attainable, and are based on HEDIS® national percentiles or the Michigan Medicaid weighted average, where applicable. MDHHS reviews, analyzes, trends, and reports HEDIS® rates internally, publicly, and to the MCE based on managed care program specifications and contractual requirements.

The managed care programs use the majority or a subset of HEDIS® measures when implementing quality oversight and engaging plans in performance improvement activities. Managed care programs utilizing the HEDIS® process include the CHCP Medicaid Health Plans, CSHCS, Healthy Michigan Plan and the Flint Medicaid Expansion (FME) Waiver; behavioral health PIHPs/CMHSPs; and MI Health Link (**Table 5**).

HEDIS® data drive the identification and prioritization of multiple quality improvement activities including but not limited to annual performance assessment to establish quality improvement program priorities and objectives, developing annual consumer guides, and assessing quality of care and services delivered to targeted populations (e.g., CSHCS, children in foster care). In addition, the PIHPs/CMHSPs are evaluated on a subset of HEDIS® measures, some jointly with the Medicaid Health Plans. In FY23, MHP/PIHP joint measures include Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) and Follow-up After Hospitalization for Mental Illness within 30 Days (FUH).

Report Cards or Profiles (Scorecards)

Guide to Michigan Medicaid Health Plans

The Comprehensive Health Care Program (CHCP) annually produces a Medicaid consumer guide entitled “*A Guide to Michigan Medicaid Health Plans*.”¹⁷ The Guide is developed by HSAG using HEDIS® and CAHPS® measures and includes ratings in the following five categories of health plan performance: (1) Doctors Communication and Service; (2) Getting Care; (3) Keeping Kids Healthy; (4) Living with Illness; and (5) Taking Care of Women. Medicaid Health Plan performance is compared to the average of all Michigan Medicaid Health Plans (MHPs) using an “apple” symbol for comparison for Above Average (four apples); Average (three apples); or Below Average (two apples). The Guide also outlines covered medically necessary services, includes the Michigan Enrolls phone number (the contracted enrollment broker), and indicates whether the MHP is accredited (e.g., National Committee for Quality Assurance). **Appendix D outlines the measures used to develop the *Guide to Michigan Health Plans*.**

Public Posting of Managed Care Quality Measures and Performance Outcomes

In accordance with 42 CFR §438.340(b)(3)(i) and 42 CFR 457.1240(e), Michigan’s managed care program quality measures and performance outcomes data on is publicly available on the MDHHS

and/or CMS web site. In general, reports include annual External Quality Review Technical Reports, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey results, Healthcare Effectiveness Data and Information Set (HEDIS®) reports, Onsite and Compliance Determination and other program specific reporting, as contractually required. **Table 7** outlines publicly available reports.

Table 7: Publicly Available Managed Care Program Quality and Performance Data

Michigan Managed Care Program	Data Reports Publicly Available
Comprehensive Health Care Program (CHCP)	Michigan Medicaid Health Equity Reports, CAHPS® and HEDIS® Statewide Aggregate Reports, External Quality Review Reports, and Healthy Michigan Plan and Flint Waiver Progress Reports.
CSHCS	Provider and Member satisfaction survey reports.
Dental Program	Healthy Kids Dental and Healthy Michigan Plan Dental CAHPS® Reports.
MI Choice Waiver	External Quality Review Technical Reports, agency accreditation status, Compliance Determination results, beneficiary satisfaction and CAHPS® survey results.
MI Health Link	CMS collects a variety of measures that examine plan performance and the quality of care provided to enrollees in the Medicare-Medicaid Plan (MMP) including MI Health Link . The data show MMP performance on quality measures including all HEDIS® data and the results of surveys; state weighted averages are provided for each measure.
Prepaid Inpatient Health Plans (PIHPs) Community Mental Health Services programs (CMHSPs)	External Quality Review Technical Reports and the Michigan Mission-Based Performance Indicator System Reports for Persons with Mental Illness, Developmental Disabilities, Emotional Disturbances, and Substance Use Disorders, that are contractually required of the 10 PIHPs and 46 CMHSPs.

Performance Bonus Models

Pay for Performance, also known as value-based payment, comprises payment models that attach financial incentives/disincentives to provider performance. Pay for Performance is part of the overall national strategy to transition healthcare to value-based medicine. The model ties provider reimbursement to metric-driven outcomes, proven best practices, and patient satisfaction, thereby aligning payment with value and quality. Performance bonus models stress quality over quantity of care and allows healthcare payers to redirect funds to encourage best clinical practices and promote positive health outcomes.

Many of Michigan’s managed care programs utilize performance bonus models in provider payment strategies. During each contract year, MDHHS withholds a specified amount of the approved capitation for each contracted health plan (CHCP, HKD, PIHP, ICO, Waiver Agency) in a Performance Bonus Pool used to award health plan/agency performance. Withholds are outlined in the respective managed care contracts and performance bonus models clearly outline the metrics and established performance standards for the specified performance period(s). Distribution of funds from the performance bonus incentive pools are contingent on the completion of the required performance of compliance metrics. The bonus withhold pool is distributed among plans that achieve performance standards established by MDHHS. Examples of components included in the plan performance bonus models include: HEDIS® and CAHPS® scores, results of focus studies, submission of required reporting (e.g., financials, encounters, etc.) and shared PIHP/MHP metrics.

Behavioral health utilizes a two-pronged approach in assessing CMHSP/PIHP compliance. The first is the Michigan Mission Based Performance Indicator System (MMBPIS). Each fiscal year PIHPs and CMHSPs are measured on performance indicators which include measurement domains of access to care, adequacy and appropriateness of services provided, efficiency (administrative cost vs. service costs), and outcomes (employment, housing, inpatient readmission). The second is a Performance Bonus Incentive Program in which PIHPs are evaluated on a small number of HEDIS®/NCQA measures, some jointly with Medicaid Health Plans.¹⁸

Similarly, MDHHS withholds a portion of the approved capitation payment from each MI Choice waiver agency which is used for the waiver agency annual performance bonus incentive. The incentives are distributed to agencies according to criteria and standards established annually by MDHHS. The criteria include an assessment of performance in quality of care, encounter data submission, enrollee acuity, and administrative functions.

To incentivize quality improvement, CMS and MDHHS withhold a portion of the capitation payment that ICOs in the MI Health Link program can earn back if established quality thresholds on performance measures are met. ICOs are expected to meet established thresholds that address but are not limited to access, assessment, care coordination, enrollee protection, and provider network. The quality withhold measures represent CMS defined measures that are required of all Financial Alignment demonstrations, as well as HEDIS® and Michigan specific measures.

Performance Monitoring: Metrics and Standards

Michigan Medicaid monitors individual managed care entity (MCE) performance against established standards and thresholds to ensure that all Medicaid enrollees receive necessary levels of care and service. Performance monitoring standards and thresholds vary depending on the nature of the managed care plan or waiver's target population, the services offered, and the relationship to other programs, and may extend beyond regulatory requirements. The purpose of performance monitoring standards is to establish an explicit process for the ongoing monitoring of health plan performance in important areas of quality, access, customer service, and reporting. The monitoring process is dynamic and reflects state and national issues that may change annually. Medicaid managed care contracts require MCEs to incorporate the performance monitoring standards into required written quality improvement plans. Performance measurement is shared with the MCE during the fiscal year and may be used to compare plan performance over time to other MCEs and to industry standards where available. Examples of MDHHS performance monitoring requirements/standards are described below. The Comprehensive Health Care Program (CHCP) established the Medicaid Health Plan (MHP) Performance Monitoring Standards (PMR) for the explicit purpose of monitoring health plan performance in the important areas of quality, access, customer services and reporting. The process is dynamic and reflects state and national issues that may change annually. For each performance area, the following categories are identified: measure, goal, minimum standard for each measure, data source, and monitoring intervals (annual, quarterly, monthly). PMR data is shared with the MHPs for ongoing analysis and trending. The PMR standards address the following: MDHHS Administrative Measures; Healthy Michigan Plan (HMP) Measures; MDHHS Dental Measures; Health Equity HEDIS® measures; CMS Core Set Measures; HEDIS®; and Managed Care Quality Measures. The PMR measure specifications align with CMS Medicaid and CHIP, and the Adult and Child Core Measures. Failure to meet the minimum performance monitoring standards may result in the implementation of remedial actions and/or improvement plans as outlined in the contract. The performance goal, minimum standard, data source and monitoring intervals are outlined in the MDHHS Comprehensive Health Care Program contract.

In addition, the CHCP developed an Auto Assignment Algorithm. The purpose of the auto-assignment algorithm is to assign beneficiaries to health plans using performance-based criteria that are dynamic,

valid, and multidimensional utilizing an equitable methodology. Auto Assignment Algorithm domains include the NCQA Medicaid and CAHPS® percentiles, MHP regional performance, and provider capacity by county. In addition, MDHHS designed a health equity measure to compare the previous year's health disparity by MHP to the current year by determining significant improvement in the Black-White disparity without decreasing overall performance.

The MI Health Link program also uses an Auto Assignment Algorithm to incentivize performance on quality measures. The purpose of the MI Health Link Passive Enrollment Algorithm is to assign beneficiaries to plans using performance-based criteria using a defined methodology. The primary goal of the Passive Enrollment Algorithm process is to reward plans for: 1) investing in members; 2) exceptional performance on national MMP metrics; 3) exceptional performance on care coordination; and 4) timely reporting. The nine measures included in the Algorithm are a mix of HEDIS® and HEDIS-like performance measures, CMS quality indicators developed specifically for MMP programs, and new metrics developed by MDHHS uniquely for MI Health Link.

The Bureau of Specialty Behavioral Health Services (SBHS) utilizes the *Michigan Mission Based Performance Indicator System (MMBPIS)* to assess PIHP and CMHSP compliance each fiscal year on performance indicators. The domains include access to care, adequacy and appropriateness of services provided, efficiency (administrative cost vs. service costs), and outcomes (employment, housing, inpatient readmission). The majority of the MMBPIS indicators have a 95% established performance standard.

MI Choice has systems in place to measure and improve performance in meeting six specific waiver assurances and requirements for the following: participant access and LOC determination; patient-centered service planning; service delivery; provider capacity and capabilities; participant safeguards related to health and welfare, rights and responsibilities, outcomes, and satisfaction; and system performance. Results from the Administrative Quality Assurance Review (AQAR) and Clinical Quality Assurance Review (CQAR) reviews are included in the CMS-372 Annual Report on Home and Community Based Services Waivers in the performance measure reporting. MI Choice also conducts the following monitoring processes in addition to the quality assurance reviews, including but not limited to, encounter and capitation data, administrative hearings and appeals decisions and resolution of complaints, and routinely monitors, reviews, and evaluates the Critical Incident Reporting System.

CMS and MDHHS conduct a joint comprehensive performance and quality monitoring process for the MI Health Link program. The MI Health Link monitoring process incorporates measures representing the CMS Core quality measures required by all Financial Alignment participants as well as Michigan specific quality measures recommended by the program. ICOs must collect and submit timely data for these measures and they must contribute to all applicable MDHHS and CMS data quality assurance processes, which include but are not limited to, responding, in a timely manner, to data quality inadequacies identified by MDHHS and rectifying those inadequacies, as directed by MDHHS. The MI Health Link measures represent nine important dimensions of quality for persons served through the program: care coordination and transitions; quality of care, health and well-being; quality of life; person-centered planning; enrollee/caregiver experience; access /availability; screen, assessment and prevention; organization structure, administration and staffing; and utilization.

Performance Improvement Projects and Interventions

In accordance with 42 CFR §438.340(b)(3)(ii) and 42 CFR 457.1240(e) Michigan Medicaid contractually requires managed care entities to conduct annual performance improvement projects (PIPs) that focus on clinical and non-clinical areas including any performance improvement projects required by CMS (**Refer to Table 5**). MDHHS programs identify priority areas for statewide PIPs through analysis of HEDIS® and CAHPS® data, population needs, legislative priorities and mandates,

and topics based on the state and national health care agenda. These priority areas may vary from year to year, and managed care programs may require specific PIPs for a subset of MCEs based on individual plan performance, plan demographics (race, ethnicity, and other population characteristics), or prevalent conditions.

PIPs are included in the managed care plan's Quality Assurance and Performance Improvement (QAPI) programs and must include use of objective indicators, system interventions, ongoing measurement, and evaluation of interventions for effectiveness, and continuation of activities to sustain improvement. Each PIP must be designed to achieve significant improvement, sustained over time, in physical and oral health outcomes and enrollee satisfaction, and must include the following elements (a) measurement of performance using objective quality indicators, (b) implementation of interventions to achieve improvement in the access to and quality of care, (c) evaluation of the effectiveness of interventions based on performance measures, and (d) planning and initiation of activities for increasing or sustaining improvement. Clinical areas may include but are not limited to high-volume or high-risk services, and continuity and coordination of care. Non-clinical areas may include appeals, grievances and trends or patterns of complaints, and/or access to and availability of services.

Many of the PIPs focus on health equity and disparity reduction. For the SFY 2022 PIP validation activity, the MHPs initiated new PIP topics that focused on disparities in timeliness of prenatal care, reporting baseline data for each specified performance indicator. MHPs with an existing disparity have a minimum of two performance indicators (a disparate sub-group performance indicator and a comparison sub-group performance indicator), and MHPs without an existing disparity have one performance indicator. For the SFY 2022 QIP validation activity, the ICOs also initiated new Quality Improvement Project (QIP) topics that focused on disparities within their populations, as applicable, and reported baseline data for each specified performance indicator.

During SFY 2021, the twenty (20) MI Choice waiver agencies continued implementing the five QIPs that were initiated in SFY 2020: 1. Prevalence of Neglect/Abuse; 2. Prevalence of Pain With Inadequate Pain Control; 3. Prevalence of Falls; 4. Prevalence of Any Injuries; and 5. Prevalence of Dehydration.

Appendix E describes CHCP, Dental, MI Health Link, behavioral health (PIHP) and MI Choice performance improvement project topics, aims and interventions.

External Quality Review (EQR)

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states to prepare an annual, external independent review of the quality and outcomes, timeliness of, and access to covered services provided by the plans, as mandated by 42 Code of Federal Regulations (CFR) §438.364. In accordance with 42 CFR §438.356, MDHHS contracts with Health Services Advisory Group (HSAG) as its External Quality Review Organization (EQRO) to conduct the mandatory and optional EQR activities as set forth in 42 CFR §438.358. EQR arrangements are also cited in 42 CFR 438.340(b)(4) of the managed care state quality strategy regulations.

MDHHS contracts with the Health Services Advisory Group (HSAG) to conduct an annual, external independent review of the quality and outcomes, timeliness of and access to covered services provided by the health plans. The purpose of these activities, in general, is to provide valid and reliable data and information about plan performance. Table 5 outlines the managed care plans that conduct EQR activities. In accordance with 42 CFR § 438.358, Michigan's EQR technical reports describe how data from activities conducted by Medicaid managed care plans were aggregated and analyzed, how

conclusions were drawn about the quality, timeliness, and access provided by contracted health plans, and assessment of health plan strengths and weaknesses.

Medicaid managed care plans are required to address the findings of the external review through its Quality Assurance and Performance Improvement (QAPI); and must develop and implement performance improvement goals, objectives, and activities in response to the external review findings. MDHHS uses findings from the following mandatory EQR activities to derive conclusions and make recommendations about the quality of, timeliness of, and access to care and services:

- Compliance monitoring – evaluation of plan compliance with federal Medicaid managed care regulations;
- Validation of performance measures - to determine the validity of each performance measure; and
- Validation of performance improvement projects (PIPs) - to ensure that the projects were designed, conducted, and reported in a methodologically sound manner, allowing real improvements in care and giving confidence in the reported improvements; and
- Network adequacy validation.

External Quality Review (EQR) Non-Duplication Option

MDHHS is committed to the nonduplication of activities through the use of information from private accreditation reviews as allowed in CFR §438.360.

The CHCP contracted Medicaid Health Plans (MHPs) must hold and maintain accreditation as a managed care organization by the National Committee for Quality Assurance (NCQA) or Utilization Review Accreditation Commission (URAC). Since all MHPs are NCQA accredited, MDHHS uses the most current NCQA Medicaid Managed Care Toolkit as a guide to compare the NCQA Health Plan Accreditation standards to the standards established through the EQR protocols, and specifically for the mandatory compliance review activity described in 42 CFR §438.358(b)(iii), to identify those areas that are fully or partially comparable to federal and state-specific contract requirements and, therefore, eligible for deeming. MDHHS then assesses the most current MHP-specific accreditation reports and findings to determine the extent of nonduplication for each MHP.

Further, the MHPs contract with an NCQA certified HEDIS® vendor annually to undergo a full audit of their HEDIS® reporting processes. As such, the results of each MHP's HEDIS® audit is used for the external quality review in lieu of completion of the mandatory validation of performance measures activity described in 42 CFR §438.358(b)(ii).

Compliance Reviews

MDHHS conducts annual or biennial compliance reviews of the Medicaid managed care entities. The compliance review includes both a desk audit and a focused review component related to specific areas of health plan performance as determined by MDHHS. Managed Care Program staff determine if contracted plans are meeting contractual requirements and assess health plan compliance as outlined respective program contracts. MDHHS reserves the right to conduct a comprehensive compliance review, as indicated.

Standard review protocol is utilized to record and document site-review findings. The site reviews include but are not limited to:

- An evaluation of system compliance, focusing on the processing of claims and encounters.
- An overview of data integration and control procedures, including discussion and observation.
- A review of how all data sources were combined and the method used to produce the performance measures.
- Interviews with plan staff involved with any aspect of performance measure reporting.

- Review of consistent, uniform person-centered and medical necessity/needs assessments.
- Review of records, administrative reviews, consumer/stakeholder meetings and consumer interviews.
- A focused review based on MDHHS identified priorities
- A closing conference at which the auditor summarized preliminary findings and recommendations.
- Follow-up to assess the status and effectiveness of plan implementation of corrective action plans, as indicated.

The Comprehensive Health Care Program (CHCP), Managed Care Plan Division conducts annual compliance reviews for the nine (9) contracted Medicaid Health Plans (MHPs) that includes at least one focused study. Examples of recent CHCP focus study topics include pharmacy quality issues, the Childhood Lead Poisoning Prevention Program (CLPPP), immunizations, and encounter quality. Recent dental program focus studies assessed EQR report performance, performance considerations with standardized quality measures, dental non-utilization, COVID reengagement, and other topics. In addition, CSHCS focused topics included healthcare transitions, sickle cell disease (program expansion, monitoring and improvement), health equity, grievances and appeals, and CSHCS Members/Family Members on MHP Boards/Workgroups.

By law, the State Agency certifies Community Mental Health Programs every three years and directly completes site reviews of PIHPs/CMHSP's and contract providers every two years. MDHHS conducts comprehensive biennial reviews of the ten (10) PIHPs. This site visit strategy includes rigorous standards for assuring the needs, including health and welfare of the waiver populations.

The MI Choice Waiver program compliance review has two parts, the Administrative Quality Assurance Review (AQAR) and the Clinical Quality Assurance Review (CQAR) which includes a MI Choice participant home visit protocol. MDHHS staff complete the AQAR biennially for each of the twenty (20) waiver agencies. The AQAR focuses on assuring that each waiver agency has policies and procedures consistent with waiver requirements and comply with State and Federal requirements. AQAR examines waiver agency policies and procedures, contract templates, financial systems, claims accuracy, and Quality Management Plans in detail seeking evidence of compliance to the AQAR standards. The CQAR review evaluates the waiver agency's enrollment, assessment, care planning, backup plans, reassessment activities, and Critical Incident reporting.

A comprehensive compliance review that includes an assessment of fourteen standards is conducted on the six (6) MI Health Link ICOs on a three-year cycle. The standards include Disenrollment: Requirements and Limitations; Member Rights and Member Information; Emergency and Post-Stabilization Services, Availability of Services, Assurance of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Confidentiality, Grievance and Appeal Systems, Sub contractual Relationships and Delegation, Practice Guidelines, Health Information Systems, and Quality Assessment and Performance Improvement Program. Annual audits are also completed for the HCBS C-Waiver population (a subset of the entire program) which incorporates measures mapped into 9 domains of care and services.

Use of Intermediate Sanctions

As required in 42 CFR 438.340(b)(7), MDHHS utilizes a variety of means to assure compliance with contractual requirements and pursues remedial actions or improvement plans, when indicated. MDHHS may pursue remedial actions or improvement plans to resolve outstanding contract requirements. If remedial action or improvement plans are not appropriate or are not successful, the managed care contracts outline the process for the use of intermediate sanctions which may include:

- Civil monetary penalties

- Appointment of temporary management
- Grant enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll
- Suspension of all new enrollment (including auto-assignment)
- Suspension of payment for recipients
- Additional sanctions allowed under state statute or regulation that address areas of noncompliance

The State may terminate the managed care entity contract if intermediate sanctions or general remedies are not successful (or if MDHHS determines that immediate termination of the Contract is appropriate). In addition, CMS and MDHHS will apply one or more sanctions outlined in the MI Health Link ICO contract, including termination, if CMS and MDHHS determine that the ICO is in violation of any of the terms of the contract. During 2020-2023, MDHHS imposed the following sanctions and/or corrective actions.

Table 8: 2020-2023 MDHHS Imposed Sanctions and/or Corrective Actions

Medicaid Program	Total Number of Sanctions	Type of Sanction	Reason
CHCP	15	Corrective Action Plan – Not Compliance Review Related	Non-Compliance with Contract Requirements
	30	Notice of Non-Compliance	Non-Compliance with Contract Requirements
	153	Corrective Action Plan – Compliance Review	MDHHS Compliance Review
	1	Warning Letter	Non-Compliance with Encounter Requirements
Dental	13	Corrective Action Plan – Compliance Review	MDHHS Compliance Review
	3	Corrective Action Plan – Non-Compliance Review	Non-Compliance with Contract Requirements
MI Health Link	19	Corrective Action/Performance Improvement Plan	1915C Waiver Audit
	20	Corrective Action/Performance Improvement Plan	EQRO Compliance Review
	20	Corrective Action/Performance Improvement Plan	Network Adequacy Validation - EQRO Secret Shopper Survey
	2	Corrective Action/Performance Improvement Plan	Non-Compliance with Encounter Requirements
MI Choice Waiver	60	Corrective Action/Performance Improvement Plan	CQAR identified non-compliance to federal regulation, contract requirements, or waiver application requirements.
	7	Corrective Action/Performance Improvement Plan	AQAR identified waiver agency's policies or procedures were non-compliant with federal regulations, contract requirements, or waiver application requirements.
SBHS	49*	Corrective Action Plan	Non-Compliance with Contract Requirements

*Includes FY21 and FY22. FY20 data unavailable.

Section III: STATE STANDARDS

MDHHS requires all managed care entities (MCEs) to maintain and monitor a network of Medicaid enrolled, qualified providers in sufficient numbers, mix, and geographic locations throughout their respective service areas for the provision of all covered services. Provider networks must be supported by written agreements and sufficient to provide adequate access to all covered services for enrollees including those with limited English proficiency, deaf or hard of hearing, or physical or mental disabilities, CSHCS enrollees and persons with special health care needs and must submit documentation to MDHHS to that effect.

Access Standards

MDHHS has established access standards to ensure that enrollees' access to care is not restricted and services are readily available. These standards, which pertain to all Medicaid managed care enrollees including persons with special health care needs, are clearly delineated in managed care program contracts. The contracted MCEs must consider anticipated enrollment and expected utilization of services with respect to all Medicaid populations when determining network adequacy and capacity. Plans must ensure contracted providers offer an appropriate range of preventive care, primary care, specialty and subspecialty, and ancillary services to meet the needs of all enrollees and submit documentation to MDHHS to that effect. MDHHS assesses plan adherence to established policies and standards and monitors compliance with these requirements through ongoing reporting processes and during annual on-site compliance visits.

Network Adequacy

The Code of Federal Regulations at 42 CFR Parts 438.68 and 457.1218 charges states holding managed care contracts with the development and implementation of network adequacy standards. 42 CFR 438.68(b)(iii) also indicates that standards pertinent to behavioral health must be developed for the adult and pediatric populations.

MDHHS requires all Medicaid managed care programs to ensure that enrollees have access to medically necessary care, supports and services and associated providers of all services. To meet this goal, MDHHS in collaboration with CMS and the managed care program establishes applicable standards to ensure enrollees have access to an adequate network of medical, pharmacy, durable medical equipment, behavioral health, and long term supports and services (LTSS) providers that are appropriate and capable of addressing the needs of diverse populations.

Managed care entities must maintain a network of qualified providers in sufficient numbers, mix, and geographic locations throughout their respective service area, including counties contiguous to contractor's service area, for the provision of all covered services. The provider network must be sufficient to serve the maximum number of enrollees specified in the contract including children with special health care needs (CSHCS) enrollees and persons with special health care needs; and consider anticipated enrollment and expected utilization of services with respect to the specific Medicaid populations (e.g., disabled, CSHCS, duals). In addition, MCEs must ensure contracted providers offer an appropriate range of preventive care, primary care, behavioral health services, and other specialty services to meet the needs of all enrollees. A network of pediatric subspecialists, children's hospitals, pediatric regional centers, and ancillary providers must be available to provide care for CSHCS enrollees.

If MDHHS grants a network exception, the entity must submit a description of how it will reasonably deliver covered services to enrollees who may be affected by the exception and how the entity will

work to increase access to the provider type in the designated county or counties. MCEs are further required to monitor, track and report to MDHHS the delivery of covered services to enrollees potentially affected by the exception.

MDHHS also requires managed care entities to ensure reasonable accommodation for enrollees related to physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities. MCEs are required to establish mechanisms to ensure network providers compliance with standards and routinely monitor compliance and take corrective action if there is a failure to comply. Finally, contracted plans/agencies must participate in MDHHS initiatives to promote the delivery of services in a culturally responsive manner to all enrollees including those with limited proficiency in English, deaf and hard of hearing (DHOH), diverse cultural and ethnic backgrounds, disabilities, and regardless of gender or other factors in accordance with 438.206(c)(2).

Table 9 outlines Medicaid managed care program access standards.

Table 9: Medicaid Managed Care Program Access Standards

Medicaid Managed Care Program	Access Standards
Comprehensive Health Care Program (CHCP): Medicaid Health Plans (MHPs)	<ul style="list-style-type: none"> • MHPs must ensure primary care physicians provide or arrange for coverage of services 24 hours a day, 7 days a week when medically necessary and primary care providers must be present a minimum of 20 hours at each practice location. • MHPs must ensure a ratio of one PCP per 500 members, except when this standard cannot be met because a geographic area does not have sufficient PCPs to meet this standard. • Consideration must be given to the geographic location of providers and enrollees. • Non-rural primary care and hospital services must be available to enrollees within 30 minutes of travel time or 30 miles unless the enrollee chooses otherwise. Exceptions to this standard may be granted under certain circumstances. • MHPs must ensure that enrollees have full freedom of choice to family planning providers (in-network and out-of-network); allow enrollees to seek family planning services, drugs, supplies and devices without prior authorization; and allow women who are pregnant at the time of enrollment to select or remain with the Medicaid maternity care provider of choice.
Children Special Health Care Services (CSHCS): Medicaid Health Plans (MHPs)	MHPs must give special consideration to the CSHCS population by seeking contracts with providers who have established relationships with CSHCS enrollees and working with non-contracted providers. If the plan does not have a contract with the provider, all claims must be paid at the Medicaid FFS rate.
Healthy Kids Dental (HKD)	<ul style="list-style-type: none"> • HKD plans must maintain a general dentist-to-enrollee ratio of at least one full-time unique general dentist per 650 members (minimum of 20 hours per week per practice location). More lenient ratios are in effect in a small number of rural counties. General dentistry providers must be accessible within 30 minutes and 30 miles in non-rural areas and 40 minutes and 40 miles in rural areas. Specialists must be available within 60 minutes and 60 miles in non-rural areas and 120 minutes and 120 miles in rural areas. • HKD plans must develop and submit an annual Network Access Plan as part of compliance review.
MI Choice Waiver: Waiver Agencies	MDHHS annually reviews MI Choice provider network lists and any updates submitted by the waiver agencies to ensure enough providers are available to meet the needs of the population served. Waiver agencies must offer a choice of provider for each MI Choice service. They must also contract with enough providers to have capacity within their network to serve 125% of anticipated service utilization. Finally, each waiver agency must have contracted network providers within a 30-mile radius or 30-minute distance from each enrollee. MDHHS may grant provider network exceptions requests for rural areas or for services in which the waiver agency uses out of network providers to meet requirements.

MI Health Link: Integrated Care Organizations (ICOs)	<ul style="list-style-type: none"> • For LTSS services and services for which Medicaid is exclusive at a minimum the ICO must have at least two (2) available providers for each provider type with sufficient capacity to accept Enrollees. • For services provided in the Enrollee's home, the ICO must assure that the Enrollee has choice of providers. • For services provided in the community, the ICO must assure that the Enrollee has a choice of providers, and the Enrollee does not travel more than thirty (30) miles or for more than thirty (30) minutes to receive the service. • If the ICO cannot assure choice within the travel time or distance for each Enrollee, it may make a request of MDHHS for a rural exception. • Appointment and Timely Access to Care Standards: <ul style="list-style-type: none"> ○ Emergency Services - Immediately 24 hours/day 7 Days per week ○ Urgent Care - Within 48 hours ○ Routine Care - Within thirty (30) Business Days of request ○ Non-urgent Symptomatic Care - Within seven (7) Business Days of request ○ Specialty Care - Within six (6) weeks of request ○ Acute Specialty Care - Within five Business Days of request ○ Emergency Dental Services- Immediately 24 hours/day 7 Days per week ○ Urgent Dental Care - Within 48 hours ○ Routine Dental Care - Within twenty-one (21) Business Days of request ○ Preventive Dental Services - Within six (6) weeks of request ○ Initial Dental Appointment - Within eight (8) weeks of request
Behavioral Health Programs: Prepaid Inpatient Health Plans (PIHPs)	<ul style="list-style-type: none"> • MDHHS utilizes the minimum time/distance standard of 30-minute/30-mile and 60-minute/60-mile for behavioral health services for urban and rural areas, respectively. • Michigan's specialty behavioral health standards reflect current federal rules for Medicaid enrollee-to-provider ratios for services congruent with community need and statewide strategic priorities. These services for adults include Assertive Community Treatment, Crisis Residential Programs, and Psychosocial Rehabilitation Programs (Clubhouses). For children, services include Crisis Residential Programs, Home-Based, and Wraparound Services. • Opioid Treatment Program standards reflect both adults and children; adults and children have distinct standards for Crisis Residential Programs. The chosen standards reflect the top quartile of enrollee-to-provider ratios (except for Crisis Residential Programs, which reflects a distinct methodology based on the number of beds per total population). • PIHP's are required to submit (upon request) a plan on how the standards will be effectuated by the PIHP's region. MDHHS expects to see nuances within the PIHPs to best accommodate the diversity of the local populations served. • PIHPs must consider at least the following parameters for their plans: maximum time and distance; timely appointments; language, cultural competence, and physical accessibility

Availability of Services

Adequacy of Capacity and Services

The State's Department of Insurance and Financial Services (DIFS) is responsible for the initial review and approval of comprehensive health plan service area and capacity. DIFS review and approval requires health plans to attest that adequate capacity is available through both contracted and out-of-network arrangements. MDHHS accepts the DIFS determination, conducts a Medicaid program network adequacy review, and issues all final approvals for the adequacy of the health plan physician, hospital, and ancillary network.

MDHHS has a Memorandum of Understanding with DIFS for the MI Choice program stating that DIFS allows MDHHS to approve entities as qualified Pre-paid Ambulatory Health Plans.

Assurances of Adequate Capacity and Services

After initial approval, MDHHS monitors the network adequacy throughout the year to assure that any changes in the network arrangements do not affect the ability of an enrollee to obtain needed care. Access, availability, and adequate capacity and services are assessed during on-site compliance visits as specified by the managed care program.

MDHHS has established provider capacity requirements for contracted managed care entities (MCE) to maintain a network of qualified providers in sufficient numbers, mix, and geographic locations. MDHHS requires MCEs to ensure adequate capacity of specialty services, ancillary services (such as durable medical equipment services) and home health services. Entities must notify the respective MDHHS managed care program if there are changes to the composition of the provider network that affects enrollee access to covered services. In addition, MCEs are required to submit provider files that provide a description of the Entities' service network, including the specialty and hospital network and other arrangements for the provision of medically necessary non-contracted specialty care.

The three-way (CMS, MDHHS, ICOs) MI Health Link contract requires ICO's to demonstrate the capacity to provide, directly or by subcontracting with other qualified entities, the full continuum of Medicare and Medicaid covered services to enrollees. The ICO must have sufficient capacity to provide home and community-based services to meet the needs of enrollees who choose to receive services in the community; and must assure that arrangement that support self-determination are available among the network of service providers.

MDHHS requires each MI Choice waiver agency to have a provider network with capacity to serve at least 125% of their expected utilization for each MI Choice service and at least two providers for each MI Choice service. This assures network capacity as well as choice of providers. Additionally, the waiver agency must have adequate contracted network providers within a 30-mile radius or 30-minute distance from each enrollee.

Access to Care During Transitions of Coverage

Transition of care requirements for Medicaid Managed Care are defined under 42 CFR, Section § 438.62(b) and § 457.1216. These regulations specify that the State must have a transition of care policy to ensure continued access to services during a transition from FFS to a managed care entity or transition from one entity to another when an enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. Given the multiple Medicaid managed care programs in Michigan, MDHHS requires each managed care program to develop a transition of care policy, as applicable to the population(s) being served, to be implemented by the respective contracted entity. The coverage periods for continuity of care may vary by managed care program. Managed care entities must make their transition of care policy publicly available and provide instructions to members on how to access continued services upon transition and be explained in the member handbook in accordance with § 438.10 and must be described in their quality strategy (as in § 438.340).

The Comprehensive Health Care Program (CHCP) is working with the Medicaid Health Plans (MHPs) to develop a transition of care policy that addresses, at a minimum, requirements to ensure an enrollee has continued access to necessary services as specified in the Federal regulations. MDHHS is recommending that the MHPs exercise clinical expertise and commitment to the optimal health outcomes of their enrollees when following the requirements.

Transitions of care for CSHCS enrollees fall under the scope of the MDHHS MSA transitions of care and Medicaid Health Plan policies. In addition, HRSA's Maternal and Child Health Bureau (MCHB) core outcomes state that "youth with special health care needs receive the services necessary to make

transitions to all aspects of adult life, including adult health care, work, and independence.” Michigan has implemented this core indicator by collaborating with youth, families, providers, and professionals. Through these collaborative efforts, Michigan provides education about the process of transition, care, and tools to begin transition planning, and works to coordinate systems of care for youth.

The MI Health Link program transition of care policy authority is outlined in the three-way contract between CMS, MDHHS, and the ICOs. Transition requirements vary based on the service and population, in accordance with the requirements and timelines set forth in Section 2.6.10. through 2.6.10.6.1.3 of the ICO Contract. The transition requirements address physician/practitioner relationships, care plans, prior-authorizations, current treatments, and levels of services as well as out-of-network providers and services.¹⁹

MDHHS ensures participants have a choice of a waiver agency, as available, to coordinate MI Choice services. A participant may choose to transfer enrollment from one waiver agency to another, as available within the region where the participant lives, or a participant may move to another region of the state. Waiver agencies are responsible for managing transfers of participants to other agencies or accepting transfers from another agency. Waiver agencies must ensure that participants are transferred from one agency to another, preserving continuity of care and the integrity of the participant’s preferences and person-centered plan. The new waiver agency must perform an initial assessment that may include a Level of Care Determination (LOCD), within the timeframes specified in MDHHS policy. The new waiver agency must also review person-centered service plan (PCSP) activity and authorize a new PCSP with the participant.

Coordination and Continuity of Care

Michigan provides comprehensive, continuous, and coordinated care to Medicaid beneficiaries enrolled in managed care. Programs contractually require plans/agencies to be responsible for coordinating and collaborating health care and support services provided to enrollees. Managed care entities are also contractually responsible for the coordination and continuity of care provided to enrollees who require integration of medical, behavioral health or substance abuse services, and to demonstrate a commitment to case managing the complex needs of enrollees.

The Comprehensive Health Care Program (CHCP) assesses the continuity of the coordination of care and case management processes during the compliance review process. In addition, continuity and coordination of care are components of the mandatory Medicaid Health Plan (MHP) accreditation process that requires plans to meet or exceed established standards to maintain accreditation status. In general, MHPs must ensure that enrollees have an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed. MHPs must also implement procedures to deliver care to and coordinate services that meet state requirements for coordinating care and services between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays and from community and social support providers.

Care coordination is a core function of the MI Health Link program. MI Health Link requires coordination of services for all individuals to ensure effective integration and coordination between providers of medical services and supplies, behavioral health, substance use disorder (SUD) and intellectual/developmental disabilities (I/DD), pharmacy, and long term supports and services (LTSS). This requires coordination between the Integrated Care Organization (ICO) and the Pre-paid Inpatient Health Plan (PIHP) or the LTSS entities, where applicable.

The ICOs are required to provide care coordination services to all enrollees through multidisciplinary integrated care teams (ICTs). The ICO care coordinators are responsible for coordinating enrollees’

medical health, behavioral health, LTSS, and social services. In addition, they conduct functional assessments to determine nursing facility level of care and prepare HCBS waiver applications. The Integrated care teams led by the care coordinators are responsible for developing and implementing comprehensive, person-centered care plans to address each enrollee's specific preferences and needs. Coordination of medical and behavioral health services is a collaboration between the ICOs and the PIHPs. ICOs are required to facilitate timely and thorough coordination and communication among the ICO, the primary care provider, PIHP and LTSS Supports Coordinators, and other providers. ICOs share information through a Care Coordination Platform which is supported by web-based technology that allows for secure access to information. The Care Coordination Platform is used to document assessments and care plans with personal goals, preferences, and enrollee approval with the care plan.¹⁴

The PIHPs provide care management services and other targeted interventions to enrollees. In addition, the MHPs and PIHPs are contractually required to work collaboratively to meet the needs of mutually served enrollees who have significant behavioral health issues and complex physical co-morbidities. Current contract language requires that PIHPs and MHPs have written coordination agreements where the plans serve mutually serviced enrollees in their respective service areas.

The written agreement describes the coordination arrangements, inclusive of but not limited to, the exchange of information, referral procedures, care coordination and dispute resolution. The arrangements must also address the integration of physical and mental health services. The goal is greater system integration across physical and behavioral health care delivery systems, as well as provision of community-based social support services. The MHPs and PIHPs recognize the value of continuing to update and enhance its Coordinating Agreement to reflect quality improvement efforts and incorporate provisions that will define and strengthen levels of streamlined collaboration.

The MHPs/PIHPs utilize the MDHHS electronic care management tool available in CareConnect360 (CC360) to document a jointly created care plan and to track contacts, issues, and services. In addition, the MHP/PIHP care managers hold case reviews at least monthly. The care managers and other team members, including CHWs, pharmacists, medical directors, and behavioral health providers, discuss shared enrollees who have significant behavioral health issues and complex physical co-morbidities and develop shared care management interventions.

MI Choice supports coordination facilitates access to, and arrangement of, services, supports, treatments, and other interventions needed and chosen by MI Choice participants which are detailed and documented in the person-centered service plan. Supports coordinators assist MI Choice enrollees with securing the services and supports identified on the person-centered service plan, regardless of payer. Supports coordinators assist enrollees with transitions of care including from home to a different setting and back, or when the enrollee chooses a different HCBS program.

Providing Care Management Services and Other Targeted Interventions

Managed care program contracts also address care management services for the Medicaid population. For example, the Comprehensive Health Care Program (CHCP) Medicaid Health Plan (MHP) contract stipulates MHPs must offer a robust care management program that meets NCQA and/or URAC accreditation standards to enrollees who qualify for these services, and other populations as designated by MDHHS, including but not limited to disabled populations, high-risk pregnancies, and chronic condition-specific populations. MHPs must risk stratify enrollee information to identify members who may qualify for intensive, moderate, or low intensity care management services. Managed care plan contracts also require plans/agencies to the extent possible, to coordinate with other care managers and supports coordinators, and refer and coordinate services with appropriate resources to reduce socioeconomic barriers, including access to safe and affordable housing, employment, food, fuel

assistance and transportation to health care appointments. Care managers should create a person-centered care plan developed in conjunction with the member, family, and care team.

MDHHS defines performance standards for MI Choice Supports Coordination within MDHHS policy which is reviewed and amended as necessary. MI Choice Supports Coordinators work with each enrollee to develop person-centered service plans. A written person-centered service plan (PCSP) documents issues, concerns, conditions, and specific supports and interventions needed. The person-centered planning process involves families and professionals, promotes community living, and honors individual preferences, choices, and abilities. Supports coordinators monitor the quality of services received by the participant and explore other funding options and service opportunities when personal goals exceed the scope of available MI Choice services. For participants choosing the self-determination option for service delivery, the supports coordinator assists in the selection, coordination, and management of those services and providers.

Coverage and Authorization of Services

Managed care contracts require managed care entities (MCEs) to have a utilization management (UM) program that encompasses, at a minimum, written policies and procedures to evaluate medical necessity, criteria used, information sources and the processes used to review and approve the provision of medical services that conform to managed care industry standards (e.g., NCQA UM accreditation standards). UM programs must have mechanisms to identify and correct under-utilization as well as over-utilization; and establish prospective (preauthorization), concurrent and retrospective procedures that include review decisions by qualified medical professionals who have the appropriate clinical expertise. The MCE should make efforts to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate. The reasons for decisions must be clearly documented and available to enrollees; and appeals mechanisms for both providers and service recipients must be well-publicized and readily available. Denial notifications must be made in a timely manner and include a description of how to file an appeal. The MCE Authorization policy must establish timeframes for standard and Expedited Authorization Decisions. MCEs must not use UM policies and procedures to avoid providing medically necessary services within the coverages established under the respective managed care contract. Mechanisms to evaluate the effects of the UM program using data on member satisfaction, provider satisfaction or other appropriate measures must be in place. Finally, if the MCE delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate. UM program examples for several of the managed care programs are provided below.

The Comprehensive Health Care Program (CHCP) contract stipulates that Medicaid Health Plans (MHPs) establish a formal utilization review committee to oversee the UM process; have sufficient resources to regularly review the UM process and make changes, as needed; conduct an annual review and reporting of UM activities, outcomes, and interventions; and the UM program must integrate with the plan's quality assessment and improvement program (QAPI). For prior authorization decisions related to CSHCS enrollees, MHPs are encouraged to consult with the Office of Medical Affairs Medical Consultants to determine pediatric sub specialists, hospitals, and ancillary providers available and appropriate to render services to CSHCS population. MHPs are also encouraged to utilize Office of Medical Affairs Medical Consultants for assistance in determining appropriate durable medical equipment for CSHCS enrollees.

The MI Health Link ICO UM programs must comply with CMS requirements and timeframes for historically Medicare primary paid services in addition to the requirements for historically Medicaid primary paid services. The ICO's UM program must ensure consistent application of review criteria for authorization decisions; and must consult with the requesting provider when appropriate. The UM program must demonstrate that enrollees have equitable access to care across the network and that UM

decisions are made in a fair, impartial, and consistent manner that serves the best interests of the Enrollees. The program must have mechanisms to detect under-utilization and/or overutilization of care including, but not limited to, provider profiles.

MI Choice waiver agencies determine the appropriateness and efficacy of services provided. As part of the Administrative Quality Assurance Review (AQAR) process, MDHHS conducts financial reviews by evaluating a sample of participants' claims to the services included on the person-centered service plan over a three-month period. This process includes reviewing the service record from inception through approved Medicaid encounter data to verify records match by date of service, amount, duration, and type of service. During Clinical Quality Assurance Review (CQAR) reviews, the person-centered service plan is compared to interRAI Home Care Assessment System (iHC) data and other information available in the record to assure the service plan meets the participants identified needs.

Structure and Operations Standards

To achieve Michigan Medicaid managed care objectives, contracted health managed care entities (MCEs) are required to adhere to structure and operations standards which are delineated in the respective program contracts. These standards ensure that plans have network of appropriately credentialed providers; enrollee information that adheres to Federal regulations pertaining to language, format, content and timeliness; maintenance of confidentiality; and enrollment/disenrollment, grievance systems, and subcontractor and delegated relationships are subject to appropriate oversight.

Program contracts require MCEs to comply with the following operational requirements, which MDHHS assesses prior to the contracting process and during on-site compliance reviews:

- Certificate of Authority to operate as a health maintenance organization in Michigan
- Organizational structure with key specified personnel
- Management information systems capable of collecting, processing, reporting and maintaining information as required
- Governing body that meets contract specifications
- Administrative requirements (i.e., quality improvement/QAPI, utilization management, provider network, reporting, member services, provider services and staffing, etc.)
- Provider Selection
- All managed care program entities must contract directly or subcontract only with qualified or licensed providers who continually meet federal and State requirements, as applicable. Provider selection processes include a requirement that plans may not discriminate against any provider with respect to participation, reimbursement, or indemnification if the provider is acting within the scope of his or her license or certification under applicable state law, solely on the basis of such license or certification. MCEs are also prohibited from establishing selection policies and procedures for providers that discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

Managed care contracts require MCEs to have written policies and procedures in place to credential and recredential all providers prior to contracting; review and authorize network provider contracts; and comply with all federal and state business requirements. The written policies and procedures must outline the monitoring of contracted providers and describe the process for sanctioning providers who are out of compliance with the plan's quality and utilization management requirements. Plans must also ensure that network providers residing and providing services in bordering states meet all applicable licensure and certification requirements within their state. Provider credentialing, recredentialing, and contracting are components of the mandatory CHCP Medicaid Health Plan accreditation process whereby plans must meet or exceed established standards to maintain accreditation status.

MDHHS requires MCEs to ensure that debarred or suspended providers are excluded from participation in their networks and identify and act upon potential fraud and abuse by members, providers, or plan employees. MCEs must also adhere to federal regulations and state law precluding reimbursement for any services ordered, prescribed, or rendered by a provider who is currently

suspended or terminated from direct and indirect participation in the Michigan Medicaid program or federal Medicare program. MDHHS assesses compliance with credentialing, recredentialing, contracting, and fraud and abuse monitoring during compliance visits.

The MI Health Link ICO's must contract directly or subcontract only with qualified or licensed providers who continually meet federal and state requirements. ICOs must check the status of long-term services and supports (LTSS) providers in the List of Excluded Individuals/Entities (LEIE), Medicare Exclusion Database (MED) and System for Award Management (SAM) initially and on a quarterly basis thereafter. Such LTSS providers include, but are not limited to, the following: adult day program, respite, adaptive medical equipment and supplies, fiscal intermediary, assistive technology, chore services, community transition services, environmental modifications, expanded community living supports – non agency staff, home delivered meals, non-medical transportation, personal emergency response system, and state plan personal care services – non agency staff.¹⁵

If a provider is terminated or suspended from the MDHHS Medicaid Program, Medicare, or another state's Medicaid program or is the subject of a State or federal licensing action, the ICO must terminate, suspend, or decline a provider from its Provider Network as appropriate.

MI Choice waiver agencies determine the status of the qualifications and certifications (if applicable) for all direct service providers, negotiate and enter into contracts with providers. Entities or individuals under subcontract with the waiver agencies must meet provider standards for MI Choice Waiver Program Services. Only providers meeting the requisite waiver requirements are permitted to participate in the waiver program. To ensure providers meet these contractual requirements, MDHHS uses the MI Choice Site Review Protocol (MICSRP) to assess the performance of waiver agencies and assure services covered by the program are performed in accordance with the waiver. The MICSRP Administrative Quality Assurance Review (AQAR) assures each waiver agency has policy and procedures consistent with waiver requirements.

Clinical Practice Guidelines

Managed care entities are required to develop or adopt, disseminate, and monitor the use of clinical practice guidelines, protocols, and practice parameters relevant to the respective plan population(s). The clinical guidelines should be based on valid and reliable clinical evidence or a consensus of health care professionals or professionals with expertise in the assessment and delivery of long-term services; stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines or are developed with involvement of board-certified providers from appropriate specialties or professionals with expertise in the assessment and delivery of services. The guidelines must not contradict existing Michigan-promulgated statute and policies, or requirements as published by the Departments of Health and Human Services, Licensing and Regulatory Authority, Insurance and Financial Services, or other State agencies.

The clinical guidelines and protocols must be reviewed and revised, as appropriate, based on national guidelines revisions, changes in valid and reliable clinical evidence, or consensus of health care professionals and providers. Approved guidelines should be available on the entity's website and disseminated, in a timely manner, to all new network providers, to all affected providers, upon adoption and revision, and, upon request, to enrollees and potential enrollees.

The guidelines should be distributed with sufficient explanation and information to enable the providers to meet the established standards. In addition, plans must establish explicit processes for monitoring the consistent application of clinical and practice guidelines across utilization management (UM) decisions and enrollee education, coverage of services; and submit to MDHHS a listing and description of clinical guidelines adopted, endorsed, disseminated, and utilized by the plan, upon request.

The Comprehensive Health Care Program (CHCP) plans are required to demonstrate processes to adopt, implement, use, and measure clinical practice guidelines as a component of the mandatory accreditation process. MDHHS uses evidence-based guidelines to develop performance standards and measures for prevention and prevalent chronic conditions, which are incorporated into the QI program. Guidelines also serve as a basis for disease management, case management, and care management program development and intervention, and utilization management programming (e.g., medical necessity determination). Up to 2023, MDHHS and all CHCP contracted MHPs endorsed the Michigan Quality Improvement Consortium (MQIC) guidelines. MQIC was a statewide collaborative body comprised of health plans, physicians, researchers, and others that develops, implements, and disseminates preventive and chronic disease clinical practices guidelines to Michigan physicians. Although MQIC dissolved in 2023, the Michigan Association of Health Plans (MAHP) has expressed intent to carry forward the initiative starting in 2024. In the meantime, the state still holds plans contractually responsible for keeping up with current clinical guidelines. In clinical areas where no MQIC guideline has been developed, MDHHS and the MHPs adopt nationally recognized, evidence-based guidelines for care. Guidelines are disseminated to providers and are made available to enrollees upon request.

Enrollee Information

Managed care contracts require member handbooks to be current, clear, and understandable. Health plans are required to maintain documentation verifying that the information in the member handbook is reviewed for accuracy at least annually. Michigan Medicaid requires the readability level of the member handbook be written at no higher than a 6.9 grade reading level and available in languages other than English when more than five percent of the health plan's enrollees speak another language. MI Health Link ICO enrollee communications materials must be translated into Prevalent Languages for all materials, as specified in the Medicare-Medicaid marketing guidance and annual guidance to the ICO on specific translation requirements for its service area. Prevalent Languages are those that meet the more stringent of either: (1) Medicare's 5 percent threshold for language translation; or (2) MDHHS's Prevalent Language requirements.

All written and oral materials directed to enrollees relating to benefits, coverage, enrollment, grievances, appeals, or other administrative and service functions (e.g., handbooks, newsletters, member enrollment materials) must be approved by MDHHS (and CMS where applicable), prior to distribution to enrollees. Member handbooks and marketing/educational materials are assessed by MDHHS during the on-site compliance visit. Enrollee information must be made available in alternative formats, upon request and as needed, to ensure effective communication for individuals who are blind or have impaired vision; and provided in a manner, format and language that may be easily understood by persons with limited English proficiency, or for those with developmental disabilities or cognitive impairments. In addition, MI Health Link enrollee information must be mailed with non-English language taglines that alert enrollees with limited English proficiency to the availability of language assistance service, free of charge, and how those services can be obtained, consistent with the requirements of 45 C.F.R. Part 92 and as applicable, mailed with a non-discrimination notice or statement, consistent with the requirements of 45 C.F.R. Part 92. Information required in member handbooks is delineated in the respective managed care program contracts.

The health plan provider directory is published separate from the member handbook. Contracts specify that the provider directory must list providers by county including provider name, address, telephone numbers and any hospital affiliation; day and hours of operation; languages spoken at the primary care sites; and whether the provider is accepting new patients.

Enrollment and Disenrollment

Managed care contracts specify enrollment, disenrollment, and lock-in processes specific to the managed care program, as applicable. Contracts prohibit discrimination against individuals eligible to enroll on the basis of health status or the need for health services; or race, color, national origin, age, disability, sex, or other factors identified in 42 CFR 438.3(d). MDHHS tracks disenrollment and transfers between managed care entities (MCEs) through a monthly report produced by MI Enrolls. MDHHS uses this report to monitor and assess for fluctuations, trends, and reasons for disenrollment or transfer and takes action, as appropriate.

Disenrollment provisions apply to all enrollees equally, regardless of whether enrollment was mandatory or voluntary. Contracted plans may not request disenrollment because of an enrollee's adverse change in physical or mental health status; utilization of medical services; diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees).

MI Choice waiver agencies assess medical/functional eligibility during an in-person visit using the Nursing Facility Level of Care (NFLOC) determination. MDHHS requires waiver agencies to put NFLOC results for all applicants in the State's NFLOC system. Nursing facility level of care determinations are made by the MDHHS MSIS system (CHAMPS) and Medicaid eligibility determinations are made by MDHHS. The waiver agency also conducts an in-depth assessment of the individual to determine whether the applicant requires and agrees to receive at least one MI Choice service on a regular basis before requesting approval of enrollment of the individual in the program.

MI Choice participants are disenrolled from MI Choice upon their admission to a nursing facility, facility-based hospice services, or an Intermediate Care Facility for Individuals with Intellectual or Developmental Disability (ICF/IID). Other reasons for disenrollment include death, moved out of the waiver agency's service area, no longer eligible, refused services, transferred to another waiver agency, based upon a hearing decision, for cause, administrative, and participant choice. All participants are provided the appropriate notice before the disenrollment is processed.

Confidentiality

Managed care programs contractually require managed care entities (MCE) to comply with all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). All enrollee information, medical records, data and data elements collected, maintained, or used in the administration of the contract must be protected from unauthorized disclosure. The MCE must provide safeguards that restrict the use or disclosure of information concerning enrollees in accordance with HIPAA privacy and security regulations; and must have written policies and procedures for maintaining and safeguarding the confidentiality of data obtained or created in the course of fulfilling its obligations under the contract in accordance with applicable State and federal laws including medical records, client information, appointment records for adult and adolescent sexually transmitted disease, and family planning services. MDHHS monitors MCE adherence to security and privacy standards during compliance visits and reviews.

Grievance and Appeals Systems

Contracted Medicaid managed care entities must have MDHHS approved, written policies and procedures for the resolution of grievances and appeals. The enrollees must be informed about the plan's internal grievance and appeal procedures at the time of initial enrollment and any other time an enrollee expressed dissatisfaction by filing a grievance with the MCE. When a MCE makes a decision subject to appeal, a written adverse action notice must be provided to the enrollee and the requesting

provider. Written policies and procedures must clearly outline timeframes for the timely adjudication of grievances and appeals.

MI Health Link enrollees may file a grievance at any time as allowed in 42 C.F.R. § 438.402(c)(2)(i); and may file an external grievance through 1-800 Medicare. The ICO must display a link to the electronic Grievance form on the Medicare.gov Internet Web site on the ICO's main Web page per 42 C.F.R. § 422.504(a)(15)(ii). Authorized representatives may file Grievances on behalf of enrollees to the extent allowed under applicable federal or State law. ICO's must coordinate enrollee grievances for Medicare behavioral health services with the PIHP when the ICO maintains a contract with the PIHP for such services. CMS and MDHHS review, approve, and monitor the ICO's Grievance and Appeals procedures.

MDHHS has established notice and appeals requirements for the MI Choice program to which waiver agencies must adhere when an adverse action has been taken for program applicants or participants. According to 42 CFR 431.201 "Action" means termination, suspension, or reduction of Medicaid eligibility or of covered services. This also includes determinations where the applicant or participant does not meet the nursing facility level of care criteria and other denials of eligibility or covered services.

MDHHS assesses compliance with complaint and grievance requirements during compliance reviews, which includes assessment of grievance and appeal logs. Grievance and appeals processes and compliance with timeframes is also a required component of the Comprehensive Health Care Program (CHCP) Medicaid Health Plan (MHP) accreditation process, which includes a review of complaint and grievance files.

Sub-Contractual Relationships and Delegation

Managed care contracts specify that the managed care entities are responsible for subcontractor adherence to all provisions of the MCE contract. MCEs are required to furnish information to the State regarding cost of the subcontract, procedures for oversight and monitoring of subcontractor performance, and any other data that may be required by the State. MCEs must notify MDHHS of the intent to delegate any contractual duties or obligations as specified in the applicable managed care program contract.

Delegation is a component of the mandatory Comprehensive Health Care Program (CHCP) Medicaid Health Plan accreditation process and is monitored by the Department of Insurance and Financial Services (DIFS) as part of the annual review of licensed Michigan health maintenance organizations.

Health Information Technology/Systems

MDHHS requires plans to maintain health information systems consistent with the requirement established in contracts and that supports all aspects of the specified managed care program. The electronic health information system must meet all applicable State and federal guidelines for privacy and security of protected health information exchanged for the purposes of treatment, payment, or operations. This includes supporting MDHHS initiatives to increase the use of Health Information Exchange and Health Information Technology (HIE/HIT) to improve care management and coordination; reduce Fraud, Waste and Abuse; and improve communication between systems of care. Plans must have the capability to collect, analyze, integrate, and report data to achieve the objectives of the Medicaid Program, that include but are not limited to:

- Implementing and maintaining an electronic data system, by which providers and other entities can send and receive client-level information for the purpose of care management and coordination; and

- Receiving admission, discharge, and transfer (ADT) type messages or information to improve care management and care coordination in response to hospital admissions and readmissions at the plan level and within its provider network. Ensuring that data received from providers is accurate and complete by verifying accuracy and timeliness; screening for completeness, logic, and consistency; collecting information in standardized formats; and identifying and tracking fraud and abuse.
- Meeting HIPAA, MDHHS and CMS guidelines and requirements for electronic billing capacity to include a management information system sufficient to support provider payments and data reporting between the health plan and MDHHS.
- Submitting performance monitoring and data (e.g., complaint and grievance data, claims and encounters, provider data files) and collecting, analyzing, and reporting quality performance data as described in 42 C.F.R. §§ 438.242(a), 422.516(a) and 423.514.

In addition, MDHHS has established rules and guidelines designed to advance the adoption and meaningful use of certified Electronic Health Record (EHR) technology through the Medicare and Medicaid EHR Incentive Programs authorized by the Health Information Technology for Economic and Clinical Health Act (HITECH). MDHHS participates in the Medicaid Electronic Health Record (EHR) incentive program pursuant to the final rule on meaningful use of EHRs under the Medicare and Medicaid EHR incentive programs. Plans are encouraged to utilize these rules as guidelines when designing and establishing HIT programs and processes. Contracted health plans must also engage in activities that further MDHHS's goal that Medicaid eligible professionals and hospitals become meaningful users. Following the sunset of Promoting Interoperability (Meaningful Use) in 2021, Michigan is well positioned to leverage past investments for ongoing interoperability and continued data sharing. Managed care plans will continue to be key champions in further health information exchange efforts.

MDHHS and the managed care programs encourage use of CareConnect360 (CC360), a statewide Web portal and care management tool developed by MDHHS to integrate physical and behavioral health-related information to provide a comprehensive view of an enrollee's health care needs. The MHPs and PIHPs currently utilize CC360 to identify and conduct care coordination and case management for mutually served beneficiaries. MHPs work collaboratively with PIHPs to identify and coordinate the provision of services to enrollees who have significant behavioral health issues and complex physical co-morbidities. The plans utilize the care management tool available in CC360 to document a jointly created care plan and to track contacts, issues, and services. CC360 is also used to improve the health and safety of children in foster care.²⁰

The MI Health Link ICOs also utilize care coordination information technology platforms to coordinate care across the delivery system. To meet contractual requirements, each ICO must implement a secure, care coordination platform to maintain the enrollee's electronic health record. The platforms facilitate information sharing and communication between the ICO, primary care provider, PIHP and LTSS Supports Coordinators, and other providers. In addition, the demonstration leveraged the Michigan Health Information Network (MiHIN), the State's health information exchange, which ICOs and PIHPs use to exchange protected health information. The State requires ICOs to transmit referrals and Level 1 assessments to the PIHPs through MiHIN.

MI Choice waiver agencies participate in MiHIN and other HIE/HIT applications to receive health information such as hospital admissions and emergency room visits about their enrollees. This information is used to assure other health care providers know the patient is a MI Choice participant and to facilitate a coordinated care transition. The waiver agencies also have access to the CC360

application and may use this to assist with coordinating care across all of the enrollee's health care providers.

Section IV: IMPROVEMENT AND INTERVENTIONS

Quality Assessment and Performance Improvement Program Interventions

Accreditation

Michigan's managed care plans have a longstanding history of exceeding national accreditation standards. In addition to contractual requirements, accreditation by a national accrediting body provides additional impetus for plans to implement continuous quality improvement processes across programs and services.

MDHHS contractually requires the Comprehensive Health Care Program (CHCP) Medicaid Health Plans (MHPs) to hold and maintain accreditation as a managed care organization by the National Committee for Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC) for Health Plans. As such, MDHHS is committed to the nonduplication of activities through the use of information from private accreditation reviews as a part of the annual compliance review process as allowed in CFR §438.360. Since all of the MHPs are NCQA accredited, MDHHS uses the most current NCQA Medicaid Managed Care Toolkit as a guide to compare the NCQA Health Plan Accreditation standards to the standards established through the EQR protocols, and specifically for the mandatory compliance review activity described in 42 CFR §438.358(b)(iii), to identify those areas that are fully or partially comparable to federal and state-specific contract requirements and, therefore, eligible for deeming. MDHHS then assesses the most current MHP-specific accreditation reports and findings to determine the extent of nonduplication for each MHP. Annually, MDHHS publishes a list of the standards and elements that will be deemed in the current compliance review activity. Refer to **Appendix F for the list of the 2021 NCQA Deemable items**.

Further, the MHPs contract with an NCQA certified HEDIS® vendor annually to undergo a full audit of their HEDIS® reporting processes. As such, the results of each MHP's HEDIS® audit is used for the external quality review in lieu of completion of the mandatory validation of performance measures activity described in 42 CFR §438.358(b)(ii).

Pre-paid Inpatient Health Plans (PIHPs) and Community Mental Health Service Programs (CMHSPs) may be accredited by a national accrediting entity for behavioral health care services such as the Commission on Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission; of the 46 CMHSPs in Michigan, all but three have national accreditation.

A majority of MI Choice waiver agencies have obtained NCQA or CARF accreditation in the area of Case Management for Long-term Services and Supports or CARF International certification for case management or home and community-based services. Program of All-Inclusive Care for the Elderly (PACE) organizations may also seek national accreditation status to provide comprehensive services and integrated care to enrollees who meet Medicaid eligibility and long-term care eligibility criteria.

Effective January 2023, MI Health Link ICOs are contractually required to have NCQA LTSS Accreditation or Distinction for Health Plans.

Accreditation status is a component of the MDHHS annual Medicaid consumer guide entitled "A Guide to Michigan Medicaid Health Plans" and is included as part of the program compliance review

process. The Michigan Department of Insurance and Financial Services (DIFS) also lists HMO Accreditation Information.

Opioid Strategy

Michigan's 2020-2023 CQS described significant numbers of opioid-related overdose deaths and identified prescription drug misuse as a serious problem. Neonatal Abstinence Syndrome (NAS) was also identified as a critical concern impacting the health and well-being of women and infants across the State. A recent study continues to indicate that access to mental illness and substance use disorder treatment remains a critical issue in Michigan.²¹

In 2019, Governor Gretchen Whitmer, MDHHS and other members of the Michigan Opioids Task Force announced a strategy to combat the opioid epidemic and developed an action plan to cut opioid-related overdose deaths by half in five years. Michigan's strategy addresses three key areas: 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. BPHASA actively participates in and supports Michigan's opioid efforts.

MDHHS utilized a State Opioid Response (SOR) Grant administered by the Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA), to support Michigan's opioid strategy and action plan. As a part of the SOR, 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 beneficiaries with chronic conditions, provide flexibility to create innovative and integrated care management models, and offer sustainable reimbursement to affect the social determinants of health. Federally mandated core services include comprehensive care management and care coordination, health promotion, comprehensive transitional care and follow-up, individual and family support, and referral to community and social services. Participation in the Health Homes models is voluntary, and enrolled beneficiaries may opt out at any time.

The Opioid Health Home (OHH) (target population: opioid use disorder) provides services to Medicaid beneficiaries with opioid use disorder who also have or are at risk of developing another chronic condition. The OHH is available in all 21 counties in Michigan's Prepaid Inpatient Health Plan (PIHP) Region 2. The goals of the OHH are to:

- Increase access to MAT and integrated behavioral, primary, and recovery-centered services for beneficiaries with Opioid Use Disorder
- Decrease opioid overdose deaths
- Decrease opioid-related hospitalizations
- Increase utilization of peer recovery coaches
- Increase the "intangibles" of health status (e.g., the social determinants of health)

In January 2023, MDHHS expanded the OHH initiative to additional Michigan counties to provide intensive care management and care coordination services for Medicaid beneficiaries with an opioid use disorder (OUD). Expansion of the OHH program will help address the complexity of physical and behavioral health conditions and improve access to essential services to Michigan's residents.²² Michigan's CMS approved State Plan Amendment allows Michigan to expand into PIHP Regions 5 and 8 as well as Barry, Berrien, Branch, Cass, St. Joseph and Van Buren counties in Region 4. The expanded SPA will allow thousands of Medicaid beneficiaries who meet the eligibility criteria to receive OHH services.

Behavioral Health Integration

MDHHS recognizes the importance of integrating both physical health and behavioral health services to effectively address enrollee needs and improve the health status of individuals. MDHHS has therefore made a commitment to strengthen Michigan's Medicaid-funded behavioral health system to accomplish this goal and advance the well-being and quality of life for Michigan residents.

As previously indicated, the newly created Behavioral and Physical Health and Aging Services Administration (BPHASA) combined Michigan's Medicaid office, services for aging adults and community-based services for adults with intellectual and developmental disabilities, serious mental illness, and substance use disorders under one umbrella within MDHHS. The restructure allows for a focus on aging and long-term care issues, and the development of innovative policies that build upon the administration's existing efforts to deliver services to adults with mild to moderate mental illness.²³ The new Bureau of Children's Coordinated Health Policy and Supports (BCCHPS) also works collaboratively with other MDHHS administrations to improve and build upon the coordination and oversight of children's behavioral health services and policies.²⁴

In Michigan, mental health and developmental disability services are delivered through county-based Community Mental Health Services Programs (CMHSPs)/Pre-paid Inpatient Health Plans (PIHPs). All Medicaid managed care programs address the integration of behavioral health services by requiring plans to coordinate behavioral health services and services for persons with disabilities with the CMHSPs/PIHPs. While contracted plans may not be responsible for the direct delivery of specified behavioral health and developmental disability services (as delineated in Medicaid policy), 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.

CareConnect 360 (CC360), a MDHHS-supported statewide web-based care management tool, enables data sharing across physical and behavioral health continuums of care. MHPS and PIHPs leverage the care coordination tool to jointly serve their shared beneficiaries. In addition, MHPs are required to facilitate placement of primary care clinicians in community mental health centers (CMHC) and behavioral health clinicians in primary care settings. More recently, the contract requires plans to offer community health worker (CHW) or peer-support specialist services has enhanced care for enrollees who have significant behavioral health issues and complex physical co-morbidities. CHWs serve as a key resource for services and information needed for enrollees to have healthier, more stable lives. Examples of CHW services include but are not limited to conducting home visits; participating in office visits; arranging for social services; and helping enrollees with self-management skills.

MDHHS determines health plan compliance with coordination of care agreement requirements and continuity and coordination of medical and behavioral health services during the annual on-site survey. In addition, continuity and coordination of care is examined as a significant component of the mandatory health plan accreditation process.

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 beneficiaries, improves beneficiary experience, and lowers cost. The population health framework is supported through evidence- and value-based care delivery models, health information technology/health information exchange and a robust quality strategy. Population health management includes an overarching emphasis on health promotion and disease prevention and incorporates community-based health and wellness strategies with a strong focus on the Social Determinants of Health, creating health equity, and supporting efforts to build more resilient communities.

MDHHS supports payment reform initiatives that pay providers for value rather than volume; 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. Paying for value in the Medicaid population moves away from fee-for-service (FFS) models and embraces accountable and transparent payment structures that reward and penalize based on defined metrics.

The 2020-2023 CQS Goal #5: “Improve quality outcomes and disparity reduction through value-based initiatives and payment reform,” specifically addressed value-based payment. Michigan managed care programs are at varying stages of implementing and incorporating Alternative Payment Models (APMs) into managed care contractual requirements. Although programs have implemented APM strategies such as value-based payments and performance bonus withholds to advance the delivery system innovations, incentivize quality care, and improve health outcomes for enrollees, this continues to be an area of opportunity.

Managed care programs are at varying degrees of payment reform; however, all programs utilize a Performance Bonus (quality withhold) with defined measures, thresholds, and criteria to incentivize quality improvement and improved outcomes. In general, MDHHS withholds a portion of the approved capitation payment which is used for a performance bonus incentive. The incentives are distributed based on the criteria and thresholds established by the respective managed care program. Contracts require plans to fully participate with MDHHS-directed initiatives to integrate systems of care and ensure all Medicaid beneficiaries, particularly those with complex physical, behavioral, and social service needs, are served by person-centered models across all health care domains. Plans may also be encouraged to propose and pilot innovative projects.

The Comprehensive Health Care Program (CHCP) contract incentivizes plans to move from FFS reimbursement to value-based payment models. In the most recent CHCP contract, MHPs were required to increase the total percentage of health care services reimbursed under value-based contracts over the term of the agreement to earn their full quality withhold payout. Value-based payment models are defined as those that reward providers for outcomes, including improving the quality of services provided, promoting provision of appropriate services, and reducing the total cost of services provided to Medicaid beneficiaries. Value-based payment models include but are not limited to total capitation models; limited capitation models; bundled payments; supplemental payments to build practice-based infrastructure; and enrollee management capabilities. MHPs were also encouraged to consider payment for new services that promote more coordinated and appropriate care, such as care management and community health work services, that are traditionally not reimbursable. In addition, MHPs must utilize the Patient Centered Medical Home (PCMH) model within their Alternative Payment Model (APM) strategy.

The PCMH model of care is intended to ensure patient care is managed across a continuum of care and specialty services will be accessed as appropriate. MDHHS recognizes provider-delivered care management and care coordination (CMCC) services are foundational to healthcare transformation efforts and whole-person care (**CQS Goal #3**). CMCC programs have the ability to improve patient education and understanding, health outcomes, engagement, and lead to time and cost savings for patients. MDHHS leveraged resources to further invest in Michigan’s CMCC workforce, identify payment models to support care management and coordination, and strengthen clinical-community linkages to better understand and work toward addressing the underlying causes of poor health outcomes and patient identified social needs.

MDHHS also recognizes the value CMCC programs bring to the Medicaid provider community such as expanding opportunities to engage patients, improving patient outcomes, providing opportunities to

extend the care team, and creating opportunities to leverage reimbursement to deliver efficient care. The MDHHS PCMH program centered on further spreading the PCMH model of care, advancing primary care capabilities, making measurable improvement in quality of care, health outcomes, utilization/cost and patient satisfaction, and increasing PCMH participation in alternative payment methodologies linked to provider performance. Provider performance metrics include quality of care, health outcome, utilization, cost of care and care management/care coordination performance measures and benchmarks as well as quality improvement activities that support and substantially align with MDHHS Medicaid managed care quality objectives. MHPs are responsible for leveraging their provider networks to deliver care management and coordination services to Medicaid patients, MDHHS will continue to monitor the MHPs through provider claims submissions and regular MHP oversight mechanisms.

Targeted Interventions for Populations Experiencing Health Disparities

Expansion of Postpartum Coverage

In an effort to reduce postpartum morbidity and mortality, effective April 2022, MDHHS provides a full twelve (12) months of continuous postpartum coverage to Michigan's Medicaid beneficiaries. The extended coverage increases access to health care coverage, ensures continuity of care during this important period, and continues regardless of any changes in circumstances such as income.

The extended coverage, approved through a State Plan Amendment as part of the American Rescue Plan Act of 2021 H.R.1319, includes full benefits, such as physical and behavioral health services, substance use disorder treatment, dental care and more. The extension also promotes access to critical behavioral health services that can reduce pregnancy-related deaths and severe maternal morbidity and improve continuity of care for chronic conditions such as diabetes, hypertension, cardiac conditions, substance use disorder and depression. The extended postpartum eligibility will provide increased opportunities for beneficiaries to complete postpartum depression screening and receive referrals to services and supports for needed treatment. The expansion is a critical component to Governor Whitmer's Healthy Moms, Healthy Babies initiative.²⁵

Expanded Dental Coverage²⁶

To improve access to dental services, in April 2023 MDHHS expanded dental benefits for adult Medicaid beneficiaries and increased reimbursement rates for dental providers. This redesigned benefit is intended to increase access to services, enhance care coordination and improve health outcomes. The addition of new services such as sealants, root canals, crowns, and care to keep your gums healthy reflect input from a broad array of stakeholders and lessons learned from the Healthy Michigan Plan (HMP) and Pregnant Women dental programs. In addition to the expanded services, MDHHS has made changes to improve beneficiary access and provider participation, as well as expand access to robust care coordination services that ensure beneficiaries are supported in accessing the services they need. As a first step in the redesign, a policy that substantially increased reimbursement rates for Medicaid dental services was implemented Jan. 1, 2023. Providers are now being paid at 100% of the Average Commercial Rate, ensuring access and incentivizing providers to treat Medicaid beneficiaries.

Medicaid beneficiaries aged 21 years and older, including HMP beneficiaries and pregnant individuals who are enrolled in a Medicaid Health Plan, Integrated Care Organization or Program of All-Inclusive Care for the Elderly will receive dental benefits through their health plan. The health plan becomes responsible for the beneficiary's dental services obtained through the health plan's dental provider network. The health plans will continue to provide robust care coordination and ensure that beneficiaries are supported in accessing the services they need. Dental services for beneficiaries who are not enrolled in a health plan will be provided through the Medicaid FFS program.²⁶

Doula Initiative²⁷

Effective January 2023, Michigan began reimbursing for doula services provided to individuals covered by or eligible for Medicaid. A doula is a non-clinical person who typically provides physical, emotional, and educational support services to pregnant individuals during the prenatal, labor and delivery, and postpartum periods. Evidence indicates doula services are associated with improved birth outcomes. Doula services have also been shown to positively impact social determinants of health, support birth equity, and decrease existing health and racial disparities.²⁸ Michigan Medicaid will cover different types of doula services, including community-based doulas, prenatal doulas, labor and birth doulas, and postpartum doulas.²⁷

Community Health Worker (CHW) Policy Initiative

In FY23 Omnibus Budget Bill (passed), Sec. 1616. (1) states that “by September 30 of the current fiscal year, the department shall seek federal authority to formally enroll and recognize community health workers as providers and to utilize Medicaid matching funds for community health worker services, including the potential of leveraging of a Medicaid state plan amendment, waiver authorities, or other means to secure financing for community health worker services.”²⁹

As a result, Michigan Medicaid is developing formal policy to incorporate CHW services as a fee-for-service recognized benefit to individuals with Medicaid coverage. Ensuring Medicaid beneficiaries have access to culturally responsive services is a key driver for acknowledging CHWs as a trusted connection within the existing service delivery model. MDHHS recognizes CHWs as catalysts for promoting health equity, improving health outcomes, supporting integration in communities and across settings, and expanding opportunities for care – ultimately addressing SDOH within Michigan communities. BPHASA is engaging stakeholders with its efforts to ensure a diverse perspective is captured to inform and provide recommendations to MDHHS around defining CHW services, qualifications, supervision, and other required policy elements.

The Comprehensive Health Care Program (CHCP) has implemented contractual requirements that have successfully integrated CHW services in the standard of Medicaid Health Plan care delivery models. Michigan is pursuing efforts to fully incorporate CHWs as a covered service for both managed care and fee-for-service beneficiaries.³⁰

The MI Choice program has had CHW services available to its enrollees since 2018. MI Choice enrollees may use this service after a hospitalization or nursing facility discharge to assure the enrollee understands and follows discharge plans, makes follow-up appointments as recommended, and understands any medication changes resulting from the hospitalization or nursing facility admission. This service also helps any enrollee access community resources, understand their disease process and how to manage it, find self-determined workers, increase independence, find housing or employment, and assures the enrollees supports coordinator is informed of the enrollee’s progress toward meeting goals identified in the person-centered service plan.

Sickle Cell Disease Coverage Expansion

Effective 10/1/2021, under the 2022 fiscal year budget signed by Governor Whitmer, the Children’s Special Health Care Services (CSHCS) program expanded to include sickle cell disease (SCD) coverage for adults over age 21. The program now covers services directly related to sickle cell, including copays, deductibles, transportation, care coordination, access to CSHCS clinics and case management. The coverage expansion improves access to health care and improves the quality of care provided in Michigan. In October 2021, there were approximately 2,800 adults in Michigan with sickle cell disease with 120 adults receiving covered benefits. As of March 2023, Medicaid/CSHCS covers approximately 440 adults over age 21 with sickle cell disease.^{31,32,33}

In April 2023, MDHHS issued a Request for Proposal (RFP) for eligible health care organizations to expand and enhance clinical services for people who have SCD. The purpose of the Sickie Cell Clinic Expansion and Enhancement Program is to improve SCD clinical services by offering support to providers to increase patient access to quality multidisciplinary health care and care coordination. Funding can also be used to establish preferred provider networks that focus specifically on SCD. The RFP seeks competitive applications that will improve access to care and medication adherence. The 12-month award period begins Oct. 1, 2023, and ends Sept. 30, 2024. MDHHS expects to award up to three applicants.³⁴

Sickle Cell Collaborative

In addition to the initiative described above, the CHCP quality withhold program includes health plan performance expectations for sickle cell treatment initiatives. For the initial phase of the initiative, health plans with a presence in eastern Michigan had to demonstrate that they were working collaboratively to provide appropriate disease management medications and screenings to minors. For future program years, CHCP intends to apply numeric benchmarks around key treatments, including antibiotics, hydroxyurea and annual transcranial doppler (TCD) Screening.

Healthy Living/Population Health Strategies

MDHHS and the Medicaid managed care programs acknowledge that an individual's health is profoundly shaped by life circumstances that fall outside the traditional purview of the health care system. Conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes. Education, nutrition, transportation, and other dynamics are examples of social determinants of health that collectively influence health outcomes.

Michigan's population health model recognizes that population health management is built upon a detailed understanding of the distribution of social, economic, familial, cultural, and physical environment factors, which impact health outcomes among different geographic locations and groups; the distribution of health conditions; and health-related behaviors and outcomes including but not limited to physical, dental, behavioral, and social needs. As a result, managed care programs are incorporating social determinants of health (SDOH) into quality assessment and improvement processes. The goal is to address health disparities, improve community collaboration and enhance care coordination, case management, targeted interventions, and complex care management services for enrollees.

All managed care plans assess the psychological well-being, functional status, cognitive ability, social/behavioral functions, and overall quality of life of participants to develop individualized, person-centered plans of care, as indicated. Prevention, health promotion and maintaining or achieving healthy lifestyle behaviors are also a high priority. Although not all programs currently contractually require plans to conduct a formal population health initiative, all programs require plans to identify opportunities for improving care, services, and outcomes of their respective populations. Programs work collaboratively with plans to develop uniform methods for targeted monitoring of members, implementing interventions and assessing opportunities for improvement.

Target populations may include those experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level. Populations may include individuals with poor health outcomes or access issues based on factors such as race, ethnicity, gender, age, primary language, disability, geographic location, or income level. Intervention strategies may include in-person support services such as Community Health Workers (CHW), patient navigators, home visiting programs, or health promotion or preventions programs delivered by community-based organizations (e.g., adult/family shelters, schools, foster homes). Managed care programs have also initiated contractual requirements to incorporate social determinants of health into processes for

analyzing data to support population health management. The goal is to address health disparities, improve community collaboration and enhance care coordination, case management, targeted interventions, and complex care management services for enrollees.

Health promotion and disease prevention services, when offered in a manner that is informed by the life experiences, personal preferences, desires, and cultures of the target population, facilitate the adoption of healthy behaviors. Plans ensure access to evidence-based/best practices educational programs, either through plan health programs or referral to local public health/community-based programs. Education and wellness programs may also be offered through multiple sources, including but not limited to websites, social media vehicles, in health care offices and facilities, public schools and through mailings.

Program Alignment with MDHHS 2022-2024 Social Determinants of Health Strategy

The MDHHS 2020-2023 CQS Goals and Objectives closely align with the MDHHS 2022-2024 Social Determinants of Health Strategy. Specifically, the Medicaid programs have made significant progress in the structural intervention areas of the SDOH Strategy by developing partnerships to advance health equity, promoting Community Health Workers (CHWs), addressing social drivers of health, and addressing chronic disease. These population health strategies require a coordinated approach, and increased collaboration and engagement among regional partners to address the burden of disease and related risk factors.³⁵

Michigan's CHCP and the Medicaid Health Plans (MHPs) have been working together to identify and implement strategies to meet the needs of beneficiaries by incorporating CHWs to assist with chronic conditions, behavioral health, and hard to reach members; increase community engagement & investment; and support the use of data to better stratify social determinants of health. CHWs integrate person-centered approaches to improve access to programs, services, and resources for populations that have been underserved. The Medicaid Health Plan Population Health Management Intervention also supports MDHHS public health initiatives focused on housing stability. Medicaid is partnering with the MDHHS Housing and Homeless Services Division on issues related to housing stability/homelessness and connecting plans to state and local partners.

The MI Choice waiver program included CHWs as a service with the 2018 waiver renewal. The purpose of this service is to work with participants who are re-enrolling in MI Choice, enrolling after a nursing facility or hospital discharge, or otherwise assist participants with obtaining access to community resources. The CHW may offer practical skills training to enable participants to remain independent, including information for recruiting, hiring, and managing workers as well as effective communication and problem solving. The CHW may also coach participants in managing health conditions, assist with scheduling appointments, facilitate coordination between various providers and assist participants with completion of applications for programs for which they may be eligible. The MI Choice waiver program also includes Home Delivered Meals and Community Transportation as program services.

The Integrated Care Organizations (ICOs) incorporate community-based health and wellness strategies with a strong focus on the Social Determinants of Health into their models of care. As required by the Three-way contract, ICO incorporate Social Determinants of Health into the process of collecting and analyzing their data. ICOs' Annual QI Work Plans include planned clinical and non-clinical initiatives, including initiatives to address Social Determinants of Health. Many ICOs have been incorporating Community Health Workers, or an equivalent, into their Care Coordination teams to supplement and support the work of Care Coordinators. MHL will align with MDHHS' policy to make CHW services Medicaid reimbursable through state plan benefit.

Integration with Public Health

The Behavioral and Physical Health and Aging Services Administration (BPHASA) is committed to partnering with the MDHHS Public Health Administration to address priority areas for Michigan residents. Partnering with Michigan's public health system supports the established CQS Goals and Objectives including:

Goal #2: Strengthen person and family-centered approaches.

Objective 2.2 Ensure referrals are made to community resources to address SDOH needs.

Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes.

Objective 4.1 Use evidence-informed approaches to address racial and ethnic disparities and health inequity.

Michigan Medicaid programs look for opportunities to collaborate with public health organizations across the state to improve the health and well-being of Michigan's residents. For example, in FY24, the CHCP program is introducing the HIV Provider Outreach Project, which requires Medicaid Health Plans to coordinate with Ryan White agencies on beneficiary and provider outreach activities related to HIV care. Similarly, the CHCP LGBTQ Care Quality Improvement Project, which engages health plans in promising practices for providing quality care tailored to LGBTQ beneficiaries, is driven by a close collaboration between Medicaid and public health state staff. Overall, this work is achieved by promoting healthy lifestyles, reducing the burden of disease, and improve health outcomes by focusing on the Social Determinants of Health and reducing health disparities to ultimately achieve health equity.

In September 2019, MDHHS announced the release of the **2020-2023 Mother Infant Health & Equity Improvement Plan (MIHEIP)**.³⁶ The MIHEIP integrates interventions across the maternal-infant dyad promoting a holistic approach to care that encompasses health and wellbeing of mothers, infants and families. The MDHHS 2020-2023 CQS Goals and Objectives closely aligned with the 2020-2023 MIHEIP which has six primary priorities: health equity; healthy girls, women and mothers; optimal birth spacing and intended pregnancy; full term healthy weight babies; infants sleeping safely; and mental, emotional and behavioral well-being.

Examples of Medicaid and public health program intersection include the MHP Low Birth Weight (LBW) project which is a multi-year LBW Pay for Performance initiative that supports and aligns MDHHS efforts to promote health equity in maternity care and infant care. The Medicaid Health Equity Project to promote health equity and monitor racial and ethnic disparities within the managed care population also aligns with MIHEIP priorities. In Michigan, deaths due to prematurity (birth prior to 37 weeks gestation) and/or low birth weight (less than five and a half pounds) are leading causes of infant mortality.³⁶

The expansion of Michigan's Medicaid coverage to 12-months postpartum provides access to critical health and dental services during the first year after pregnancy; promotes access to critical behavioral health services that can reduce pregnancy-related deaths and severe maternal morbidity; and improves continuity of care for chronic conditions such as diabetes, hypertension, cardiac conditions, substance use disorder and depression. Extending postpartum eligibility also increases opportunities for beneficiaries to complete postpartum depression screening and receive referrals to services and supports for needed treatment, such as the Medicaid Maternal Infant Health Program (MIHP) and other home visiting programs.

The Medicaid Health Plans are also focused on educating pregnant individuals on utilization of oral preventive services and care coordination by CHWs and engagement with the Maternal Infant Health

Program. In addition, MDHHS is diligently working on initiatives to expand access and eligibility to programs that support mental health and well-being. In 2022, MDHHS increased its investment in children's behavioral health services by developing a new Bureau of Children's Coordinated Health Policy and Supports. To date, the bureau has developed and issued \$6 million in grants for community mental health service programs to explore innovative ways to support children and families in crisis, and for efforts to expand workforce to support the growing demand for mental health services across the state.³⁷

In addition, managed care program contracts require and/or promote community collaboration and participation in community-led initiatives to improve the health and well-being of populations served by the plans. This may include participating in community health needs assessments (CHNA) and community health improvements conducted by hospitals and local public health agencies or other regional health coalitions. Where applicable, plans enter into agreements with community-based organizations to coordinate population health improvement strategies to address the socioeconomic, environmental, and policy domains; as well as provide services such as care coordination and intensive care management as needed and supported by evidence-based medicine and national best practices. Plans also implement Community Health Worker (CHW) interventions to address Social Determinants of Health to promote prevention and health education tailored to the needs of the community. CHWs may conduct home visits to assess barriers to healthy living and accessing health care; assist with scheduling medical and behavioral health visits; arrange for social services (such as housing and heating assistance); and assist with self-management skills.

The Children's Special Health Care Services (CSHCS) program is another example of a key Medicaid and public health partnership. CSHCS is mandated by Michigan Public Health Code, in cooperation with the federal government under Title V of the Social Security Act, and the annual MDHHS Appropriations Act. Title V charges CSHCS with promoting the development of systems of care that are family-centered, community-based, coordinated, and culturally competent with a focus on health equity. In Michigan, children and youth who have both CSHCS and Medicaid coverage are enrolled into a Medicaid Health Plan (MHP). Although CSHCS is a separate program from Medicaid, CSHCS partners closely with Medicaid to provide care and services to CSHCS enrollees. The MHPs are responsible for all of the medical care and treatment of their members while community-based services are available through the local health department CSHCS offices.

The Title V state action plans address the following priority areas for the current five-year cycle (FY 2021-2025) to improve the health of the maternal and child health (MCH) population in Michigan:

- Low-risk cesarean delivery.
- Breastfeeding.
- Infant safe sleep.
- Bullying prevention.
- Transition for youth with special health care needs to adult health care.
- Oral health care for women and children.
- Childhood lead poisoning prevention.
- Immunizations for children and adolescents.
- Medical care and treatment for children with special health care needs.
- Healthy and intended pregnancy.
- Behavioral and mental health services.

These MCH priorities address needs across five federally identified population domains: women/maternal health, perinatal/infant health, child health, adolescent health, and children with special health care needs.³⁸ There is significant correlation between the **Title V priority areas** and the Medicaid managed care program quality improvement performance metrics and initiatives. These similarities provide opportunities for collaboration among MDHHS program areas in the areas of

maternal, child and behavioral health. CSHCS program integration with the MHPs related to transitions in care (transition to adulthood) and training providers on the transition process are also important areas for MHP/CHSCS program coordination.

Medicaid has a strong partnership with Michigan's **Family Planning Program** which provides high quality reproductive health care to women, men, and teens at low or no-cost; and assists individuals/families to plan their desired family size and spacing of children; or to prevent an undesired pregnancy. The Managed Care Division has worked closely with the Family Planning Program on several quality improvement projects in recent years. The Medicaid Health Plan (MHP) Low Birth Weight (LBW) project promoted web-based reproductive counseling education developed by the Family Planning Program. MDHHS Family Planning Program staff also actively engaged with the Michigan Medicaid Adult Medicaid Quality: Improving Maternal and Infant Health Outcomes in Medicaid and CHIP grant project. The intent of this multiyear project was to increase the use of effective methods of contraception among all women in Medicaid and CHIP to improve birth spacing and self-determined pregnancies.

Medicaid also works closely with the MDHHS **Chronic Disease and Injury Control** section. Both chronic diseases and injuries have a significant impact on the health and well-being of our state's residents. Chronic diseases and injuries also contribute to rising health care costs and contribute to increased morbidity and mortality. Medicaid partners with the Chronic Disease and Injury Control on high priority conditions including but not limited to asthma, cardiovascular disease, obesity, cancer, diabetes/prediabetes, HIV/STDs, and tobacco. Managed care plans utilize established MDHHS chronic disease and prevention programs and educational materials; and program data are shared among the managed care programs/plans, where applicable.

Similarly, Medicaid has partnered with public health staff to require health plans to engage with the "We Treat Hep C" awareness program. Building on this, the CHCP began tracking health plan performance on an array of custom coded Hepatitis C care quality metrics starting in FY23, including Lifetime Hepatitis C Screening (members 18 years of age and older who have received at least one screening for Hepatitis C at any time during the measurement period), Hepatitis C Screening During Pregnancy (the percentage of women who had a live birth who were screened for hepatitis C during their pregnancy) and Hepatitis C Treatment (members ages 3 years of age and older who have been diagnosed with Hepatitis C and have received one or more prescriptions for direct-acting antiviral medication during the measurement period). While these measures are not included in the quality withhold program, starting in FY24 Medicaid Health Plans (MHPs) will be subject to performance benchmarks on these measures and will be subject to compliance action if the benchmarks are not met.

Health Information Technology

Michigan's Medicaid data warehouse plays a key role in the state's ability to measure, evaluate, and report QI program outcomes. The warehouse also includes human services agency data (e.g., justice, treasury, and education), which provides the opportunity to explore data across different continuums of care, including health and human services. The investment in the State of Michigan has been recognized for its acquisition of a business intelligence system, which includes advanced analytics, data mining, data warehousing, and decision support capabilities.

A key component of data analysis is the ability to link Medicaid data to Michigan vital records data. These linkages are essential to MDHHS's ability to report the CMS Adult and Child Core measures Elective Delivery (PC-01), Cesarean Section (PC-02) and Live Births Weighing Less Than 2,500 Grams (LBW).

Michigan has also developed the Michigan Care Improvement Registry (MCIR), formerly Michigan Childhood Immunization Registry). MCIR was initially created in 1998 to collect reliable immunization information for children; however, as a result of a 2006 revision to the Michigan Public Health Code, MCIR was able to transition from a childhood immunization registry to a lifespan registry including Michigan citizens of all ages. MCIR is an approved data source for HEDIS® immunization and lead testing data; and has the potential to serve as a fully functional birth to death registry for preventive and chronic health care indicators. Recent MCIR enhancements include the addition of a “flag” for children who are not up to date on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) well child visits according to the American Academy of Pediatrics Bright Futures Recommendations for Preventive Pediatric Health Care periodicity schedule. A high-risk indicator flag was also added to identify individuals who lived in Flint during the water crisis time frame and have the potential of lead exposure. All Medicaid Health Plans have access to MCIR for their respective members.

Over the last five years, Michigan has made great strides in coordinating care of high-utilizer beneficiaries who also identify as homeless. Understanding that insufficient or unstable housing is a key determinant of health, Michigan sought to integrate key data to better serve beneficiaries. Through a partnership with the Michigan Coalition Against Homelessness, MDHHS was able to identify homeless beneficiaries via the Michigan Homeless Management Information System (HMIS), the statewide homeless database. MDHHS has established an ongoing feed of the HMIS homeless data into the Medicaid Data Warehouse, which is then matched up to Medicaid claims data to better identify the intersection of a beneficiary’s health conditions and housing needs. The initiative also partnered with communities to help prioritize permanent housing solutions to those Medicaid beneficiaries identified from the Data Warehouse match. The health and housing pilot initiative has demonstrated great promise in identifying social determinants of health within the Medicaid program through the integration of housing data within the Medicaid data warehouse. MDHHS continues to leverage the Medicaid Data Warehouse by expanding analytical capabilities via a web-based application known as CareConnect360. CC360 allows designated users including Michigan’s contracted Medicaid Health Plans, Prepaid Inpatient Health Plans, and Community Mental Health Service Providers a portal view into key coordination information on their respective beneficiaries on an individual and population level basis. The CC360 application contains key utilization and program level data that facilitates care coordination across health and human continuums of care. In addition, the application makes it possible to effectively assess and analyze populations and healthcare program data; enhance the decision-making process at the point of care; and improve outcomes. In addition, it is a key enabler of shared care coordination for physical and behavioral health care plans.

MDHHS continues to support broader statewide interoperability through policies aimed at participation in statewide health information exchange use cases. Managed care plans and their contracted providers are required and/or encouraged to engage in use cases that help facilitate and enable broader care coordination via the statewide infrastructure. As a result, Michigan’s plans and providers have more timely access to key clinical information and can share information across different systems via the health information exchange.

Section V: DELIVERY SYSTEM REFORMS

MDHHS has implemented multiple Medicaid delivery system reforms and continues to work with the Medicaid managed care programs to expand innovative solutions to improve care and services for Michigan residents. The text below outlines some important system changes that have occurred in recent years.

Directed Payments and Quality

MDHHS uses Medicaid Data from the MMIS system in combination with the Symmetry rules engine to generate quality measure rates for both the directed payment programs for practitioner services and hospitals. Service encounters and Diagnosis Related Group (DRG) codes are submitted to MDHHS by the Medicaid Health Plans. Service claims and encounters and Diagnosis Related Group (DRG) codes are submitted to MDHHS by providers and payors. Symmetry is a rules engine with built-in queries for several hundred quality of care measures that can be compared to National Standards. Symmetry measures are sourced from national standard specifications from organizations such as: NCQA Healthcare Effectiveness Data and Information Set (HEDIS®), CMS Merit-based Incentive Payment System (MIPS), Agency for Healthcare Research and Quality (AHRQ), and Pharmacy Quality Alliance (PQA).

The primary objective of MDHHS Directed Payment Programs is to increase Medicaid beneficiary access to quality care and services which advances CQS Goal #1: Ensure high quality and high levels of access to care. Quality measures including those specific to access are currently being reviewed and vetted for potential application to directed payment reimbursement strategies in the future.

Directed Payment Program for Practitioner Services

Michigan's directed payment program for practitioner services, which Michigan refers to as the **Specialty Network Access Fee (SNAF)** program, acts as an enhanced Medicaid reimbursement program. While the methodology was updated in State Fiscal Year 2019 to comply with Section 438.6(c) of the Medicaid Managed Care Rule, the overall program has been active since 2008. The SNAF program is intended to act as the Managed Care version of Michigan's enhanced payment program for Fee for Service as outlined in Section 4.19b of the state's Medicaid State Plan. The program is operated as a joint effort between the State and seven Public Entities, consisting of six public universities and a municipally owned hospital. The main objective of the SNAF program is to increase access to specialty practitioners to the Medicaid beneficiaries. To accomplish this objective, providers who are enrolled in the SNAF receive supplemental payment for services rendered to eligible Medicaid beneficiaries.

The program employs the services of a wide array of provider types. The program currently has approval from CMS to provide enhanced reimbursement to eleven different provider types (see Section 4.19b of Medicaid State Plan for listing).²⁴ The wide outreach that the State's collaboration with the Public Entities provides, enables the procurement of a diverse and varied population of specialty providers. Program enrollees range from Family Medicine practitioners to more nuanced specialty providers such as neurosurgeons. The SNAF program has also been very instrumental in increasing provider participation in the State's Medicaid program. In 2019, approximately one-fourth of active physicians (approximately 10,500) within the state were involved with the SNAF program throughout the year. This population of practitioners provided services to nearly one million Michigan Medicaid beneficiaries in 2019.

The SNAF program incentivizes greater provider participation in the Medicaid program by offering supplemental payments to providers in addition to what the provider may have initially been reimbursed by Medicaid Health Plans (MHPs). To this end the SNAF reimburses practitioners using a directed payment methodology and pays practitioners according to the guidelines set forth by the Physician Upper Payment Limit (UPL). Using the physician UPL guidelines, SNAF participants can receive enhanced reimbursement, up to the Average Commercial Rate (ACR) for services provided to Medicaid beneficiaries. Since the State is offering reimbursement that is typical of what is offered by commercial payers, it does mandate as a condition of participation in the program that providers offer Medicaid patients the same levels of access that they generally afford their patients with commercial

health insurance. This is done to ensure that beneficiary access to these practitioners can be commensurate to the benefit providers receive from a higher level of reimbursement. SNAF Quality Performance Measures are listed in **Appendix G**.

Participating Public Entities and MHPs

For a practitioner to participate in this program, the practitioner's employing practice must either be directly owned/controlled by one of these Public Entities or have a contractor status with the entity. Practitioners in the SNAF program provide a wide array of services to Michigan's Medicaid population, including primary care, emergency services, surgeries, and anesthesiology, to name a few. MDHHS works in collaboration with the Public Entities and the MHPs to ensure that Michigan's Medicaid Managed Care beneficiaries are able to access necessary services and receive quality care. Representatives from MDHHS, the Public Entities, and MHPs meet on a routine basis to discuss ways to improve the SNAF program and outcomes for Medicaid beneficiaries. MDHHS has also conducted program reviews of the SNAF program to determine best practices and identify additional ways to improve the program. While improving access is the primary goal, MDHHS is also using this opportunity to measure other quality indicators to assess the SNAF program.

To better understand the quality performance of the SNAF program and determine the improvement areas, MDHHS generated 16 quality measures (refer to **Appendix G**). Some of these measures assess the potential statewide impact of the SNAF program, such as "*Child and Adolescent Well-Care Visits*." Other measures, such as HbA1c testing for comprehensive diabetes care, assess and compare the quality of care provided by SNAF participating practitioners and Medicaid providers not enrolled in the SNAF program. Results are available at the member level to help identify individual gaps in care and can also be stratified by MHP, program, race/ethnicity, etc., to support population health.

The quality measures chosen to explore the care provided by SNAF providers were based on several factors: access to health care, the prevalence of chronic conditions seen in the Michigan Medicaid population and suggested measures by CMS.

High prevalence of chronic conditions has been a key driver of healthcare costs in the United States, and Medicaid beneficiaries tend to have higher rates of chronic diseases than people not on Medicaid. Chronic conditions, especially when they present as comorbidities, often require the need for specialty care. Therefore, MDHHS analyzes performance for a set of three (3) HEDIS® and (4) AHRQ – Prevention Quality Indicators (PQIs) measures. PQIs are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions". These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. The PQIs are population based and adjusted for covariates.

In addition to the measures previously mentioned, MDHHS focuses on three (3) Women—Adult Care measures and one (1) Pregnancy Care measure. Women make up about 55% of the adult population in Michigan's Medicaid's program and Medicaid pays for about 45% of the births in Michigan.

The Medicaid Managed Care program's goal is to offer high levels of access to care to its beneficiaries, combined with higher quality care provided by SNAF enrolled practitioners compared to the Non-SNAF counterparts. **Appendix G** outlines baseline, rates and performance targets along with a comparison of SNAF Participating Providers to Non-Participating Providers for the Diabetic HEDIS measures and Women- Adult Care & Pregnancy measures. Overall, SNAF participating providers had higher performance rates than non-participating providers. MDHHS will continue to work with its MHP and Public Entity partners in the SNAF program to improve Medicaid beneficiaries' access to care and to ensure that quality care is provided by the participating practitioners.

Directed Payment Program for Hospital Services

Michigan's directed payment program for hospital services, which Michigan refers to as the **Hospital Reimbursement Adjustment (HRA) program**, acts as an enhanced Medicaid reimbursement program. While the methodology was updated in State Fiscal Year 2018 to comply with Section 438.6(c) of the Medicaid Managed Care Rule, the overall program has been active since 2007. The program was designed to ensure adequate funding is available to incentivize hospitals to participate in the Medicaid managed care program, thereby assuring enrollees have access to vital hospital services and can receive necessary medical care.

In the current form of HRA, Michigan's contracted Medicaid Health Plans (MHPs) provide a uniform percentage increase to the base health plan payments made to Michigan hospitals for actual inpatient and outpatient services provided to Medicaid managed care enrollees. The percentages proposed for FY21 (70% - inpatient, 87.3% - outpatient) were generated based on past HRA amounts and conform with the federally established managed care upper payment limit (UPL). The UPL is the amount paid by Medicare for similar services covered by the MHP; the HRA increases the total amount paid to hospitals but ensures that it does not exceed the UPL. The purpose, therefore, of the HRA is to supplement Michigan's lower base hospital rates to align the total hospital payments more closely with the amount normally paid by Medicare. This increased payment rate helps ensure access to hospital services that Michigan's Medicaid beneficiaries need.

Participating Hospitals and MHPs

Payments for the HRA program are made to all Michigan hospitals that provide qualifying inpatient and outpatient services to Medicaid Managed Care beneficiaries. In the first half of State Fiscal Year 2020, there were 149 hospitals that provided qualifying services and received a corresponding HRA payment. These 149 facilities consist of both urban and rural hospitals, including 37 critical access hospitals, children's hospitals, and rehabilitation hospitals. Note that inpatient psychiatric services are managed through Michigan's Prepaid Inpatient Health Plans (PIHPs) and directed payments for these services are covered separately.

MDHHS works in collaboration with the hospitals and Medicaid Health Plan (MHP) partners to ensure that Michigan's Medicaid Managed Care beneficiaries can access necessary services and receive quality care. Michigan requires through its contract that MHPs must develop programs for improving access, quality, and performance with both In-Network and Out-of-Network hospitals. The MHPs are to collaborate with MDHHS on design methodology, data collection, and evaluation, and must make all payments to both In-Network and Out-of-Network hospitals as defined by the jointly developed methodology. In addition, representatives from MDHHS, hospitals, the Michigan Hospital Association, and MHPs meet on a routine basis to discuss ways to improve the HRA program and outcomes for Medicaid beneficiaries. While improving access is the primary goal, MDHHS is also using this as an opportunity to measure other quality indicators to assess the HRA program.

To better understand the quality performance of the HRA program and determine the improvement areas, MDHHS generates quality measure rates, some of which include demographic stratification to expand our efforts and focus on population health and health equity (refer to **Appendix H**). Results are available at the member level to help identify individual gaps in care and can also be stratified by MHP, program, race/ethnicity, etc., to support population health.

The quality measures chosen to explore the care provided by hospitals in the HRA program were based on hospital specific related measures and those measures suggested by CMS. With the primary goal of the HRA program being to ensure access to vital hospital services for Michigan's Medicaid beneficiaries, the first measures include components related to health services access. Lack of access can result in unmet health needs, delays in receiving the appropriate care, inability to access

preventative services, unreasonable financial burdens, and preventable hospitalizations. The analysis encompasses HEDIS® Access to Care measures; measures that focus on the quality of care being provided in the hospital setting; performance for a set of three Prevention Quality Indicators (PQI) measures; and a pregnancy care measure related to cesarean section procedures (refer to **Appendix H**).

PQIs are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. The PQIs are population based and adjusted for covariates.

In addition, MDHHS analyzes a pregnancy care measure related to cesarean section procedures. MDHHS stratifies this measure to expand quality improvement efforts to include population health and health equity.

Michigan's performance on these measures highlights the importance of the HRA program. **Appendix H** outlines HRA program baseline, quality performance rates and targets. The Medicaid Managed Care program offers high levels of access to care to its beneficiaries, while the observed Plan All-Cause Readmission Rate, which is below the expected rate, shows an example of hospitals doing their part to provide quality care to the beneficiaries. MDHHS will continue to work with its MHP and hospital partners in the HRA program to improve Medicaid beneficiaries' access to care and to ensure that quality care is provided by the participating Michigan hospitals. In addition, the Symmetry tool has proven to be a powerful asset the department can utilize to measure quality in target populations within the beneficiary and provider demographics. MDHHS will further explore this tool to provide additional information and feedback that can be used to identify successes and ways to improve the program.

Psychiatric Hospital Reimbursement Adjustment (HRA) Program

Similar to the overall HRA program, the purpose of the psychiatric HRA is to ensure access to high quality care for all Michigan Medicaid beneficiaries. Payments to psychiatric facilities under the HRA program are made to 53 hospitals as of FY2020. Michigan's Prepaid Inpatient Health Plans (PIHPs) provide a per diem add on for inpatient psychiatric services reported as encounters during the prior quarter. Annually, the per diem rate is analyzed to ensure overall payments are within federally established Medicare upper payment limits. MDHHS monitors performance based on *Follow up After Hospitalization for Mental Illness* measure rates.

Information Technology and Symmetry

Michigan continues to build on the strength of the Medicaid Data Warehouse by providing key analytic tools like Symmetry to improve and enhance managed care priorities. Symmetry is a rules-engine tool using evidence-based specifications produced and updated annually by national quality organizations that leverages the Medicaid Data Warehouse to measure, report, and compare data across programs or populations.

Specifically, Symmetry allows for comparisons by measures, conditions, episodes of care, or risk at an individual member or population level. MDHHS leverages the Symmetry tool for measure reporting including reporting the Centers for Medicare and Medicaid Services (CMS) adult and child core measure sets, health home reporting, numerous stratifications (e.g., race/ethnicity, age, gender), Medicaid program reporting for the Healthy Michigan Plan, and quarterly Medicaid Health Plan performance monitoring. Symmetry is also being used to evaluate impact of Alternative Payment Models (APMs), sustain Patient Centered Medical Home (PCMH), assess directed payments, pursue health equity, encourage shared metrics (e.g., behavioral and physical health measures), or add non-HEDIS® measures to the Medicaid Health Plan (MHP) performance monitoring measure set. For

example, Symmetry may be used to support Blood Lead Screening, social determinants of health or the Opioid Strategy or any other strategic priority of MDHHS.

In addition, Symmetry is expected to provide enhanced information to plans via the CareConnect360 portal to assist in measuring results, evaluating episodes of care, identify high-risk populations, and monitor chronic conditions. The tool will allow plans more complete information on their shared metrics for members receiving both behavioral health and physical health along with supporting health equity efforts by displaying stratifications by plan and by race to better identify gaps in care at the member level.

Michigan has invested significant resources to collaboratively vet data with all stakeholders, including the managed care plans, hospitals, providers, and other areas of MDHHS to ensure data validation and measurement alignment. As MDHHS needs and priorities change, Symmetry promises to be a flexible and accommodating tool for meeting evolving quality goals. Future plans include enhanced reporting capacity for waiver programs, public health programs, health equity efforts, and Specialty Network Access Facility quality monitoring.

Integration of Behavioral and Physical Health Care

The MDHHS is eager to collaborate with stakeholders across the state to strengthen Michigan's Medicaid-funded behavioral health system, building on our state's history and expertise. To meet this goal, MDHHS outlined a vision for care integration that brings together physical and specialty behavioral health services to better meet the whole person needs of individuals with significant mental health, substance use disorder, and intellectual or developmental disabilities. Currently, this population receives physical health benefits and care management from the Medicaid Health Plans (MHPs), and behavioral health benefits and case management from the Prepaid Inpatient Health Plans (PIHPs). MDHHS has identified an opportunity to create an integrated system that reduces complexity, lowers barriers to care, and makes it easier for individuals to navigate.

The vision for care integration aims to simplify access to care, support the growing demand for behavioral health services, and improve health and quality of life outcomes. Core values include preserving and strengthening a person-centered, family-driven, youth guided and recovery-oriented approach to care, that is community-based, recovery oriented, culturally competent and evidence-based.

A crucial part of delivering high quality health care services includes the sharing health information among providers, health plans, and patients. Sharing information helps providers coordinate effectively with each other and helps patients make informed decisions about their care by using a person-centered approach. This is particularly important for coordinating physical health and behavioral health services, which have historically been separated. Michigan is making strides to integrate care and ensure necessary information is flowing among these key partners. The overall goal is to improve outcomes for people with behavioral health needs by increasing access to evidence-based, integrated, and recovery-oriented interventions. It is essential that all parties that share patient information do so in a manner that supports holistic care for the individual while protecting individual privacy, to minimize the potential for stigmatization or discrimination.

Section VI: CONCLUSIONS AND OPPORTUNITIES

Michigan Medicaid implemented many interventions that have made a positive impact on the care, services, and outcomes for beneficiaries. This section highlights successes and opportunities in the following areas: health plan performance, managed care program performance, and MDHHS/Medicaid.

Health Plan Performance Strengths and Opportunities

Health Plan Performance: Strengths

Michigan Medicaid's managed care program structure and strong collaborative model with contracted health entities continues to demonstrate success, with contracted entities meeting and exceeding established requirements in the areas of infrastructure, administrative practices, access and availability, coverage and benefits, quality assessment and improvement, and utilization. Managed care entities (MCEs) actively participate statewide assessment methods (e.g., HEDIS® and CAHPS®/member surveys, performance improvement projects, performance monitoring, compliance visits) and External Quality Review processes. MCEs also actively engage in MDHHS and CMS performance bonus activities which incentivize performance and quality improvement (**Refer to Table 6**).

SFY 2022 and SFY 2023 EQR Medicaid Program Technical Reports addressed the following 2020-2023 CQS Goals:

- Goal 1: Ensure high quality and high levels of access to care
- Goal 2: Strengthen person and family-centered approaches.
- Goal 3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external).
- Goal 4: Reduce racial and ethnic disparities in healthcare and health outcomes.
- Goal 5: Improve quality outcomes and disparity reduction through value-based initiatives and payment reform.

HEDIS® performance levels for Michigan Medicaid plans meet established thresholds based on national percentiles for a variety of measures, but also reveal opportunities for efforts driven by the CQS to produce needed improvement with certain metrics. Overall CAHPS® reports also show high performance and member satisfaction with MCE programs. Mandated External Quality Review assessments, which evaluate MCE performance related to the quality of, timeliness of, and access to the care and services they provide, also demonstrate consistent compliance with federal Medicaid managed care regulations, and validity of performance measures and Performance Improvement Projects (PIP).

Comprehensive Health Care Program (CHCP) overall statewide average performance, which includes the Children's Special Health Care Services, Healthy Michigan Plan, and Flint Medicaid Expansion (FME) Waiver populations, varied over the 2020-2023 CQS timeframe.

The State Fiscal Year 2022 External Quality Review Technical Report for **Medicaid Health Plans (MHPs)** indicates of the 70 reported rates that were comparable to national Medicaid percentiles, 13 of the Michigan Weighted Averages (MWA) rates fell below the 25th percentile and a total of 26 rates (about 37 percent) were below the 50th percentile. These results demonstrate a general statewide improvement in performance in comparison to the MY 2020 rates, which showed approximately 63 percent of the rates falling below the 50th percentile. Areas of strength were noted in multiple domains including Child & Adolescent Care, Women—Adult Care, Pregnancy Care, Access to Care and Living With Illness. Multiple measures indicators ranked above the 50th percentile and demonstrated significant improvement from the HEDIS® MY 2020 MWA.

In 2022, MHPs successfully implemented and submitted baseline data for the new state-mandated PIP topic focused on improving the timeliness of prenatal care and eliminating disparities related to timely receipt of prenatal care.³⁹

MHPs received an overall validation status of Met, indicating that overall, the MHPs designed methodologically sound PIPs. The interventions implemented through the course of the PIP cycle are,

or will be, aimed at eliminating the racial and ethnic disparity identified by each MHP, or improving timeliness of prenatal care for the lowest-performing population for those MHPs without an identified disparity. The PIP interventions should also have a positive effect on the Prenatal and Postpartum Care—Timeliness of Prenatal Care performance measure, as the rate for this performance measure ranked below the Medicaid 50th percentile and did not demonstrate an improvement from measurement year (MY) 2020 to MY 2021. In addition, MHP Compliance review scores across each of the six performance areas ranged from 92% to 98%.³⁹

The Sate Fiscal Year 2022 External Quality Review Technical Report for **Dental Health Plans** outlines a comprehensive assessment of the performance of Michigan’s two Dental Health Plans (DHP) and the overall strengths and weaknesses related to the provision of dental services. The Performance Measurement Validation activity included a comprehensive review of the DHPs’ rates for seven EPSDT dental and oral health services performance measures reported to CMS using Form CMS-416 (i.e., CMS-416 EPSDT performance measures). Rates for four of the CMS-416 EPSDT performance measures increased by over 5 percentage points from SFY 2020 to SFY 2021 for one of the dental plans. Although the second plan demonstrated improvement in the performance measure rate calculation process, performance measure rates were noted to have less than a 5-percentage point increase from SFY 2020 to SFY 2021 data. The SFY 2022 PIP validation process for Remeasurement Year 1 data for ongoing PIP topics, demonstrated overall methodological validity for each of the DHP’s improvement projects.⁴⁰

The 2022 External Quality Review Technical Report for **Prepaid Inpatient Health Plans** Community Mental Health Services Programs (CMHSPs)/Pre-paid Inpatient Health Plans (PIHPs) demonstrates areas of high performance in managing and adhering to expectations established for the Medicaid program through State and federal requirements. The PIHPs were required to report performance measurement data to MDHHS using the specifications documented in the PIHP Reporting Codebooks included as part of Michigan Mission-Based PIHP Performance Indicator System (MMBPIS). Through the EQR Performance Measure Validation process, it was determined that all but one PIHP had reportable rates that could be used in QI efforts. Additionally, of the thirteen (13) performance measures included under MMBPIS, four measures have an MDHHS-established Minimum Performance Standard (MPS), and three of the four measures are further stratified by populations for a total of seven indicators having an established MPS. Program wide, the MPS of 95 percent was met for three performance indicators where benchmarks were established. In addition, the MMBPIS performance indicators that demonstrate the effectiveness of the PIHPs’ care coordination efforts indicate that overall, statewide the PIHPs performed better than the MPS of 15 percent (i.e., rates are lower than 15 percent) for both the children and the adult populations, and performance improved from the 2021 rates for the associated indicators. Strong performance in this program area implies that the PIHPs implemented effective care coordination processes, such as ensuring members had effective transition plans prior to discharge.

In SFY 2022 the PIHPs also initiated new PIP topics that focused on disparities within their populations, as applicable, and reported baseline data for each specified performance indicator. The EQRO PIP design validation process demonstrates that nine of the ten PIHP’s MET the overall methodological validity requirements.⁴¹

The SFY 2022 External Quality Review Technical Report for the **MI Health Link Integrated Care Organizations (ICOs)** demonstrates that MDHHS and the MI Health Link program are making improvements to ensure high quality and high levels of access to care. Specifically, improvements in indicator rates were seen in the following domains: Prevention and Screening, Cardiovascular Conditions, Diabetes, Musculoskeletal, Behavioral Health, and Access/Availability of Care. Of note,

The indicator rate for the *Osteoporosis Management in Women Who Had a Fracture* measure indicator rate improved by 9.15 percentage points from the previous year; and the indicator rate for the *Initiation of Alcohol and Other Drug Dependence Treatment* measure improved by 10.94 percentage points.⁴²

In 2022, the ICOs were also responsible for initiating a new Quality Improvement Plan (QIP) to address healthcare disparities within their population. The ICOs were required to identify existing racial or ethnic disparities within the regions and populations served and determine plan-specific topics and performance indicators. Through the QIP activity, the ICOs' implemented interventions are aimed at eliminating those racial and ethnic disparities. Four of the six ICOs received an overall validation of Met, indicating those ICOs designed methodologically sound QIPs. Additionally, the network requirements analysis of the NAV activity demonstrated that, overall, the MI Health Link program had a sufficient network of LTSS providers, with most MDHHS-established minimum network requirements being met.⁴³

The SFY 2022 External Quality Review Technical Report for the **MI Choice Wavier** demonstrates areas of strength related to the quality, timeliness, and accessibility of care and services. The overarching aggregated findings from the PIP, PMV, compliance review, and CAHPS® analysis activities demonstrate that the MI Choice Waiver program focused its quality improvement efforts on care management processes and person-centered planning to support waiver members' access to services in accordance with their individualized health needs. Additionally, through CAHPS®, MDHHS is assessing members' satisfaction with their healthcare and, specifically, with the quality of services being provided to them by waiver agency staff members and providers. MDHHS and the waiver agencies focused strategies on quality of care by implementing quality improvement initiatives that are intended to ensure the health, safety, and wellbeing of members by mitigating risks that could lead to poor health outcomes. Through the CQAR process, MDHHS mandates immediate corrective action when issues are identified that may impact a member's ability to maintain optimal function, make informed choices, preserve independence and community integration, and/or create barriers to quality care or access to timely and necessary services.⁴⁴

Health Plan Performance: Opportunities

Key areas of opportunity for **CHCP and the Medicaid Health Plans** are related to Childhood Immunization Status; Well-Child Visits; Lead Screening in Children; Immunizations for Adolescents and Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and Continuation and Maintenance Phase indicators which demonstrated statistically significant declines in SFY 2022. Lead Screening in Children had the highest number of MHPs demonstrating a statistically significant decline in HEDIS®MY 2021, as well as an MWA decrease of nearly 19 percentage points from HEDIS®MY 2020. There was also a significant decline for the *Cervical Cancer Screening* and *Breast Cancer Screening* measures, *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessations Strategies*; and *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure indicators.³⁹

Dental Health Plan opportunities centered on further improving CMS-416 EPSDT performance measure rates and incorporating stringent validation quality audit checks when applying state fiscal year specifications prior to final submission of rates.⁴⁰

The results of the MI Health Link program secret shopper survey suggested that members may be experiencing barriers in accessing dental services. Overall, a high volume of dental providers reported not accepting an ICO, the MI Health Link program, and/or new patients. Many of the ICOs delegate the delivery of dental services to a dental subcontractor, which is likely a contributing factor to why dental

providers reported they are not accepting the ICO or the MI Health Link program. Additionally, of the dental providers who reported accepting an ICO, the MI Health Link program, and new patients, only 60.4 percent of callers were offered an appointment. Considering all surveyed providers, only 16.7 percent resulted in an offered appointment. While the average appointment wait time was 37 days, in many instances, the maximum wait time was significantly above MDHHS' appointment time standard of eight weeks for initial dental appointments. These results indicate opportunities to mitigate barriers to ensure dental services are accessible and available. MDHHS required all ICOs to implement a CAP to remediate the deficiencies identified through the survey. As MDHHS has elected to conduct another dental provider secret shopper survey activity in SFY 2023.⁴³

Areas of opportunity for the **Community Mental Health Services Programs (CMHSPs)/Pre-paid Inpatient Health Plans (PIHPs)** were identified for several performance indicators. Program wide, performance indicator #4a, *the percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days*, did not meet the Minimum Performance Standard (MPS) of 95 percent for either the children or the adult population, and performance declined substantially from the 2021 rates for this indicator. These findings suggest that members were not being seen at all or were not being seen in a timely manner after being discharged from psychiatric inpatient units. This could be the result of ineffective transitions of care processes or an insufficient network of mental health providers to provide services to the Medicaid members with diagnosed mental illnesses.

In addition, although MPS were not established for performance indicators #2, *the percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service*; #2e, *the percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of non-emergency request for service for persons with SUDs*; and #3, *the percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment*, statewide performance rates declined from 2021 to 2022 for all three indicators and all applicable populations. These data indicate there is considerable opportunity for MDHHS and the PIHPs to ensure new child and adult Medicaid members can access timely SUD and mental health treatment.⁴¹

The **MI Health Link program** SFY 2022 External Quality Review Technical Report for the Integrated Care Organizations (ICO's) identified opportunities for improvement in these primary areas of focus: person-centered care planning process and transition of care processes. The PMV activity results also demonstrated continued opportunities to enhance access to quality care as several HEDIS® measures declined in performance from the previous year. Within the Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Musculoskeletal Conditions, Behavioral Health, and Access/Availability of Care domains, ten indicator rates declined in performance from the previous year. The measures with the greatest percentage point decline (i.e., greater than 3 percentage points) included *Breast Cancer Screening*, *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid*, and *Follow-Up After Hospitalization for Mental Illness*. Additionally, although the overall network requirements analysis of the Network Adequacy Validation activity demonstrated the MI Health Link program had a sufficient network of LTSS providers, three ICOs failed to meet all minimum network requirements for provider capacity and time/distance. These provider types included Adult Day Program, Assistive Technology—Van Lifts and Tie Downs, Dental, Hearing Aids, Hearing Examinations, MIHP Agency, and NEMT. While, in most cases, the ICOs contracted with all available providers in their region(s), opportunities may exist for improving access to care and services.⁴³

EQRO comprehensive assessment of the **MI Choice Waiver Program and waiver agencies** identified opportunities for improvement within the program related to the quality, timeliness, and accessibility of care and services. Although the Program focuses on person-centered planning and members'

individual needs, waiver members may not be engaging with family and friends or participating in activities within their communities as often as they would like based on the CAHPS® domain, Planning Your Time and Activities which received the lowest score statewide. However, it was noted that the CAHPS® survey was conducted during a time when individuals may have avoided physical contact with family and friends due to the COVID-19 pandemic, which may have negatively impacted this domain. The EQRO assessment also noted discrepancies within the data reviewed or the data were not available as expected. The discrepant and incomplete data created challenges in evaluating each waiver agency's performance in the domains of quality, timeliness, and access to care as it relates to member outcomes. Opportunities for improvement were also identified related to the PIP activity (design and methodology), Clinical Quality Assurance Review (CQAR) compliance review processes, and the PMV activity (development of standard performance measures to evaluate waiver agency performance).⁴⁴

MDHHS and the managed care programs assessed the quality of healthcare and services as described in program EQRO Technical Reports with a focus on measures where there were declines in performance. The most significant challenge to improvement was felt to be due to the coronavirus disease 2019 (COVID-19) pandemic, specifically related to member access to preventive services including immunizations, screenings, testing and dental services, and accessing chronic conditions including behavioral health. Many provider and dental offices were limited to emergent care beginning in 2020, and members may have been hesitant to visit medical and dental facilities due to fear of contracting COVID-19. These barriers to care were reflected in lower measurement rates, even though health plans continued to promote healthy behaviors and screenings and demonstrated overall adequate provider networks. HEDIS performance rates for CHCP, Michigan's largest Medicaid managed care benefit program, showed overall improvement in measurement year 2021 compared to 2020, which is a potential indication that statewide quality performance will continue to rebound in the years following the onset of the pandemic.

Member Satisfaction

As previously described, the managed care programs conduct member surveys to assess satisfaction with the health plan and the **Consumer Assessment of Healthcare Providers and Systems (CAHPS®)** is the primary survey tool used to assess member satisfaction. Member survey results are an important component of Medicaid program management and oversight and provide an opportunity to identify concerns regarding the quality and access to care members receive. Survey findings provide MDHHS with information to determine if the Medicaid managed care plans progress toward the CQS Goal #1: Ensure high quality and high levels of access to care.

Michigan's most recent **Medicaid Health Plan** Adult and Healthy Michigan Plan CAHPS® reports indicate members' *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor* were key drivers of member experience. Highlights of the NCQA Comparisons and Trend Analysis findings for the MDHHS Medicaid Program indicate high performance in the areas of *Customer Service* (75th–89th percentile) and Effectiveness of Care Measures (*Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*) which fell between the 50th–74th percentile.⁴⁵ In addition, the HMP report reveals the *How Well Doctors Communicate* Composite Measure fell within the 50th–74th percentile.⁴⁶

Similarly, the **MHP Child CAHPS®** report shows key drivers of member experience analysis on three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. NCQA Comparisons and Trend Analysis findings also show the Child Composite Measure *How Well Doctors Communicate* fell within the 50th–74th percentile.⁴⁷

The **Healthy Kids Dental (HKD)** Survey yielded 10 measures that include four global rating measures, three composite measures, and three individual item measures. HSAG performed an analysis of key drivers for three measures: *Rating of Dental Plan*, *Rating of All Dental Care*, and *Would Recommend Dental Plan*. Survey items identified for each of the three measures as being key drivers of member experience for the HKD program include appointment availability, coverage of dental services, and the availability of adequate information on the dental plan.⁴⁸

The Adult CAHPS® Dental Plan Survey was also conducted to evaluate the quality of dental services provided to adult Medicaid members enrolled in the **Healthy Michigan Plan (HMP) health plans**. The HMP Dental CAHPS® Survey also included an analysis of key drivers for three measures: *Rating of Dental Plan*, *Rating of All Dental Care*, and *Would Recommend Dental Plan*. Key drivers of member experience for the HMP Dental program include coverage of dental services, the availability of information about how their dental plan works, and their dental plan customer service did not always give them the information or help they needed. In addition, the HMP health plan results were compared to the MDHHS HMP Program average to determine if the HMP health plan results were statistically significantly different than the MDHHS HMP Program average. There were no statistically significant differences for the following measures: *Rating of Regular Dentist*, *Rating of Finding a Dentist*, *Access to Dental Care*, and *Dental Plan Information and Services*.⁴⁹

As previously described, the **MI Health Link** program secret shopper survey suggested that members may be experiencing barriers in accessing dental services. These results indicate opportunities to mitigate barriers to ensure dental services are accessible and available to members in the MI Health Link program. A follow-up dental provider secret shopper survey will be conducted during SFY 2023.⁴³

The 2022 **Children's Special Health Care Services (CSHCS)** Program Member Experience Report represents child members enrolled in the CSHCS Fee-for-Service (FFS) program and the Medicaid Health Plans (MHPs). An analysis of key drivers of member experience for the following measures: *Rating of Health Plan*, *Rating of Health Care*, and *Rating of Specialist Seen Most Often*. Data analysis indicates the Composite Measures *How Well Doctors Communicate* and *CSHCS Family Center* scores are statistically significantly higher in 2022 than in previous years. A comparison analysis between the survey results of those children who were less medically complex to those that were more medically complex indicates the less medically complex subgroup scores were statistically significantly higher than the medically complex subgroup across the following measures: *Rating of Health Plan*, *Rating of Health Care*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, and *Access to Specialized Services*. Based on the 2022 survey findings, opportunities to improve member experiences may include revising available health plan written, web-based, and customer service information; assessing and increasing access to specialty care appointments; and working with providers to improve communications with members.⁵⁰

MDHHS requested that the HCBS CAHPS® Survey be Conducted for the **MI Health Link** program to gather direct feedback from members receiving HCBS about their experiences and the quality of LTSS they receive. Eleven of the fifteen (15) reportable measures had median scores above 90 (using a scale of 0 to 100), with three of those measures above 95, indicating many members reported having positive experiences. The measures with the highest scores included *Rating of Personal Assistance and Behavioral Health Staff*, *Rating of Case Manager*, and *Not Hit or Hurt by Staff*. However, the *Reliable and Helpful Staff* measure experienced a statistically significant decline in the median score compared to the previous year's results. Further, the lowest performing measure was *Planning Your Time and Activities* with a score of 73.5, 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.⁴³

Statewide CAHPS® Home and Community-Bases Services Survey results for the **MI Choice Waiver program** demonstrated high satisfaction with the program across multiple domains that address issues such as the quality of the patient caregiver relationship, helpfulness of the case manager, respondent's feelings of self-determination, met need, and physical safety. The CAHPS® survey asks 46 questions which can be grouped into 11 domains of objective and actionable information for quality improvement. Ten of the eleven domains scored above 90%. Enrollees indicated high satisfaction with having their needs met, 94.6% indicated staff knew what was in their service plan, and 86.9% indicated their person-centered service plan included all the things important to them. Enrollees rated the help received from personal assistance staff, homemakers, and their case managers at 91% and above. In addition, approximately 90% indicated that they have a way of getting to medical appointments, that the ride was easy to get in and out of, and that the ride arrives on time.⁵¹

MDHHS/Managed Care Program: Accomplishments

Establishing Measurable Performance Objectives

In response to CMS feedback on the MDHHS 2020-2023 CQS and after review of the June 2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit, the MDHHS CQS Core Team spent considerable time assessing and revising the CQS Objectives with a goal of meeting the required Medicaid Managed Care and CHIP Managed Care Final Rule, (CFR) § 438.340.

Michigan's EQRO also recommended that the CQS be revised to include the specific performance metrics MDHHS will use to evaluate progress toward achieving the CQS Goals. EQR reports across the programs noted that the metrics should be specific, measurable, attainable, relevant, and time-bound, and take into consideration the health status of all populations served by MDHHS Medicaid managed care programs.

As a result, the 2020-2023 CQS Objectives were streamlined and/or revised, and relevant performance measure(s) were identified for each 2023-2026 CQS Objective. The successful alignment of CQS goals and objectives with established performance measures reflects a new process among the Michigan Medicaid managed care programs.

Appendix D of the attached 2020-2023 CQS Effectiveness Evaluation includes a crosswalk of the MDHHS 2023-2026 CQS Goals and Objectives with corresponding measures. Challenges moving forward will include review of measure data and trends and the identification of opportunities for continuous quality improvement.

Health Equity Data Collection and Reporting

MDHHS and the Medicaid managed care programs are committed to improving the access, care and services provided to Medicaid beneficiaries with the goal of reducing health disparities. Michigan Medicaid programs have been implementing health equity reporting and monitoring processes for varying periods of time. The CQS Goals and Objectives pursue an integrated framework for population health improvement and a commitment to eliminating disparate outcomes within Medicaid managed care populations. While all CQS Goals & Objectives incorporate the concept of health equity and health disparities, Goal #4 specifically describes the intent to "Reduce racial and ethnic disparities in healthcare and health outcomes."

Since developing the 2020-2023 CQS, MDHHS and the managed care programs have continued to work toward implementing data-driven approaches to identify and address racial and ethnic disparities. This approach includes strengthening processes to improve quality of care and services; implementing

data driven outcomes measurement; pursuing efforts to identify and address social determinants of health (SDOH), health equity and disparities; and advancing payment methodologies. Managed care programs have or are in the process of implementing health equity initiatives to collect race/ethnicity data to eliminate racial and ethnic disparities by focusing on key vulnerable populations. In addition, programs have supported health promotion and disease prevention through community-based health and wellness strategies that focus on identifying and addressing SDOH, creating health equity, and supporting efforts to build more resilient communities. FY23 Medicaid program contractual requirement examples, include but are not limited to the following:

- Requiring health plans to incorporate SDOH into the process of collecting and analyzing data to support the reduction of health disparities and develop interventions that identify, and address lived experiences.
- Requiring plans to conduct clinical and non-clinical Health Disparities Quality Improvement Projects aimed at achieving statistically significant improvement in selected quality measures for a disparate sub-population.
- Implementing incentive programs related to the reduction of measurable racial/ethnic disparities.
- Establishing health equity metrics and monitoring utilization based on race/ethnicity.

MDHHS and the Medicaid programs will continue to move forward with interventions and strategies to reduce racial and ethnic disparities in healthcare and health outcomes.

The Medicaid managed care programs are at varying degrees of maturity regarding assessing program data for racial and ethnic disparities. The managed care programs are committed to using a data-driven approach to identify root causes of racial and ethnic disparities and addressing health inequity at its source whenever possible. This process includes gathering input from stakeholders at all levels (MDHHS, beneficiaries, communities, providers) to ensure people of color are engaged in the intervention design and implementation process. A data driven approach also requires identifying a valid/reliable system to quantify and monitor racial/ethnic disparities to identify gaps in care and reduce identified racial disparities among the managed care populations.

BHDDA specifically intends to focus on identifying potential disparities within the disabled/disability populations moving forward.

Systems and interventions to address Social Determinants of Health (SDOH) are also key to successfully addressing health disparities and health care inequities. Managed care programs are contractually requiring many of the health plans to develop a process for incorporating SDOH into processes for analyzing data in support of population health management.

Single Preferred Drug List (MSA 20-51)

MDHHS has a longstanding innovative approach to address Medicaid pharmacy benefits. In 2016 MDHHS implemented a Managed Care Common Formulary per Section 1806 of Public Act 84 of 2015. The purpose of the Common Formulary is to promote continuity of care, reduce interruptions in drug therapy due to a change in health plan, streamline drug coverage policies, facilitate collaboration among health plans, and reduce administrative burden for providers.

In 2020, MDHHS developed a Michigan Preferred Drug List (PDL) (Common Formulary) that is used by both the Medicaid Health Plans and the Fee-for-Service (FFS) pharmacy program. The Single PDL aligns coverage of PDL drug products under managed care with FFS and simplifies pharmacy coverage for program beneficiaries and prescribers. MDHHS and the plans worked to collaboratively implement the required Medicaid policy and procedures to implement the PDL.⁵²

COVID-19 Policy

During the federal Coronavirus 2019 Public Health Emergency (PHE) declaration, CMS provided state Medicaid programs flexibilities allowing for individuals to gain or maintain coverage and access to care. Since the initiation of the PHE, MDHHS has implemented over 100 programmatic flexibilities to help minimize the strain to the Medicaid program and its beneficiaries, and Michigan's health care providers and systems. These changes were implemented under a variety of federal and State authorities, and impact almost all aspects of the Medicaid delivery systems. Following the policy changes, MDHHS established a working group to evaluate the new policies and determine if they warrant extended consideration (if permissible) beyond the federal emergency orders. The Medicaid led workgroup focused on three areas: behavioral health, data, and coding. Throughout the COVID-19 PHE, ongoing discussion and analysis of beneficiary and provider impacts due to the policy changes were undertaken. In addition, in preparation for the end of the federal PHE declaration, MDHHS developed an "Unwinding Operational Plan" to help inform beneficiaries, providers, managed care plans, and other valued stakeholders of the steps MDHHS will take to return to standard operations.⁵³

COVID-19 Public Health Emergency (PHE) 2023 Benefit Changes

Many changes were made to the Medicaid program's eligibility, administration, and policies to ease rules for providers and prevent Medicaid beneficiaries from losing health insurance. As per recent federal legislation, Michigan restarted monthly eligibility renewals for both fee-for-service Medicaid and Medicaid Health Plan (MHP) beneficiaries in June 2023. Certain waived policies that were in place during the PHE are now in the process of unwinding and will continue the unwind process as the authority for these policies expire. As a result, Medicaid beneficiaries will have to renew their coverage as Medicaid eligibility redeterminations are resumed to comply with federal legislation. Renewals for traditional Medicaid and the Healthy Michigan Plan were also initiated in June 2023 and will continue through May 2024.⁵³

COVID-19 Telemedicine/Telehealth

Telemedicine/telehealth services were implemented under Executive Order 2020-86 as a way to provide needed care and services to individuals while practicing social distancing and limiting potential exposure to COVID-19. Executive Order 2020-86 expanded telehealth options for Michigan residents by authorizing and encouraging health care providers to use telehealth services when medically appropriate and after obtaining consent from patients in a safe and compliant manner and that meets Michigan Mental Health Code. Under the Executive Order many health services, such as mental health care, drug treatment, and home health services were able to be provided via telehealth. Medicaid coverage for telehealth services also allowed for the use of remote patient monitoring and asynchronous platforms. Health care insurance providers were required to reimburse for virtual telehealth visits. Examples of additional policy flexibilities that were implemented in response to the PHE include Telemedicine, Face-to-Face, Person-Centered Service Plan, Prior Authorization, Direct Care Worker/Wage Increase, and Level of Care Determinations, among others. Each flexibility is being reviewed and determination made for continuation with or without modification beyond the PHE end, temporary extension for a defined period of time following PHE end, or termination upon PHE end.⁵³

Integration with the National Quality Strategy

Michigan strives to align the state's Quality Strategy with National Quality Strategy (NQS). The NQS, mandated by the Affordable Care Act of 2010, is a national plan to improve the delivery of health care services, patient health outcomes, and population health. In January 2022, the CMS published an updated National Quality Strategy with the goal of establishing "a resilient, high-value health care system that promotes quality outcomes, safety, equity, and accessibility for all individuals, especially for people in historically underserved and under-resourced communities."⁵⁴

The eight CMS 2022 National Quality Strategy Goals are to:

1. Embed Quality into the Care Journey
2. Advance Health Equity
3. Promote Safety
4. Foster Engagement between Individuals and their Care Teams
5. Strengthen Resilience in the Health Care System
6. Embrace the Digital Age
7. Incentivize Innovation & Technology
8. Increase Alignment of Performance Metrics, Programs, Policy, and Payment⁴

Aligning with the NQS will enable Michigan to approach the CQS from a strategic perspective, focusing on population health and engaging in continuous improvement consistent with national efforts under ACA. It also enables Michigan to mindfully increase quality improvement efforts for special populations, disparities reduction, integrated care, value-based delivery models and identify gaps in areas such as community engagement.

SUMMARY

MDHHS is committed to improving the health and well-being of Michigan residents. To meet this goal, Michigan's Medicaid managed care programs collaboratively developed this 2023-2026 Comprehensive Quality Strategy (CQS) which outlines the managed care program strengths and opportunities for improvement. Further development and integration of quality improvement program functions will continue to positively impact the care and services provided to all Medicaid populations and programs which is consistent with the National Quality Strategy (NQS). Alignment with the MDHHS strategic priorities additionally supports the provision of services and strategies to improve the health, safety, and prosperity of the Michigan's residents.

Over the course of the 2023-2026 CQS, a priority area for MDHHS includes the ongoing assessment and trending of the newly established CQS Goals and Objectives measures and performance targets to identify opportunities for improvement across the Medicaid managed care programs. Additional opportunities to advance CQS goals and meet the needs of Michigan's Medicaid managed care populations through:

- Continuing efforts to pursue and focus on the identification and reduction of health disparities to improve the access, care and services provided to Medicaid beneficiaries.
- Implementing data driven outcomes measurement and efforts to identify and address social determinants of health (SDOH).
- Developing partnerships to advance health equity, promoting Community Health Workers, and addressing social drivers of health and chronic disease.
- Utilizing population health management strategies that emphasize health promotion and disease prevention and incorporates community-based health and wellness and supporting efforts to build more resilient communities.
- Incorporating SDOH's into the process of collecting and analyzing data; conducting clinical and non-clinical Performance Improvement Projects; establishing health equity metrics; monitoring utilization based on race/ethnicity; and requiring plans to address disparities in measure rates.

The MDHHS CQS reflects an active, ongoing, and iterative process that requires effective communication among internal and external stakeholders, managed care programs, and providers (CQS Goal #3). MDHHS is committed to seeking opportunities to enhance quality improvement processes, implementing evidence-based strategies and monitoring outcomes across all of Michigan's managed care programs.

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Appendix A: Michigan Medicaid Managed Care Programs

Managed Care Program	Program Description
Comprehensive Health Care Program (CHCP): Medicaid Health Plans	<p>MDHHS contracts with nine (9) managed care plans in targeted geographical service areas comprised of 83 counties (divided into 10 regions) and provides services to approximately 2.2 million managed care beneficiaries in the state. Michigan’s waiver requires managed care enrollees to obtain services from specified Medicaid Health Plans (MHPs) based on the county of residence.</p> <p>CHCP employs a population health management framework and contracts with high-performing health plans to build a Medicaid managed care delivery system that maximizes the health status of beneficiaries, improves Beneficiary experience, and lowers cost. MDHHS supports the MHPs to achieve these goals through evidence- and value-based care delivery models, supported by health information technology/health information exchange and a robust quality strategy. MHPs must provide the spectrum of primary and preventive care and use the principles of population health management to prevent chronic disease and coordinate care along the continuum of health and wellbeing. Effective utilization of these principles is intended to maintain or improve the physical and psychosocial wellbeing of individuals through cost-effective and tailored health solutions, incorporating all risk levels along the care continuum. Population health management also includes an overarching emphasis on health promotion and disease prevention and will incorporate community-based health and wellness strategies with a strong focus on the Social Determinants of Health, creating Health Equity, and supporting efforts to build more resilient communities. MDHHS further supports implementation of payment reform initiatives that pay providers for value rather than volume; 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. Paying for value in the Medicaid population moves away from fee-for-service (FFS) models and embraces accountable and transparent payment structures that reward and penalize based on defined metrics.</p>
Michigan’s Children’s Health Insurance Program (CHIP): MICHild	<p>MICHild is a Medicaid program managed by the Medical Services Administration, MDHHS. It is for the low-income uninsured children of Michigan’s working families. Since January 1, 2016, Michigan administers its Title XXI Children’s Health Insurance Program (CHIP) as a Medicaid expansion program through the Comprehensive Health Care Program (CHCP) Medicaid Health Plans (MHPs). Children enrolled in MICHild are considered Medicaid beneficiaries and are entitled to all Medicaid covered services in accordance with current Medicaid policy. The MICHild Medicaid program provides Medicaid health care coverage for children who are age zero to eighteen; have income at or below 212% of the Federal Poverty Level under the Modified Adjusted Gross Income methodology (MAGI); do not have other comprehensive medical insurance; do not qualify for other MAGI related Medicaid programs; and are residents of Michigan. Administering MICHild through the MHPs affords this population access to Medicaid covered services including school-based services, home help, Maternal Infant Health Program (MIHP), podiatry and non-emergency medical transportation (NEMT), expanded autism services, and a comprehensive array of preventive, diagnostic, and treatment services provided through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit as defined in the Medicaid Provider Manual. The MICHild population is included in all Medicaid quality assessment and data analyses.</p>
Children’s Special Health Care Services (CSHCS) Program	<p>CSHCS is a program within MDHHS for children and some adults with special health care needs and their families. CSHCS is mandated by the Michigan Public Health Code, Public Act 368 of 1978, Part 58, children and youth with special health care needs (MCL 333.5801 – 333.5879), in cooperation with the federal government under Title V of the Social Security Act, Sec.501. [42 U.S.C. 701] (a) 1 (D) and the annual Michigan Department of Health and Human Services (MDHHS) Appropriations Act. Title V charges CSHCS with promoting the development of systems of care that are family-centered, community-based, coordinated, and culturally competent with a focus on health equity. CSHCS enrollment is contingent upon having one or more qualifying conditions that necessitate the expertise of a specialty provider to manage. CSHCS strives to enable individuals with special health care needs to have improved health outcomes and an enhanced quality of life through the appropriate use of the CSHCS system of care. Program goals are to: assist individuals with special health care needs in accessing the broadest possible range of appropriate medical care, health education and supports; assure delivery of these services</p>

	<p>and supports in an accessible, family centered, culturally competent, community based and coordinated manner; promote and incorporate parent/professional collaboration in all aspects of the program; and to remove barriers that prevent individuals with special health care needs from achieving these goals.</p> <p>Beginning in October 2012, individuals who have both CSHCS and Medicaid coverage are enrolled into Medicaid Health Plans (MHP), although individuals do not need to be in Medicaid managed care to be a CSHCS enrollee. Approximately 65% of the CSHCS population is enrolled in managed care, 15% are in Medicaid Fee-for-Service (FFS) and the remaining members are enrolled in CSHCS only. Although CSHCS is a separate program from Medicaid, CSHCS partners closely with the Medicaid program. This allows for greater efficiency in administering the two programs and allows both programs to collaborate on the care of a beneficiary so there is no duplication of services. The MHPs are responsible for all of the medical care and treatment of their members. Community based services beyond medical care and treatment are still available through the local health department CSHCS offices. Because of this mandatory enrollment, the state Medicaid agency requires coordination between the MHPs and CSHCS; and managed care contracts are developed to ensure consideration of the unique needs of the CYSHCN population.</p>
Healthy Michigan Plan (Medicaid Expansion)	<p>On September 16, 2013, Michigan Public Act 107 of 2013 was signed into law and directed the creation of the Healthy Michigan Plan. The Healthy Michigan Plan (HMP), Michigan's Medicaid Centers for Medicare and Medicaid (CMS) Expansion program, was approved by CMS on December 30, 2013. The 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. The central features of the HMP are to extend health care coverage to low-income Michigan citizens who are uninsured or underinsured and to implement systemic innovations to improve quality and stabilize health care costs through a continued emphasis on value-based services. Other key features include incentives for healthy behaviors to encourage personal responsibility; encouraging use of high-value services; and promoting overall health and well-being.</p> <p>The State began accepting applications for the Healthy Michigan Plan on April 1, 2014. Michigan has continued to experience higher than anticipated enrollment in HMP.</p> <p>HMP enrollees receive benefits required under the Affordable Care Act and all of the Essential Health Benefits required by federal law and regulation. Enrollees will also receive three benefits not covered through the current State Plan: habilitative services, hearing aids, and the full complement of preventive health services. All HMP beneficiaries are mandatorily enrolled into a Medicaid Health Plan (with the exception of those meeting plan enrollment exemption or voluntary enrollment criteria). As required by State law, MDHHS has submitted the required CMS waivers to modify the Healthy Michigan Plan since 2013 to maintain coverage for individuals enrolled in the program.</p>
Flint Medicaid Expansion Waiver	<p>In 2016, MDHHS received a 1115 waiver from CMS to expand Medicaid coverage and benefits to individuals affected by the Flint Water Crisis. The Flint Water Crisis occurred when the city's water source was changed in April 2014 to the Flint River. Over 100,000 residents were affected and among those were approximately 25,000 infants and children.⁵⁴</p> <p>Michigan's 1115 Waiver entitled the Flint, Michigan Section 1115 Demonstration was approved in March 2016 through February 2021. The overarching goal of the waiver is to "identify and address any physical or behavioral health issues associated with actual or potential exposure to lead hazards." Specifically, the waiver expanded eligibility of all Medicaid benefits for low-income children (up to age 21 including children born to eligible pregnant individuals and pregnant individuals (through two months post-delivery) served by the Flint water region from 4/1/2014 through the date when the water is deemed safe. The specific eligibility modifications included: increasing the income threshold to offer coverage to children and pregnant individuals in households with higher income levels; eliminating cost sharing and Medicaid premiums for eligible enrollees; and permitting eligible children and pregnant individuals above the 400% FPL and served by the Flint water system to buy into Medicaid benefits by paying premiums.</p> <p>The demonstration also added a Targeted Case Management (TCM) benefit to all low-income children (up to age 21 including children born to eligible pregnant individuals) and pregnant individuals (through two months post-delivery) served by the Flint water system as of 4/1/2014. The activities included in the TCM benefit were to: assist enrolled eligible children and pregnant individuals served by the Flint water system to gain access to needed medical, social, educational,</p>

	and other service(s). The Flint Medicaid Expansion (FME) Waiver continues to provide expansion of health services to address potential health risks and diseases possibly incurred during exposure to lead during the Flint Water Crisis.
Managed Long-Term Services and Supports	<p>Long-term services and supports (LTSS) provide assistance with an individual's activities of daily living (ADLs) and instrumental activities of daily living (IADLs) to help them remain independent in the least restrictive setting of their choice. When Medicaid LTSS are provided under a managed care system rather than a fee-for-service system, they are called Managed Long-Term Services and Supports (MLTSS). Under a MLTSS system, managed care organizations, under contract with the State, coordinate the delivery of all approved supports and services for each program participant. MDHHS operates three capitated programs: MI Choice home and community-based services waiver, the Program of All-Inclusive Care for the Elderly (PACE) and the MI Health Link demonstration project.</p> <p>Although these programs constitute managed care, they operate independently of one another rather than under the continuum of a fully integrated managed care system. The Michigan Legislature first began signaling its interest in having Medicaid long term supports and services (MLTSS) provided through a managed care arrangement in 2013.</p> <p>The MLTSS discussion intensified in FY 2018 and FY 2019, when MDHHS began an initiative to develop a plan for the eventual expansion of MLTSS across the long-term care spectrum. Medicaid services included in the MLTSS initiative comprise those provided by: Skilled Nursing Facilities and County Medical Care Facilities; Hospital Long Term Care Units; MI Choice waiver; MI Health Link Waiver; PACE; Home Health agencies; State plan Private Duty Nursing (PDN) services; Hospice services; Home Help; Personal Care Services/Community Placement Services; and Community Transition Services. Expected benefits include increasing efficiency of the LTSS system, promoting community inclusion by incentivizing services in less restrictive settings, and ensuring quality throughout the system. This approach can be used as a mechanism to streamline and integrate systems, increase coordination and collaboration, and improve the experience of the customer. While it might not be the primary consideration in play, managed care systems are often thought to have a financial benefit due to the efficiencies involved. Descriptions of the three MLTSS programs in Michigan, the MI Choice home and community-based services waiver, the MI Health Link demonstration project, and the Program of All-Inclusive Care for the Elderly (PACE), are below.</p>
MI Choice Waiver Program	<p>MI Choice is a waiver program to deliver home and community-based services to elderly persons and other adults with physical disabilities who meet the Michigan nursing facility level of care criteria. The waiver is approved by the Centers for Medicare & Medicaid Services (CMS) under sections 1915(b) and 1915(c) of the Social Security Act. The MI Choice Waiver Program (MI Choice) began in 1992 as the Home and Community Based Services for the Elderly and Disabled (HCBS/ED) waiver program which became available in all Michigan counties October 1, 1998. It became a managed care program with the approval of the waiver renewal application on October 1, 2013. The program allows individuals to live independently while receiving LTSS in their home or a community-based setting.</p> <p>MI Choice is limited to serving older adults (age 65 and over) and persons with disabilities (age 18 and older). The goal of MI Choice is to provide home and community-based services and supports to participants using a person-centered planning process that allows them to maintain or improve their health, welfare, and quality of life. MI Choice participants receive services from entities classified as Prepaid Ambulatory Health Plans (PAHPs), otherwise referred to as waiver agencies. MDHHS currently contracts with 20 waiver agencies throughout the state to operate and administer the MI Choice waiver.</p>
MI Health Link Demonstration	<p>Michigan launched the MI Health Link demonstration in March 2015 to integrate care for dually eligible Medicare and Medicaid beneficiaries in four regions in the state. The goal of MI Health Link is to provide seamless access to high quality care through coordination of services currently covered separately by Medicare and Medicaid.</p> <p>MI Health Link is a health care option for Michigan adults, ages 21 or over, who are enrolled in both Medicare and Medicaid, and live in the counties of Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Macomb, St. Joseph, Van Buren, Wayne or any county in the Upper Peninsula. MI Health Link offers a broad range of medical and behavioral health services, nursing home care,</p>

	<p>pharmacy and home and community-based services through managed care entities called Integrated Care Organizations (ICO) and Medicaid's existing Pre-paid Inpatient Health Plans (PIHP). Michigan retained the existing carve-out for Medicaid behavioral health services, which relies on PIHPs to manage mental health and substance use disorder (SUD) services, and the habilitation supports (HAB) waiver for persons with intellectual or developmental disabilities (I/DD). The ICOs receive capitated payments from CMS and the State to finance all Medicare and Medicaid services, including a home and community-based services (HCBS) waiver specifically for demonstration enrollees.</p>
Program of All-Inclusive Care for the Elderly	<p>The Program of All-Inclusive Care for the Elderly (PACE) is a capitated benefit authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing for frail, elderly individuals that meet Nursing Facility Level of Care criteria. For most PACE participants (enrollees), the comprehensive service package permits them to continue living at home while receiving services rather than being institutionalized. The PACE model is centered on the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible.</p> <p>In general, eligibility criteria require that individuals be age and medically qualified, meet Medicaid's Nursing Facility Level of Care eligibility criteria, live within the approved geographic area of the PACE organization, be able to live safely in the community (not residing in a nursing facility) at the time of enrollment, and not be concurrently enrolled in the MI Choice waiver program, MI Health Link, or a Health Maintenance Organization (HMO). In Michigan, services are provided through thirteen PACE organizations who operate twenty-four (24) centers in lower Michigan. (PACE is not a statewide service.) The PACE service package includes all Medicare and Medicaid covered services, and other services as determined necessary by the interdisciplinary team. The PACE organization enters into a three-party agreement with the Centers for Medicare and Medicaid Services and the Michigan Department of Health and Human Services (MDHHS). A contract is also signed between the PACE organization and MDHHS.</p>
Dental Managed Care Programs	<p>MDHHS operates and oversees multiple managed care dental programs.</p> <p><u>Healthy Kids Dental:</u> The Healthy Kids Dental program provides dental services to beneficiaries under age 21. In May 2000, the State initiated the Healthy Kids Dental program as a pilot program to help improve the dental health of Medicaid-enrolled children. After years of continued investment and expansion into additional counties, on October 1, 2016 Healthy Kids Dental became available to all children statewide. MDHHS currently contracts with two dental plans, Blue Cross Blue Shield of Michigan and Delta Dental of Michigan, Inc., to provide dental services to approximately 1 million youth under the age of 21 statewide.</p> <p><u>Adult Dental:</u> Effective April 2023 MDHHS expanded dental benefits for adult Medicaid beneficiaries to increase access to services, enhance care coordination and improve health outcomes. Medicaid beneficiaries aged 21 years and older, including HMP beneficiaries and pregnant individuals who are enrolled in a Medicaid Health Plan, Integrated Care Organization or Program of All-Inclusive Care for the Elderly receive dental benefits through their Medicaid health plan. The plan is responsible for beneficiary dental services obtained through the health plan's dental provider network. Dental services for beneficiaries who are not enrolled in a health plan will be provided through the Medicaid FFS program.</p>
Behavioral Health Managed Care	<p>The Bureau of Children's Coordinated Health Policy & Supports (BCCHPS) was created to improve and build upon the coordination and oversight of children's behavioral health services and policies. BCCHPS carries out responsibilities specified in the Michigan Mental Health Code (Public Act 258 of 1974 as amended) and the Michigan Public Health Code (Public Act 368 of 1978 as amended) related to children's behavioral health services. It also administers Medicaid Waivers for children and youth with intellectual or developmental disabilities, mental illness, and serious emotional disturbance. BCCHPS upholds that services must be designed specifically for the needs of children, including those transitioning through different health care settings. Additionally, BCCHPS prioritizes the critical importance of including families in addressing the health needs of children. BCCHPS is also working to make services timelier for youth so they can access the most appropriate services when they are needed rather than turning to an emergency room or child welfare services. BCCHPS works hand-in-hand with other MDHHS administrations to address children's behavioral health crises and to focus on expanding dedicated partnerships and advocate relationships.</p>

	<p>BCCHPS services and supports in Michigan are delivered through county-based community mental health services programs (CMHSPs). Michigan uses a managed care delivery structure including 10 Prepaid Inpatient Health Plans (PIHPs) who contract for service delivery with forty-six (46) Community Mental Health Service Programs (CMHSP's) and other not-for-profit providers to provide mental health, substance abuse prevention and treatment, and developmental disability services. PIHPs are required to have an extensive array of services that allows for maximizing choice and control on the part of individuals in need of service. Individual plans of service are developed using a person-centered planning process for adults and family driven and youth guided services for children. Outpatient mental health services are available through Medicaid Health Plans (MHPs) for persons who are not eligible for Medicaid Services through PIHPs and their CMHSP networks.</p> <p>The Bureau of Specialty Behavioral Health Services is responsible for the implementation and management of a community-based system of care serving people with serious mental illness, serious emotional disturbance, co-occurring disorders, substance use disorders and intellectual developmental disabilities. Services are delivered through 10 prepaid inpatient health plans, 46 community mental health services programs and other community-based organizations. Funding sources for services in this system of care are through state general funds, federal grant funds, and federal funds supporting Medicaid and the Healthy Michigan Plan. The bureau is responsible for ongoing contract, program, and quality management activities and for assuring that federal and state conditions (applications, renewal requests, service, reporting and evaluation requirements) associated with these funding sources are met.</p>
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Michigan Department of Health and Human Services

2020 – 2023 Comprehensive Quality Strategy Effectiveness Evaluation

FINAL July 2023

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Executive Summary for Effectiveness Evaluation

This is the first Effectiveness Evaluation for the Michigan Department of Health and Human Services (MDHHS) Medicaid Comprehensive Quality Strategy (CQS). Development of the MDHHS 2020-2023 CQS initiated a new process of integrating traditionally separate quality improvement goals and objectives into a common set of overarching Medicaid managed care quality strategies that encompass all managed care programs within the MDHHS. Michigan's 2020-2023 CQS provides a summary of the work being done to assess and improve the quality of care and services provided and reimbursed by Michigan's Medicaid managed care programs, in accordance with state and federal laws and regulations which follow the principles of quality measurement, monitoring, and improvement. The CQS provides the framework to accomplish its overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality across all Michigan Medicaid managed care programs.

During the CQS three-year timeframe, MDHHS initiated improvements that impact the CQS and the Medicaid managed care programs. Improvement opportunities were identified based on 1) Centers for Medicare & Medicaid Services (CMS) feedback on the 2020-2023 CQS; 2) internal review and recommendations from the CQS Leadership and Core Teams; and 3) feedback from Michigan's External Quality Review Organization (EQRO), the Health Services Advisory Group (HSAG).

Key improvements described in this 2020-2023 CQS Effectiveness Evaluation include:

1. Alignment of CQS Goals & Objectives with the CMS National Quality Strategy and MDHHS Strategic Priorities
2. Inclusion of Baseline Data and Target-Setting for Performance Metrics
3. Alignment of CQS Quality Goals to Measurable Objectives
4. Increased Focus on Reducing Health Disparities
5. Alignment with Michigan's 2022-2024 Social Determinants of Health (SDOH) Strategy

Michigan's managed care programs have made significant progress toward implementing strategies to meet the 2020-2023 CQS Goals and Objectives to improve the access, quality of care and services to Medicaid beneficiaries. The programs successfully conducted a process evaluation to assess progress toward meeting the 2020-2023 CQS Goals & Objectives, revised the Goals & Objectives in preparation for the 2023-2026 CQS, and identified relevant performance measures for each of the revised CQS Objectives. During this initial three-year CQS cycle, programs have also implemented data driven outcomes measurement and pursued efforts to identify and address social determinants of health (SDOH), health equity and reduce health disparities through collaborative efforts and health plan contractual requirements.

Moving forward, MDHHS and the Medicaid managed care programs will continue to work collaboratively to further integrate CQS quality improvement strategies to positively impact the lives of Michigan's Medicaid beneficiaries.

Effectiveness Evaluation Introduction

This is the first Effectiveness Evaluation for the Michigan Department of Health and Human Services (MDHHS) Medicaid Comprehensive Quality Strategy (CQS).

Michigan's 2020-2023 CQS provides a summary of the work being done to assess and improve the quality of care and services provided and reimbursed by Michigan's Medicaid managed care programs, in accordance with state and federal laws and regulations which follow the principles of quality measurement, monitoring, and improvement. The CQS provides the framework to accomplish its overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality across all Michigan Medicaid managed care programs.

Michigan's managed care programs include:

- Adult Behavioral Health- Bureau of Specialty Behavioral Health Services (SBHS)
- Children's Behavioral Health - Bureau of Children's Coordinated Health Policy & Supports (BCCHPS)
- Children's Special Health Care Services (CSHCS)
- Comprehensive Health Care Program (CHCP)
- Dental Health Program
- MI Choice Waiver Program
- MI Health Link Demonstration
- Program of All-Inclusive Care for the Elderly (PACE)

Development of the 2020-2023 CQS initiated a new process of integrating traditionally separate quality improvement goals and objectives into a common set of overarching Medicaid managed care quality strategies that encompass all managed care programs within the MDHHS.

To guide the CQS development process, MDHHS established Leadership and Core Teams. The CQS Leadership Team is comprised of individuals representing senior Medicaid leadership from the Behavioral and Physical Health and Aging Services Administration (BPHASA) and the Bureau of Children's Coordinated Health Policy and Supports (BCCHPS). The CQS Core Team includes representatives from each of the eight (8) Medicaid managed care programs listed above.

Michigan Medicaid collaboratively identified and agreed upon CQS goals and objectives that pursue an integrated framework for overall population health improvement and a commitment to eliminating disparate outcomes within subpopulations in Medicaid managed care. Fundamental to the concept of population health improvement is a commitment to health equity and addressing health disparities. The CQS also strives to align with the Centers for Medicare and Medicaid Services (CMS) National Quality Strategy and the MDHHS Strategic Priorities.

2023-2026 CQS Goals:

- Goal #1: Ensure high quality and high levels of access to care.
- Goal #2: Strengthen person and family-centered approaches.
- Goal #3: Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external).
- Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes.
- Goal #5: Improve quality outcomes through value-based initiatives and payment reform.

Since the submission of the MDHHS 2020-2023 CQS ([Link in Appendix A](#)), MDHHS has initiated a number of improvements that impact the CQS and the Medicaid managed care programs.

Improvement opportunities were identified based on 1) Centers for Medicare & Medicaid Services (CMS) feedback on the 2020-2023 CQS; 2) internal review and recommendations from the CQS Leadership and Core Teams; and 3) feedback from Michigan's External Quality Review Organization (EQRO), the Health Services Advisory Group (HSAG).

Key improvements described in the 2020-2023 CQS Effectiveness Evaluation are summarized as follows:

1. Alignment of CQS Goals & Objectives with the CMS National Quality Strategy and MDHHS Strategic Priorities
2. Inclusion of Baseline Data and Target-Setting for Performance Metrics
3. Alignment of CQS Quality Goals to Measurable Objectives
4. Increased Focus on Reducing Health Disparities
5. Alignment with Michigan's 2022-2024 Social Determinants of Health (SDOH) Strategy

Improvement 1: Alignment of CQS Goals & Objectives with the CMS National Quality Strategy and MDHHS Strategic Priorities

Although the 2020-2023 CQS aligned with the values and foundational principles of prior MDHHS Administrative Leadership, new MDHHS strategic priorities were established for Fiscal Years 2023 – 2027. The updated MDHHS strategic priorities follow a March 2022 reorganization of the Health and Aging Services Administration to the Behavioral and Physical Health and Aging Services Administration (BPHASA).

BPHASA combines Michigan's Medicaid office, services for aging adults and community-based services for adults with intellectual and developmental disabilities, serious mental illness, and substance use disorders under one umbrella within MDHHS. BPHASA is also the designated State Unit on Aging. The new structure integrates MDHHS teams that focus on aging and long-term care issues and allows BPHASA to develop innovative policies that benefit our state and its residents. The restructure also builds upon the administration's existing efforts to deliver services to adults with mild to moderate mental illness.¹

The MDHHS mission, vision and strategic priorities further delineate the Department's commitment to providing care and services to improve the health, safety, and prosperity of Michigan residents. The mission of MDHHS is to provide services and administer programs to improve the health, safety, and prosperity of the residents of the state of Michigan. MDHHS's vision is to deliver health and opportunity to all Michiganders, reducing intergenerational poverty and promoting health equity.²

MDHHS Strategic Priorities for Fiscal Years 2023 – 2027:

- Public health investment
- Racial equity
- Address food & nutrition, housing, and other social determinants of health (SDOH)
- Improve the behavioral health service system for children & families
- Improve maternal-infant health & reduce outcome disparities
- Reduce lead exposure for children
- Reduce child maltreatment & improve rate of permanency within 12 months
- Fully implement the Families First Preservation Services Act (FFPSA) state plan
- Expand & simplify safety net access
- Reduce opioid & drug related deaths

- Ensure all administrations are managing to outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances.

In alignment with the MDHHS mission and vision, all Michigan Medicaid managed care programs are committed to health equity, reducing health disparities, and addressing social determinants of health. The 2020-2023 CQS Goals & Objectives pursue an integrated framework for both overall population health improvement and a commitment to eliminating unfair outcomes within Medicaid managed care populations.

In addition, in January 2022, the Centers for Medicare and Medicaid Services (CMS) published an updated National Quality Strategy with the goal of establishing “a resilient, high-value health care system that promotes quality outcomes, safety, equity, and accessibility for all individuals, especially for people in historically underserved and under-resourced communities.”³

The CMS 2022 National Quality Strategy Goals:

1. Embed Quality into the Care Journey
2. Advance Health Equity
3. Promote Safety
4. Foster Engagement between Individuals and their Care Teams
5. Strengthen Resilience in the Health Care System
6. Embrace the Digital Age
7. Incentivize Innovation & Technology
8. Increase Alignment of Performance Metrics, Programs, Policy, and Payment³

To ensure alignment, the CQS Core and Leadership Teams reviewed the MDHHS 2020-2023 CQS Goals and Objectives to identify opportunities to clarify and/or revise the CQS Objectives in preparation for the next iteration of the MDHHS 2023-2026 CQS. Overall, the MDHHS 2020-2023 CQS Goals and Objectives were determined to reflect key elements of both the MDHHS Strategic Priorities and the CMS 2022 National Quality Strategy goals.

Alignment of the revised MDHHS CQS Goals and Objectives are outlined in **Appendix B**.

Improvement 2: Inclusion of Baseline Data and Target-Setting for Performance Metrics

Michigan’s CQS provides a summary of the work being done to assess and improve the quality of care and services provided and reimbursed by Michigan’s Medicaid managed care programs following the principles of quality measurement, monitoring, and improvement. As previously stated, development of the MDHHS 2020-2023 CQS initiated a new process of integrating traditionally separate quality improvement goals and objectives into a common set of overarching Medicaid managed care quality strategies that encompass all managed care programs within the MDHHS.

To meet this goal, the Medicaid managed care programs collaboratively identified and agreed upon 2020-2023 CQS goals and objectives; however, specific performance metrics were not identified in this first iteration of the CQS. To meet CMS expectations as outlined in the June 2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit, a process evaluation of the 2020-2023 CQS Goals and Objectives was undertaken.⁴

MDHHS required the Medicaid managed care programs to evaluate program status as “meeting” or “not meeting” the CQS objectives across each of the five 2020-2023 CQS Goals. The iterative evaluation process which occurred over a two-year period was supported by in-depth discussions during CQS Core Team meetings and through individual Medicaid program meetings to validate common application of the CQS objective definitions.

The CQS goals and objectives evaluation process was initiated shortly after submission of the MDHHS 2020– 2023 CQS to CMS in January 2021. To accomplish the evaluation and track program responses, Medicaid managed care programs completed Qualtrics surveys for each CQS objective. The managed care programs were asked to assess program status against the following categories: meeting the objective; not meeting the objective but could without significant additional resources; not meeting the objective but could with substantial additional resources; not feasible to achieve the objective during the next three years; and “other” status. In addition, programs identified intervention strategies and resources needed to fully meet the objective(s).

As a part of the assessment process, the CQS Core and Leadership Teams recognized the importance of assuring programs were assessing themselves against a common benchmark. As a result, work was undertaken to establish common definitions for each CQS objective. Programs conducted self-assessments against the common objective definitions in early 2022 and MSU-IHP conducted individual program interviews May – June 2022 to assure consistent application across programs. Team activities related to program evaluation of the goals and objectives continued through March 2023.

Complete results of the CQS program evaluation assessments are outlined in Appendix C. The table outlines the number of Medicaid managed care programs meeting the CQS Objectives, and includes 2022 baseline program performance, a program performance target and supporting program intervention(s). A summary of the evaluation results is included in **Table 1**, below.

Table 1: Summary 2020-2023 CQS Goals & Objectives Evaluation: Programs Meeting Objectives

	Objective 1	Objective 2	Objective 3	Objective 4	Objective 5	Objective 6
Goal #1	7/7	4/7	6/7	7/7	7/7	
Goal #2	5/7	7/7	7/7	7/7	4/7	
Goal #3	4/7	3/7	4/7			
Goal #4	4/7	4/7	5/7	4/7	3/7	5/7
Goal #5	6/7	3/7				

*The

numerator denotes the number of Medicaid managed care programs meeting the CQS objective.

Overall, Michigan Medicaid managed care programs reported fully meeting six (6) of twenty-one (21) Objectives included in the 2020-2023 CQS. Three of the six objectives were related to GOAL #1: Ensure high quality and high levels of access to care; and three were for GOAL #2: Strengthen person and family-centered approaches.

Goal #3, Objective #1: “Establish common program-specific quality metrics and definitions to collaborate meaningfully across program areas and delivery systems,” presented significant challenges for the Medicaid managed care programs and generated meaningful discussion among MDHHS CQS Core team members. Programs utilize a number of standardized quality measure sets, including Healthcare Effectiveness Data and Information Set (HEDIS), Long-term services and supports (LTSS), Medicare Health Outcomes Survey (HOS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) to assess the quality of care and services provided to Medicaid beneficiaries. There are contractual requirements for care coordination, joint care planning, shared metrics, and care management processes for ongoing coordination and integration of services. Michigan’s Mission-Based

Performance Indicators (MMBPIS) are used to measure quality performance in Michigan’s behavioral system. Certain MMBPIS measures share some specifications with HEDIS measures, but none are fully aligned. The current joint metrics with MHPs and PIHPs are an example of meaningful collaboration across program areas; and program administrators have been working to phase in additional performance standards for the MMBPIS measure set. The formation of the Behavioral and Physical Health and Aging Services Administration (BPHASA) may present opportunities to align quality reporting standards across Medicaid managed care programs.

The ongoing discussion and dialog resulted in the Core Team successfully aligning the revised 2023-2026 CQS Goals & Objectives to measurable objectives as outlined in ***Improvement 3: Alignment of Quality Goals to Measurable Objectives***. A crosswalk of the MDHHS 2023-2026 CQS Goals and Objectives with corresponding measures is included in **Appendix D**.

Goal #5: “Improve quality outcomes and disparity reduction through value-based initiatives and payment reform,” was also challenging for the Medicaid managed care programs, particularly with respect to Objective #2: “Align value-based goals and objectives across programs.” The Michigan Medicaid managed care programs are at various stages of implementing and incorporating Alternative Payment Models (APMs) into managed care contractual requirements. Although programs have implemented APM strategies such as value-based payments and performance bonus withholds to advance the delivery system innovations, incentivize quality care, and improve health outcomes for enrollees, this continues to be an area of opportunity.

Improvement 3: Alignment of Quality Goals to Measurable Objectives

In response to CMS feedback on the MDHHS 2020-2023 CQS and after review of the June 2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit, the MDHHS CQS Core Team spent considerable time assessing and revising the CQS Objectives with a goal of meeting CMS quality strategy expectations and requirements. As a result of the collaborative review process, the 2020-2023 CQS Objectives were streamlined and/or revised, and relevant performance measure(s) were identified for each CQS Objective. The alignment of specific CQS goals and objectives with established performance measures reflects a new process among the Michigan Medicaid managed care programs. This work was primarily accomplished in early FY2023.

Table 2 outlines the MDHHS 2020-2023 and revised 2023-2026 CQS Goals and Objectives. Overall, duplicative objectives were deleted and the number of CQS objectives were reduced to provide clarity and a focused intent across programs.

Table 2: Comparison MDHHS 2020-2023 to 2023-2026 CQS Goals and Objectives

2020-2023 Goals & Objectives	2023-2026 Goals & Objectives
<p>GOAL #1: Ensure high quality and high levels of access to care.</p> <p>1.1 Ensure outreach activities and materials meet the cultural and linguistic needs of the managed care populations.</p> <p>1.2 Assess and reduce identified racial disparities.</p> <p>1.3 Implement processes to monitor, track and trend the quality, timeliness and availability of care and services.</p> <p>1.4 Ensure care is delivered in a way that maximizes consumers health and safety.</p> <p>1.5 Implement evidence-based, promising, and best</p>	<p>GOAL #1: Ensure high quality and high levels of access to care.</p> <p>1.1 Monitor, track and trend the quality, timeliness and availability of care and services.</p> <p>1.2 Promote prevention, treatment, services and supports to address acute and chronic conditions in at-risk populations.</p> <p>1.3 Ensure services are delivered to maximize beneficiaries’ health and safety.</p>

practices that support person-centered care or recovery-oriented systems of care.	
2020-2023 Goals & Objectives	2023-2026 Goals & Objectives
<p>GOAL #2: Strengthen person and family-centered approaches.</p> <p>2.1 Support self-determination, empowering individuals to participate in their communities and live in the least restrictive setting as possible.</p> <p>2.2 Facilitate an environment where individuals and their families are empowered to make healthcare decisions that suit their unique needs and life goals.</p> <p>2.3 Ensure that the social determinants of health needs and risk factors are assessed and addressed when developing person-centered care planning and approaches.</p> <p>2.4 Encourage community engagement and systematic referrals among health care providers and to other needed services</p> <p>2.5 Promote and support health equity, cultural competency, and implicit bias training for providers to better ensure a network-wide, effective approach to health care within the community.</p>	<p>GOAL #2: Strengthen person and family-centered approaches.</p> <p>2.1 Facilitate an environment where individuals and their families are empowered to make healthcare decisions that suit their unique needs and goals.</p> <p>2.2 Ensure referrals are made to community resources to address SDOH needs.</p>
2020-2023 Goals & Objectives	2023-2026 Goals & Objectives
<p>GOAL #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external).</p> <p>3.1 Establish common program-specific quality metrics and definitions to collaborate meaningfully across program areas and delivery systems.</p> <p>3.2 Support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations.</p> <p>3.3 Promote the use of and adoption of health information technology and health information exchange to connect providers, payers, and programs to optimize patient outcomes.</p>	<p>GOAL #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external).</p> <p>3.1 Support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations.</p> <p>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.</p>
2020-2023 Goals & Objectives	2023-2026 Goals & Objectives
<p>GOAL #4: Reduce racial and ethnic disparities in healthcare and health outcomes.</p> <p>4.1 Use a data-driven approach to identify root causes of racial and ethnic disparities and address health inequity at its source whenever possible.</p> <p>4.2 Gather input from stakeholders at all levels (MDHHS, beneficiaries, communities, providers) to ensure people of color are engaged in the intervention design and implementation process.</p> <p>4.3 Promote and ensure access to and participation in health equity training.</p> <p>4.4 Create a valid/reliable system to quantify and monitor racial/ethnic disparities to identify gaps in care and reduce identified racial disparities among the managed care populations.</p> <p>4.5 Expand and share promising practices for reducing racial disparities.</p> <p>4.6 Collaborate and expand partnerships with community-based organizations and public health entities across the state to address racial inequities.</p>	<p>GOAL #4: Reduce racial and ethnic disparities in healthcare and health outcomes.</p> <p>4.1 Use evidence-informed approaches to address racial and ethnic disparities and health inequity.</p>

2020-2023 Goals & Objectives	2023-2026 Goals & Objectives
<p><i>GOAL #5: Improve quality outcomes and disparity reduction through value-based initiatives and payment reform.</i></p> <p>5.1 Promote the use of value-based payment models to improve quality of care.</p> <p>5.2 Align value-based goals and objectives across programs.</p>	<p><i>Goal #5: Improve quality outcomes through value-based initiatives and payment reform.</i></p> <p>5.1 Promote value-based payment models that improve quality of care.</p>

Michigan Medicaid monitors a wide range of process, outcome, and satisfaction measures, and all programs contractually require plans to track and submit performance data. The measure selection process included the identification of national quality organization endorsed measures including but not limited to the CMS Child, Adult and Behavioral Health Core Sets; CMS Managed Long Term Services and Supports (MLTSS) metrics; the National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS); and Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. In addition, specific MDHHS program data were considered for inclusion. Examples include the MI Choice Waiver and MI Health Link Person-Centered Planning Processes, compliance review/audits, and Michigan’s Mission-Based Performance Indicators (MMBPIS). External Quality Review (EQR) Technical reports were also used to identify opportunities to improve performance related to the quality of, timeliness of, and access to care and services provided by Michigan’s managed care plans. **Appendix D outlines a crosswalk of the MDHHS 2023-2026 CQS Goals and Objectives with corresponding measures.**

The table in Appendix D includes a description of the quality measure, the measure source, statewide baseline performance by program and related 2023-2026 CQS Goals and Objectives.

Improvement 4: Increased Focus/Commitment to Identifying and Reducing Health Disparities

While the requirement to reduce disparities is codified in federal and state law, MDHHS and the Medicaid managed care programs are committed to improving the access, care and services provided to Medicaid beneficiaries with the goal of reducing health disparities. This commitment supports the MDHHS’s vision is to deliver health and opportunity to all Michiganders, reducing intergenerational poverty and promoting health equity. It also aligns with CMS 2022 National Quality Strategy which pursues “a resilient, high-value health care system that promotes quality outcomes, safety, equity, and accessibility for all individuals, especially for people in historically underserved and under-resourced communities.”³

The 2020-2023 CQS Goals and Objectives pursue an integrated framework for population health improvement and a commitment to eliminating disparate outcomes within Medicaid managed care populations. While all CQS Goals & Objectives incorporate the concept of health equity and health disparities, Goal #4 specifically describes the intent to “Reduce racial and ethnic disparities in healthcare and health outcomes.”

To guide implementation of the CQS, MDHHS is utilizing the following foundational principles:

- A focus on health equity and decreasing racial and ethnic disparities;
- Addressing social determinants of health (SDOH); and
- Using an integrated data-driven approach to identify opportunities and improve outcomes.

Michigan’s CQS emphasizes:

- Health equity;

- Quality, safety, and coordination of care delivered to special populations;
- Enhanced health delivery models (e.g., patient centered medical homes, integration of medical and behavioral health payment transformation);
- Patient and community engagement; and
- Effective population management to improve prevention and treatment of chronic conditions and the leading causes of mortality.

Since developing the 2020-2023 CQS, MDHHS and the managed care programs have worked toward strengthening processes to improve quality of care and services; implementing data driven outcomes measurement; pursuing efforts to identify and address social determinants of health (SDOH), health equity and disparities; and advancing payment methodologies. The MDHHS population health management program includes an overarching emphasis on health promotion and disease prevention that includes incorporating community-based health and wellness strategies into program interventions with a heightened focus on identifying and addressing SDOH, creating health equity, and supporting efforts to build more resilient communities.

Examples of these efforts are demonstrated in FY23 Medicaid program contract requirements, include but are not limited to:

- Requiring health plans to incorporate SDOH into the process of collecting and analyzing data to support the reduction of health disparities and develop interventions that identify, and address lived experiences.
- Requiring plans to conduct clinical and non-clinical Health Disparities Quality Improvement Projects aimed at achieving statistically significant improvement in selected quality measures for a disparate sub-population.
- Implementing incentive programs related to the reduction of measurable racial/ethnic disparities.
- Establishing health equity metrics and monitoring utilization based on race/ethnicity.
- Reviewing /analyzing CAHPS data to ensure satisfaction with the program.
- Including initiatives to address SDOH as well as initiatives targeting populations experiencing health disparities.
- Analyzing National Core Indicators response rates with data on race
- Assessing SUD service data by race; and using encounter data to calculate behavioral health, HEDIS-like measures.
- Including measures in the Performance Bonus Withhold programs that are stratified by race/ethnicity and contractually requiring plans to address disparities in measure rates.

Health Equity Reporting and Tracking

Michigan Medicaid managed care programs have been implementing health equity reporting and monitoring processes for varying periods of time.

In an effort to comply with federal and state law and toward the goal of ensuring high quality healthcare for all Medicaid managed care beneficiaries, the ***Comprehensive Health Care Program (CHCP)*** developed the ***Medicaid Health Equity Project*** in early 2010. All Michigan Medicaid Health Plans (MHPs) began submitting data in 2011 (Year 1) and have continued the reporting process annually. A total of 14 measures across four health domains have been tracked over time and, with the exception of removing one measure in 2016, the health equity project measures have remained the same since 2012. These data are analyzed and reported in both plan-specific and statewide reports. The Medicaid Health Equity Project published its tenth Annual report in 2023. The Year 10 Report includes measurement year 2019 data for 13 HEDIS measures. **A list of the reported measures is included in Table 3.**⁵

Table 3: Comprehensive Health Care Plan (CHCP) Reported Health Equity Measures

Health Domain	Measure	Abbreviation	Reported Since
Women - Adult Care and Pregnancy Care	Breast Cancer	BCS	2011
Women - Adult Care and Pregnancy Care	Cervical Cancer Screening	CCS	2011
Women - Adult Care and Pregnancy Care	Chlamydia Screening in Women – total	CHL	2011
Women - Adult Care and Pregnancy Care	Postpartum Care	PPC	2012
Child and Adolescent Care	Childhood Immunization Status - Combination 3	CIS	2011
Child and Adolescent Care	Immunizations for Adolescents - Combination 1	IMA	2012
Child and Adolescent Care	Lead Screening in Children	LSC	2012
Child and Adolescent Care	Well Child Visits (3-6 Years)	W34	2012
Access to Care	Children and Adolescents' Access to PCP (25 Months-6 Years)	CAP	2011
Access to Care	Adults' Access to Preventive/Ambulatory Health Services (20-44 years)	AAP	2011
Living with Illness	Comprehensive Diabetes Care - HbA1c Testing	CDC1	2011
Living with Illness	Comprehensive Diabetes Care - Eye Exams	CDC2	2012
Living with Illness	Comprehensive Diabetes Care - Medical Attention for Nephropathy	CDC3	2012
Health Plan Diversity	Race/Ethnicity Diversity of Membership	RDM	2011

Source: Medicaid Health Equity Project Year 10 Report (HEDIS 2020) All Medicaid Health Plans, November 2022⁵

Two types of comparisons are made in the analyses under the Medicaid Health Equity Project: one looking at the difference between each non-White minority population and the White population and one looking at the difference between each racial/ethnic population and the HEDIS 2020 national Medicaid 50th percentile. In 2020, at least one minority population showed a significant difference from the White population for 12 of the 13 measures. In addition, rates for African American CHCP beneficiaries fell significantly below that of White beneficiaries for 9 measures.⁵

One of the largest disparities has been found in the postpartum care (PPC) measure, where the gap between African American and White women was 9.94 percentage points in 2020, an improvement in the 2019 gap of 13.79 percentage points. PPC has been the center of many efforts to improve perinatal care quality in the CHCP. While continued efforts are needed to reduce this disparity, CHCP has placed a significant emphasis on the PPC measure by incorporating it into multiple performance monitoring and incentive tools. CHCP contractually requires all MHPs to develop a Health Equity Program with an annual work plan to address disparities; and the MHP performance bonus includes health equity measures. In addition, beginning in 2016, MHPs were contractually required to implement a community health worker (CHW) program in collaboration with community-based organizations to reduce barriers to care and address member needs. These CHW programs are intended to reduce health disparities and improve the health of Medicaid beneficiaries through outreach, health promotion and promoting health literacy. CHW programs also provide an opportunity to connect individuals to community resources to address SDOH.⁵

In 2022, Children's Special Health Care Services (CSHCS), MI Health Link (MHL), and MI Choice Waiver (MCW) initiated health equity projects to assess disparities in their respective populations. The goal of the **CSHCS 2022 Health Equity Project** is to eliminate racial and ethnic disparities in healthcare and health outcomes by focusing on key vulnerable populations. Objectives are to create a

valid/reliable system to quality and monitor racial/ethnic disparities; and to promote transparency and accountability to drive improvement in disparities and pursue equity in a meaningful and consistent way. The approach to establishing the extent to which disparities exist for the CSHCS population includes assessing the differences between the CSHCS and traditional populations and among racial/ethnic groups and geographic areas. Phase I of the project will assess measures related to developmental screening, lead screening, access to care, and Sickle Cell Disease.

The **MHL Health Equity Project** collected race/ethnicity data on specified measures from the Integrated Care Organizations (ICOs) and submitted the first data analysis report for years 2017, 2018 and 2020 in December of 2022.⁶ The ICOs submitted performance data on a select list of measures and the aggregated statewide rates were presented for all racial/ethnic populations enrolled in the MI Health Link program. The goal of the project is to continue to improve quality in the MHL program while decreasing overall disparities that may be present.⁷

The new MHL Annual Health Equity Project Report includes twelve (12) quality measures that will be used to identify and trend health disparities at a program level over time. **Table 4** outlines the quality measures included in the MHL report.

Table 4: MI Health Link (MHL) Reported Health Equity Measures

Measure	Abbreviation	Report Years
Adult Access to Care 20-44	AAP2044	2017, 2018, 2020
Adult Access to Care 45-64	AAP4564	
Adult Access to Care 65+	AAP65+	
Adult Access to Care Total	AAPTOT	
Antidepressant Medication Management-Acute Phase Treatment	AMM	
Breast Cancer Screenings	BCS	
Controlling High Blood Pressure	CBP	
Comprehensive Diabetes Care Eye Exam	CDCEye	
Comprehensive Diabetes Care HbA1c Control <8%	CDCControl	
Comprehensive Diabetes Care- Poor HbA1c Control	CDCPoorControl	
Colorectal Cancer Screening	COL	
Follow Up After Hospitalization for Mental Illness within 30 Days	FUH	
Plan All-Cause Readmission- Observed Readmissions 18-64	PCR1864	
Plan All-Cause Readmission-Observed Readmissions 65+	PCR65+	
Transitions of Care- Medication Reconciliation Post-Discharge	TRC	
Annual Dental Visit	ADV	

Source: Expanding Equity in MI Health Link Years 2017, 2018, 2020⁶

In SFY 2022, ICOs were also responsible for initiating a new Quality Improvement Project (QIP) to address healthcare disparities within their population. While MDHHS did not mandate a statewide topic, the ICOs were instructed to identify existing racial or ethnic disparities within the regions and populations served and determine plan-specific topics and performance indicators. Through the QIP activity, the ICOs implemented interventions aimed at eliminating those racial and ethnic disparities. Additionally, MDHHS requires each ICO's quality program to include a process for identifying and addressing health disparities in access to healthcare and health outcomes experienced by different member populations. Each ICO's QIP and other activities or initiatives targeting populations experiencing health disparities must be reported through the annual quality program evaluation. The ICOs' quality programs will be reviewed during the SFY 2023 compliance review activity.

In January 2022, MDHHS received a 2-year grant from the Michigan Health Endowment Fund (MHEF) which allows the ***MI Health Link, MI Choice, Home Help, Home Health, and PACE programs to identify barriers to and increase the use of home and community-based services (HCBS)***. The project was based on October 2020 MDHHS data that found racial and ethnic disparities in Long-Term Supports and Services (LTSS) Program enrollment data (e.g., Black individuals may use Home Help more and MI Choice and PACE less than expected; Hispanic beneficiaries use all LTSS programs less than expected; and only half of the people who apply for Home Help are approved for services). The goal of the Health Equity Project is to provide opportunities, services, and programs to ensure equitable access to Michigan's HCBS programs. Project activities include working with local communities to learn what keeps someone from using HCBS services and analysis of Medicaid data to determine if HCBS services offered to individuals differs based on race or ethnicity.⁸

MDHHS contracts with two prepaid ambulatory health plans (PAHPs), referred to as dental health plans (DHPs), to administer the dental services. The PAHPs provide care and services to children through the Healthy Kids Dental (HKD) program. MDHHS is currently evaluating disparity in oral health for children and adults through performance measure monitoring and reporting of the plan performance based on gaps found in racial/ethnic stratifications. These data analyses are part of the DHP performance withhold. MDHHS is also currently considering activities such as the CAHPS survey in which the results could be stratified by race/ethnicity. MDHHS' contract with the DHPs has defined time and distance access standards. Moving forward, stratifying the results of these access standards and care experience may identify whether members with different races/ethnicities have equal access to Medicaid providers. MDHHS also plans to require the DHPs to target disparate populations in future PIP activities, as applicable, and focus interventions on reducing any identified racial and/or ethnic disparities.

MDHHS recently expanded dental benefits for adult Medicaid beneficiaries and increased reimbursement rates for dental providers. Benefit enhancements and service delivery began April 1, 2023. This redesigned benefit will directly help beneficiaries by increasing access to services, enhancing care coordination, and improving health outcomes. Medicaid beneficiaries will not lose any dental care benefits with these changes; however, the way services are delivered may change slightly. Medicaid beneficiaries aged 21 years and older, including Healthy Michigan Plan (HMP) beneficiaries and pregnant women who are enrolled in a Medicaid Health Plan, Integrated Care Organization or Program of All-Inclusive Care for the Elderly will receive dental benefits through their health plan. The health plan becomes responsible for the beneficiary's dental services obtained through the health plan's dental provider network. The health plans will continue to provide robust care coordination and ensure that beneficiaries are supported in accessing the services they need. Dental services for beneficiaries who are not enrolled in a health plan will be provided through the Medicaid FFS program.⁹

In addition, MDHHS and the ***Michigan Oral Health Coalition (MOHC)*** have collaborated to develop a focused strategic action plan that outlines the specific steps planned to positively impact oral health in Michigan over the next four years. The overall vision is that all Michiganders have the knowledge, support, and care they need to achieve optimal oral health. The plan identifies measurable goals, strategies, and activities to raise awareness of the importance of oral health; improve the oral and overall health of Michiganders; fortify and sustain the oral health infrastructure; promote health equity; and reduce health disparities. The three goals of the 2025 Michigan State Oral Health Plan (SOHP) include:

- Michiganders understand the value of daily oral health care and preventive dental care and have the tools to care for their mouths every day.
- Michigan citizens, dental professionals, and medical providers understand the connection between oral health and overall health.

- Michiganders have access to preventive and restorative oral health care because the state has developed the necessary infrastructure to effectively serve everyone.

The DHPs are contractually required to promote the overall goals, objectives, and activities of the 2025 Michigan SOHP among network providers.¹⁰

MDHHS' *Bureau of Children's Coordinated Health Policy and Supports (BCCHPS)* participated in an MDHHS *Equity Impact Assessment Demonstration* that examined racial equity access for children and families offered Trauma Focused Cognitive Behavioral Therapy. The *Bureau of Specialty Behavioral Health Services (SBHS)* has undertaken initial research to understand potential target areas, such as disparities in Substance Use & Substance Use Disorders (SUD) care and has a quality withhold program that targets racial disparities.

Prepaid Inpatient Health Plans (PIHPs) collect data by race on response rates to the National Core Indicators, a consumer experience survey for persons with intellectual or developmental disability (IDD). PIHPs also use HEDIS specifications for quality reporting on some of Michigan's Mission-Based Performance Indicator System (MMBPIS). An initiative to review race data on SUD service access began in 2020; and a process to use encounter data to calculate HEDIS-like measures for behavioral health related conditions was undertaken in March 2021.

The 2021 MPHI report *“Racial/Ethnic and Geographic Disparities in Behavioral Healthcare in Michigan Medicaid”* analyzed regional PIHP performance on four HEDIS measures by race. **Table 5 outlines the four PIHP health equity measures.** Data analyses for most measures indicate disparities in quality of care exist in all counties and PIHP regions.¹¹ Measures included in the PIHP Performance Bonus Withhold program are also stratified by race/ethnicity and starting FY21 PIHPs are contractually required to address disparities in measure rates.

Table 5: Prepaid Inpatient Health Plan (PIHP) Health Equity Measures

Measure	Abbreviation	Reporting Periods
Follow-up after Emergency Department Visit for Mental Illness within 30 days	FUM-30	CY 2018, 2019, and the 1 st six months CY 2020 (1/1/20 – 6/30/20)
Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse Dependence within 30 days.	FUA-30	
Follow-up after Hospitalization for Mental Illness within 30 days (FUH-30).	FUH-30	
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment within 34 days	IET-34	

Source: Racial/Ethnic and Geographic Disparities in Behavioral Healthcare in Michigan Medicaid ¹¹

All Michigan Medicaid managed care programs support and contractually require the provision of culturally and linguistically appropriate services (CLAS) and the collection of race/ethnicity, language, gender identity and sexual orientation data using standardized methods to assess for disparities and focus quality improvement efforts to improve the provision of culturally and linguistically appropriate services and decrease health care disparities.

Performance Improvement Projects (PIPs)

Michigan's Medicaid managed care programs contract with Health Services Advisory Group (HSAG) to conduct the annual assessments of mandatory and optional External Quality Review (EQR) activities, as described in 42 CFR §438.358. The EQR activities included as part of these assessments were conducted consistent with the associated EQR protocols developed by the Centers for Medicare & Medicaid Services (CMS). HSAG uses analyses and evaluations of EQR activity findings from State

Fiscal Year activities to comprehensively assess plan performance in providing quality, timely, and accessible healthcare services to Medicaid members. **Links to program EQRO Reports are included in Appendix A.** Activities and opportunities for program improvement in the areas of identifying and reducing health disparities are outlined below.

Comprehensive Health Care Program (CHCP)

The CHCP EQR Report includes the following Medicaid managed care populations: adults and children, MI Child (Michigan's Children's Health Insurance Program), Children's Special Health Care Services (CSHCS), and the Healthy Michigan Plan (HMP). CHCP contracts with nine Medicaid Health Plans to provide care and services to beneficiaries in these populations.

MDHHS continued to place significant emphasis on pregnancy during SFY 2021 through state-mandated Addressing Disparities in Timeliness of Prenatal Care PIPs. While the MHPs identified several potential barriers to members accessing timely prenatal care, nine of the 10 MHPs demonstrated a positive outcome through their PIP activities, such as demonstrating improvement over the baseline, sustaining improvement of the baseline, and/or eliminating the existing disparity.¹²

Although MDHHS mandated the MHPs conduct an Addressing Disparities in Timeliness of Prenatal Care PIP to support improvement, many women were not always having, or accessing timely, prenatal and/or postpartum care visits, as demonstrated through lower CHCP performance for the Prenatal and Postpartum Care measure rates. Both measure rates ranked below the 25th percentile and demonstrated a statistically significant decline from the prior year. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.¹² Several of the MHPs reported barriers related to the COVID-19 pandemic, which may have had a negative impact on the performance for this measure. These barriers included changing priorities and duties of clinical staff members, limited in person ambulatory and non-critical care, and member reluctance to seek in person care due to fears of contracting COVID-19; these noted barriers also adversely impacted data collection, reporting processes, and intervention activities. Other MHPs reported potential barriers including member mistrust in providers, lack of use of telehealth services/comfort level with telehealth services, and the change in the specifications for the Prenatal and Postpartum Care measure. The performance in the Prenatal and Postpartum Care measure indicators has been identified as a program-wide weakness during the prior two annual EQRs.¹²

In FY2022, MDHHS required the MHPs to initiate a new PIP topic focused on disparities in the timeliness of prenatal care that further supported improvement in this lower performing statewide program area. MDHHS held a dedicated MHP workgroup session in October 2022, to share promising practices among plans (e.g., effective interventions for reducing racial disparities and improving performance in prenatal care, among other quality metrics).¹² MHPs with an existing disparity have a minimum of two performance indicators (a disparate sub-group performance indicator and a comparison sub-group performance indicator), and MHPs without an existing disparity have one performance indicator. The MHPs reported baseline data for each specified performance indicator in FY2022.¹³ **The PIP topics and performance indicators are outlined in Table 6.**

The PIP validation activity demonstrated that eight of the nine MHPs received an overall validation status of Met, indicating that overall, the MHPs designed methodologically sound PIPs. The interventions implemented through the course of the PIP cycle are aimed at eliminating the racial and ethnic disparity identified by each MHP or improving timeliness of prenatal care for the lowest-performing population for those MHPs without an identified disparity. Interventions implemented by the MHPs may also have a positive effect on the Prenatal and Postpartum Care - Timeliness of Prenatal Care performance measure. The rate for this performance measure ranked below the Medicaid 50th percentile and did not demonstrate an improvement from measurement year (MY) 2020 to MY 2021.

MDHHS and the MHPs will continue quality improvement efforts to ensure CHCP pregnant members are accessing a prenatal visit in the first trimester or within 42 days of enrollment with an MHP.¹³

Table 6: Medicaid Health Plan (MHP) PIP Topics and Performance Indicators

Performance Improvement Project Topic	Performance Indicators
Addressing Disparities in Timeliness of Prenatal Care	1. Timeliness of prenatal care in rural designated ZIP Codes. 2. Timeliness of prenatal care in urban designated ZIP Codes.
Reducing Racial Disparities Within Timeliness of Prenatal Care	1. Black women residing in Region 10 (disparate group). 2. White women residing in Region 10 (comparison group).
Improving the Timeliness of Prenatal Care	Measuring the percentage of Black/African-American pregnant women who have a prenatal visit within 42 days of enrollment or within the first trimester.
Addressing Disparities in Timeliness of Prenatal Care	1. The percentage of deliveries that received a prenatal care visit as a member of an organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization for Black members. 2. The percentage of deliveries that received a prenatal care visit as a member of an organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization for White members.
Addressing Disparities for Timeliness of Prenatal Care: Addressing Racial Health Disparities	1. Improve the PPC [Prenatal and Postpartum Care]-Timeliness of Prenatal Care rate for the Black (non-Hispanic) population residing in Region 6 in order to reduce the disparity to the comparison subgroup. 2. Maintain the performance of the HEDIS PPC-Timeliness of Prenatal Care performance result for eligible White (nonHispanic) members residing in Region 6.
Addressing Disparities for Timeliness of Prenatal Care	1. Timeliness of Prenatal Care—Black. 2. Timeliness of Prenatal Care—White.
Improving Timeliness of Prenatal Care for African-American Women	1. The percentage of African-American women that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment with Priority Health. 2. The percentage of Caucasian women that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment with Priority Health.
Addressing Disparities in Timeliness of Prenatal Care	Timeliness of prenatal care for African-American/Black members in Region 10.
Reducing Racial Disparities in Adult Ambulatory and Preventive Access to Care in Members Ages 20–44	1. Annual Ambulatory or Preventative Visit for UPP Black members. 2. Annual Ambulatory or Preventative Visit for UPP White members.

Source: State Fiscal Year 2022 External Quality Review Technical Report for Medicaid Health Plans¹³

Dental Health Program

MDHHS administers and oversees the Healthy Kids Dental (HKD) program, which provides Medicaid and Children’s Health Insurance Program (CHIP) dental benefits to members from birth through 20 years of age. MDHHS contracts with two prepaid ambulatory health plans (PAHPs), referred to as dental health plans (DHPs), to administer the dental services. The DHPs contracted with MDHHS during FY2021 were Blue Cross Blue Shield of Michigan (BCBSM) and Delta Dental of Michigan (DDMI).

The 2021 PIP focused on increasing dental utilization among enrolled Medicaid and CHIP beneficiaries. DHPs continued focused efforts to implement interventions aimed at increasing dental

utilization in FY2022 reporting Remeasurement Year 1 data. Through the PIP activity, the HKD program has focused efforts on improving access to dental services for children, which should improve overall oral health. This aligns with the 2025 Michigan State Oral Health Plan's (SOHP's) goal of having Michiganders understand the value of daily oral health care and preventive dental care and have the tools to care for their mouths every day. The PIP validation activity confirmed that both BCBSM and DDMI designed methodologically sound PIPs, which should support members' timely access to high-quality dental providers and improve their oral health.^{14, 15} Moving forward, MDHHS will consider activities in which the DHPs report the PIP results stratified by race/ethnicity.

Table 7: Dental Health Plan (DHP) PIP Topics and Performance Indicators

Performance Improvement Project Topic	Performance Indicators
Increasing the Number of Members Ages 0–5 Accessing Dental Services	The percentage of BCBSM HKD member visits to a dental provider in the selected federal fiscal year based on data.
Increasing Dental Utilization in Ages One and Two	1. Providers Rendering Treatment 2. Increase Ages One and Two Dental Utilization Percentages

Source: State Fiscal Year 2022 External Quality Review Technical Report for Dental Health Plans¹⁵

MI Choice Waiver (MCW)

MCW and its contracted waiver agencies are focusing strategies on quality of care by implementing quality improvement initiatives that are intended to ensure the health and welfare of members by mitigating risks that could lead to poor health outcomes. In FY 2021, the waiver agencies continued implementing the **five PIPs (referred to as quality improvement projects (QIPs) for the MCW Program), that were initiated in FY 2020**. Each waiver agency develops a QMP biennially that addresses CMS and MDHHS quality requirements, including the MDHHS required QIPs. The five QIP indicators for the waiver agencies for the SFY 2020 and SFY 2021 review years include: 1. Prevalence of Neglect/Abuse; 2. Prevalence of Pain with Inadequate Pain Control; 3. Prevalence of Falls; 4. Prevalence of Any Injuries; and 5. Prevalence of Dehydration. The MCW QIP EQR validation process identified opportunities for improvement in PIP design, methods, documentation, and alignment with CMS guidance within CMS EQR Protocols for implementing PIPs to assess and improve processes and outcomes of care and accurately measure PIP outcomes. Opportunity also exists for assessment of health disparities in MCW PIP processes and outcome measures.¹⁶

MI Health Link

For the MI Health Link (MHL) FY 2022 Quality Improvement Project (QIP) validation activity, the six contracted Integrated Care Organizations (ICOs) initiated new QIP topics that focused on disparities within their populations, as applicable, and reported baseline data for each specified performance indicator. While MDHHS did not mandate a statewide topic, ICOs were instructed to identify existing racial or ethnic disparities within the regions and populations served and determine plan-specific topics, performance indicators and interventions aimed at eliminating the identified racial and ethnic disparities. The QIP topics and performance indicators are outlined in **Table 8**.¹⁷

Table 8: Integrated Care Organization (ICO) QIP Topics and Performance Indicators

Quality Improvement Project Topic	Performance Indicators
Comprehensive Diabetes Care—HbA1c [Hemoglobin A1c] Test: Decreasing the Disparity Between White and African American Members	1. Comprehensive Diabetes Care—HbA1c Test: Black or African American (Non-Hispanic or Latino). 2. Comprehensive Diabetes Care—HbA1c Test: White (Non-Hispanic or Latino).
Transitions of Care, Medication Reconciliation Post-Discharge	1. Medication Reconciliation Post-Discharge for Disparate Group: Members Identified as Black/African American.

	2. Medication Reconciliation Post-Discharge for Comparison Group: Members Identified as White.
Reducing Controlling Blood Pressure Disparity Between Black/African American and White/Caucasian Members	1. The percentage of African American members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year. 2. The percentage of Caucasian members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.
Addressing Race and Ethnic Health Disparities: Statin Therapy for Patients With Diabetes	1. HEDIS statin therapy for patients with diabetes adherence performance—African American/Black population—all regions. 2. HEDIS SPD adherence performance—White population—all regions.
Addressing Disparities in Controlling Blood Pressure	1. Controlling high blood pressure—Black. 2. Controlling high blood pressure—White.
Annual Dental Care	1. Annual dental visit for UPHP American Indian/Alaskan Native MI Health Link (MHL) members. 2. Annual dental visit for UPHP White MHL members.

Source: State Fiscal Year 2022 External Quality Review Technical Report for Integrated Care Organizations¹⁷

Bureau of Specialty Behavioral Health Services (SBHS)

For the FY 2021 PIP validation, the Prepaid Inpatient Health Plans (PIHPs) continued work on their MDHHS-mandated PIP topics, reporting Remeasurement 2 data and outcomes for each study indicator. Through the PIP activity, SBHS focused efforts on member engagement in appropriate care including medication management, screenings and testing, medication assistance for tobacco use cessation, and post-hospitalization care to improve members' overall mental and physical health.

In SFY 2022, SBHS elected to initiate a new PIP topic focused on reducing racial or ethnic disparities.¹⁸ In response, the PIHPs initiated new PIP topics focused on disparities within their populations, as applicable, and reported baseline data for each specified performance indicator.¹⁹ **Table 9** outlines the FY2022 PIP topics and performance indicators for the ten contracted PIHPs.

Although MDHHS did not mandate a statewide topic, the PIHPs were instructed to identify existing racial or ethnic disparities within the regions and populations served and determine plan-specific topics and performance indicator(s). Eight of the 10 PIHPs identified existing racial and ethnic disparities and interventions were aimed at eliminating the disparities. The SFY 2022 PIP validation process indicated that nine of the ten PIHPs designed a methodologically sound PIP that should support improvement in health outcomes and reduce disparities within the Behavioral Health Managed Care program.¹⁹

Table 9: FY2022 Prepaid Inpatient Health Plans (PIHP) PIP Topics and Performance Indicators

Quality Improvement Project Topic	Performance Indicators
Increase the Percentage of Individuals Who Are Diagnosed with a Co-Occurring Disorder and Are Receiving Integrated Co-Occurring [COD] Treatment from a Network Provider	The percentage of individuals ages 12 years and older who are diagnosed with a co-occurring disorder that are receiving co-occurring treatment from a member CMHSP.
The percentage of individuals ages 12 years and older who are diagnosed with a co-occurring disorder that are receiving co-occurring treatment from a member CMHSP.	Client enrollment.
FUH [Follow-up After Hospitalization for Mental Illness] Metric: Decrease in Racial Disparity Between Whites and African Americans/Black	1. FUH Metric for Adults and Children Combined Who Identify as African American/Black. 2. FUH Metric for Adults and Children Combined Who Identify as White.

Reducing Racial Disparities in Follow-Up After Emergency Department [ED] Visit for Alcohol and Other Drug Abuse or Dependence	<ol style="list-style-type: none"> 1. The percentage of African-American/Black beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence. 2. The percentage of White beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence.
Improving the Rate of New Persons Who Have Received a Medically Necessary Ongoing Covered Service Within 14 Days of Completing a Biopsychosocial Assessment and Reducing or Eliminating the Racial Disparities Between the Black/African American Population and the White Population	<ol style="list-style-type: none"> 1. The percentage of new persons who are Black/African American and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment. 2. The percentage of new persons who are White and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.
Reduction of Disparity Rate Between Persons Served who are African American/Black and White and miss their appointment for an initial Biopsychosocial (BPS) Assessment and Assist Individuals in scheduling and keeping their initial assessment for services	<ol style="list-style-type: none"> 1. Initial assessment no-show rate for African American consumers. 2. Initial assessment no-show rate for White consumers.
Reducing the Racial Disparity of African Americans Seen for Follow-Up Care within 7-Days of Discharge from a Psychiatric Inpatient Unit	<ol style="list-style-type: none"> 1. Follow-Up within 7 Days After Hospitalization for Mental Illness for the Black or African-American Population. 2. Follow-Up within 7 Days After Hospitalization for Mental Illness for the White Population.
Improving Antidepressant Medication Management—Acute Phase	<ol style="list-style-type: none"> 1. The rate for White adult members who maintained antidepressant medication management for 84 days. 2. The rate for African-American adult members who maintained antidepressant medication management for 84 days.
Increase Percentage of Adults Receiving and a Reduction in Racial Disparity Between Caucasian and African Americans Served Post Inpatient Psychiatric Hospitalizations	<ol style="list-style-type: none"> 1. The percentage of Caucasian adults discharged from a psychiatric inpatient unit who are seen for follow-up care within seven calendar days. 2. The percentage of African-American adults discharged from a psychiatric inpatient unit who are seen for follow-up care within seven calendar days.
Reducing Racial/Ethnic Disparities in Access to SUD Services	<ol style="list-style-type: none"> 1. The percentage of new persons (Black/African American) receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders. 2. The percentage of new persons (White) receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders.

Source: State Fiscal Year 2022 External Quality Review Technical Report for Prepaid Inpatient Health Plans¹⁹

Improvement 5: Alignment with the MDHHS 2022 – 2024 SDOH Strategy: Michigan’s Roadmap to Healthy Communities

When developing the MDHHS 2020-2023 CQS, a representative from the MDHHS Office of Race Equity, Diversity and Inclusion (REDI) (formerly the Office of Equity and Minority Health) was included on the team to ensure the CQS visioning, and planning process maintained a focus on health equity and health disparities reduction. One of the REDI major activities is to support and initiate programs and policies to address social determinants of health that contribute to health inequities for racial and ethnic minority populations in Michigan.

MDHHS and the Medicaid managed care programs acknowledge that an individual's health is profoundly shaped by life circumstances that fall outside the traditional purview of the health care system. Conditions in the places where people live, learn, work, and play, affect a wide range of health risks and outcomes. Education, nutrition, transportation, and other dynamics are examples of social determinants of health that collectively influence health outcomes.

Michigan's population health model recognizes that population health management is built upon a detailed understanding of the distribution of social, economic, familial, cultural, and physical environment factors, which impact health outcomes among different geographic locations and groups; the distribution of health conditions; and health-related behaviors and outcomes including but not limited to physical, dental, behavioral, and social needs. As a result, managed care programs are incorporating social determinants of health (SDOH) into quality assessment and improvement processes. The goal is to address health disparities, improve community collaboration and enhance care coordination, case management, targeted interventions, and complex care management services for enrollees.

Target populations may include those experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level. Subpopulations may include individuals with poor health outcomes or access issues based on factors such as race, ethnicity, gender, age, primary language, disability, geographic location, or income level. Intervention strategies may include in-person support services such as Community Health Workers (CHW), patient navigators, home visiting programs, or health promotion or preventions programs delivered by community-based organizations (e.g., adult/family shelters, schools, foster homes). Managed care programs have also initiated contractual requirements to incorporate social determinants of health into processes for analyzing data to support population health management. The goal is to address health disparities, improve community collaboration and enhance care coordination, case management, targeted interventions, and complex care management services for enrollees.

Medicaid managed care plans assess the psychological well-being, functional status, cognitive ability, social/behavioral functions, and overall quality of life of participants to develop individualized, person-centered plans of care, as indicated. Prevention, health promotion and maintaining or achieving healthy lifestyle behaviors are also a high priority. Although not all programs currently contractually require plans to conduct a formal population health initiative, programs do require plans to identify opportunities for improving care, services, and outcomes of their respective populations. Programs work collaboratively with plans to develop uniform methods for targeted monitoring of members, implementing interventions and assessing opportunities for improvement.

MDHHS 2022-2024 Social Determinants of Health Strategy: *Michigan's Roadmap to Healthy Communities*

The MDHHS 2022-2024 Social Determinants of Health Strategy takes a focused approach to align state and local efforts to make a greater impact on communities.²⁰

"The goal of the MDHHS SDOH Strategy is to: Improve the health and social outcomes of all Michigan residents while working to achieve health equity by eliminating disparities and barriers to social and economic opportunity."

"The SDOH Data Strategy outlines action steps that will be taken to improve data quality, produce complete data sets, and measure the effects of policies and programs." SDOH Strategy Focus Areas include:

- Supporting communities
- Advancing health equity
- Supporting vulnerable populations

- Strengthen community engagement to support community-driven solutions
- Utilizing data and analytics
- Maximizing data to support SDOH and health equity efforts²⁰

Phase I of the SDOH Strategy promoted the alignment of efforts at the state, local, and community level and the improvement of programs and policies through an in-depth internal review. It prioritized efforts in three focus areas – health equity, housing stability, and food security – to be most impactful and align with existing state of Michigan-sponsored initiatives and SDOH taskforce recommendations. Phase II of the SDOH Strategy builds on improvement and alignment efforts from Phase I, with a focused effort on health equity through multisector collaboration and supporting holistic solutions. Four structural interventions form the foundation of Phase II of the SDOH Strategy:

1. Partnerships to advance health equity
2. Community information exchange (CIE)
3. Community Health Workers (CHWs)
4. Social Accelerator Plan to Reduce Chronic Disease social drivers²¹

The SDOH Accelerator Plan to Reduce Chronic Disease, will include strategies to reduce chronic disease by addressing social drivers of health (e.g., food and nutrition, housing, and transportation) and supporting individuals with existing chronic conditions. The Accelerator Plan aims to reduce disparities in health outcomes related to chronic disease, focusing on populations disproportionately impacted by chronic disease.²¹

Medicaid Program Alignment: MDHHS 2022-2024 Social Determinants of Health Strategy

The ***MDHHS 2020-2023 CQS Goals and Objectives*** closely align with the ***MDHHS 2022-2024 Social Determinants of Health Strategy***. Specifically, the Medicaid managed care programs have been making significant progress in the structural intervention areas of the SDOH Strategy by developing partnerships to advance health equity, promoting Community Health Workers (CHWs), addressing social drivers of health, and addressing chronic disease. These population health strategies require a coordinated approach, and increased collaboration and engagement among regional partners to address the burden of disease and related risk factors.

Michigan's ***CHCP and the Medicaid Health Plans (MHPs)*** have been working together to identify and implement strategies to meet the needs of beneficiaries by incorporating CHWs to assist with chronic conditions, behavioral health, and hard to reach members; increase community engagement & investment; and support the use of data to better stratify social determinants of health. CHWs integrate person-centered approaches to improve access to programs, services, and resources for populations that have been underserved. In FY23, MHPs are providing MDHHS with CY22 screening and referral data and submitting a narrative describing opportunities and challenges around data collection and program implementation.

The Medicaid Health Plan Population Health Management Intervention also supports MDHHS public health initiatives in the area of housing stability. Medicaid is partnering with the MDHHS Housing and Homeless Services Division on issues related to housing stability/homelessness and connecting plans to state and local partners.²² In addition, CHCP introduced a new measure MHP performance component to gather contextual analysis (i.e., societal, cultural, economic) related to barriers to improving rates for the following measures: Low Birth Weight (LBW) and Childhood Immunizations-Combo 3. The analysis must include successes, opportunities, and an action plan for improving these measures. In addition, MHPs are required to provide a flow chart and process explanation for how they plan to coordinate high-risk pregnant women of color to reduce the likelihood for LBW and congenital syphilis. The MHP Regional Collaboratives require plans to work together and with community

partners to improve the care of children within the state. The goal of the Collaboratives is to regionally demonstrate statistically significant improvement in the Childhood Immunization-Combo 7 rate and three sickle cell measures.²³

The **MI Choice waiver program** included Community Health Workers as a service with the 2018 waiver renewal. The purpose of this service is to work with participants who are re-enrolling in MI Choice, enrolling after a nursing facility or hospital discharge, or otherwise assist participants with obtaining access to community resources. The CHW may offer practical skills training to enable participants to remain independent, including information for recruiting, hiring, and managing workers as well as effective communication and problem solving. The CHW may also coach participants in managing health conditions, assist with scheduling appointments, facilitate coordination between various providers and assist participants with completion of applications for programs for which they may be eligible.

The MI Choice waiver program also includes Home Delivered Meals as a program service. During the Public Health Emergency, MDHHS lifted some of the requirements for receiving home delivered meals so that any MI Choice participant in need would have access to them. MI Choice also expanded the definition of a home delivered meal to include meal kit delivery services, food from restaurants, and membership fees for grocery delivery services. These measures will be added to the waiver program permanently with its renewal in 2023.

The MI Choice program also includes Community Transportation as a service. This service allows MI Choice participants access to their community for both medical and non-medical needs. It is easier for MI Choice participants to secure transportation to medical appointments through the waiver agency than through other processes. This assures that MI Choice participants have needed access to medical appointments. On the 2022 CAHPS survey, 92.4% of participants surveyed indicated they had a way of getting to medical appointments, the ride was easy to get in and out of, and the ride arrived on time.

The Michigan Mental Health Code, MCL 330.1712, establishes the right for all individuals to have an Individual Plan of Service (IPOS) developed through a person-centered planning process. In accordance with 42 CFR 438.208(b)(2)(i), **PIHPs** must implement person-centered planning in accordance with the MDHHS Person-Centered Planning Policy.²⁴ The person-centered planning process must include coordination of services between settings of care, focuses on the individual's goals while still meeting his/her basic needs (food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation). PIHPs must also initiate efforts to ensure the integration of primary and specialty behavioral health services for Medicaid beneficiaries. These efforts must focus on persons that have a chronic condition such as a serious mental health illness, co-occurring substance use disorder, children with serious emotional disorders or a developmental disability and have been determined by the plan to be eligible for Medicaid Specialty Mental Health Services and Supports. In addition, in accordance with 42 CFR, PIHPs must take all appropriate steps to assure that substance use disorder treatment services are coordinated with primary health care.

The **Opioid Health Home (OHH)** provides comprehensive care management and coordination services to Medicaid beneficiaries with opioid use disorder who also have or are at risk of developing another chronic condition. The OHH functions as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries work with an interdisciplinary team of providers to develop an individualized recovery care plan to best manage their care. The model elevates the role and importance of peer recovery coaches and community health workers to foster direct empathy and connection to improve overall health and wellness. In doing so, this will attend to a beneficiary's complete health and social needs.²⁵

The OHH program has three key goals: 1) improve care management of beneficiaries with opioid use disorders, including Medication Assisted Treatment (MAT); 2) improve care coordination between physical and behavioral health care services; and 3) improve care transitions between primary, specialty, and inpatient settings of care.²⁶

The ***Integrated Care Organizations (ICOs)*** incorporate community-based health and wellness strategies with a strong focus on the Social Determinants of Health into their models of care. As required by the Three-way contract, ICO incorporate Social Determinants of Health into the process of collecting and analyzing their data. ICOs' Annual QI Work Plans include planned clinical and non-clinical initiatives, including initiatives to address Social Determinants of Health. The evaluation of SDOH needs is built into the Standardized Health Risk Assessment (HRA) conducted with MHL enrollees within 60 days of enrollment and annually thereafter. ICOs include a plan to address SDOH needs identified in the HRA in enrollee's Individual Integrated Care and Supports Plan (IICSP). Enrollees with unmet needs due to low or no access to needed resources such as caregiver, housing, food, transportation, and shelter are automatically stratified as high risk, with required monthly contacts from ICOs, until these needs are met. To support ICOs efforts to address food insecurity, MDHHS provides a monthly list of enrollees who receive SNAP benefits. Many ICOs have been incorporating Community Health Workers, or an equivalent, into their Care Coordination teams to supplement and support the work of Care Coordinators. MHL will align with MDHHS' policy to make CHW services Medicaid reimbursable through state plan benefit.

Medicaid Program Alignment: Mother Infant Health & Equity Improvement Plan

The MDHHS 2020-2023 CQS Goals and Objectives also closely align with the MDHHS 2020-2023, **Mother Infant Health & Equity Improvement Plan (MIHEIP)**. The MIHEIP has six primary priorities: health equity; healthy girls, women and mothers; optimal birth spacing and intended pregnancy; full term healthy weight babies; infants sleeping safely; and mental, emotional and behavioral well-being.²⁷

Examples of Medicaid and public health program intersection include the MHP Low Birth Weight (LBW) project which is a multi-year LBW Pay for Performance initiative that supports and aligns MDHHS efforts to promote health equity in maternity care and infant care. The Medicaid Health Equity Project to promote health equity and monitor racial and ethnic disparities within the managed care population also aligns with MIHEIP priorities. In Michigan, deaths due to prematurity (birth prior to 37 weeks gestation) and/or low birth weight (less than five and a half pounds) are the leading causes of infant mortality.²²

The expansion of Michigan's Medicaid coverage to 12-months postpartum provides access to critical health and dental services during the first year after pregnancy; promotes access to critical behavioral health services that can reduce pregnancy-related deaths and severe maternal morbidity; and improves continuity of care for chronic conditions such as diabetes, hypertension, cardiac conditions, substance use disorder and depression. Extending postpartum eligibility also increases opportunities for beneficiaries to complete postpartum depression screening and receive referrals to services and supports for needed treatment, such as the Medicaid Maternal Infant Health Program (MIHP) and other home visiting programs.

The Medicaid Health Plans are also focused on educating the pregnant women on utilization of oral preventive services and care coordination by CHWs and engagement with the Maternal Infant Health Program.

In addition, MDHHS is diligently working on initiatives to expand access and eligibility to programs that support mental health and well-being. In 2022, MDHHS increased its investment in children's behavioral health services by developing a new Bureau of Children's Coordinated Health Policy and Supports. To date, the bureau has developed and issued \$6 million in grants for community mental health service programs to explore innovative ways to support children and families in crisis, and for efforts to expand workforce to support the growing demand for mental health services across the state.²⁸

Effectiveness Evaluation Summary

Significant work has been accomplished during the initial three years of Michigan's 2020-2023 CQS. The CQS Core and Leadership Teams have coalesced to collaboratively accomplish the challenging task of revising the 2020-2023 CQS Goals & Objectives for the next CQS cycle. This process included identifying key measures and establishing performance goals for each CQS objective. In addition, programs have undertaken significant effort during this time period to address health equity and identify health disparities through data reporting, analysis, and the implementation of interventions to address social determinants of health.

Key improvements described in this first MDHHS 2020-2023 CQS Effectiveness Evaluation are outlined below:

Alignment of CQS Goals & Objectives with the CMS National Quality Strategy and MDHHS Strategic Priorities

Although the 2020-2023 CQS aligned with the values and foundational principles of prior MDHHS Administrative Leadership, new MDHHS strategic priorities were established for Fiscal Years 2023 – 2027. The updated priorities followed a March 2022 reorganization of the Health and Aging Services Administration to the Behavioral and Physical Health and Aging Services Administration. The MDHHS mission, vision and strategic priorities further delineate a commitment to providing care and services to improve the health, safety, and prosperity of Michigan residents. In January 2022, the Centers for Medicare and Medicaid Services (CMS) also published an updated National Quality Strategy. After review, the MDHHS 2020-2023 CQS Goals and Objectives were determined to reflect key elements of both the MDHHS Strategic Priorities and the CMS 2022 National Quality Strategy goals.

Inclusion of Baseline Data and Target-Setting for Performance Metrics

The MDHHS 2020-2023 CQS initiated a new process of integrating traditionally separate quality improvement goals and objectives into a common set of overarching Medicaid managed care quality strategies that encompass all managed care programs within the MDHHS. Early in the CQS development process, the Medicaid managed care programs collaboratively identified and agreed upon 2020-2023 CQS goals and objectives; however, specific performance metrics were not identified. In an effort to meet CMS expectations as outlined in the June 2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit, a process evaluation of the 2020-2023 CQS Goals and Objectives was undertaken. Each managed care program evaluated their program status as "meeting" or "not meeting" the CQS objectives across each of the five 2020-2023 CQS Goals. Overall, Michigan Medicaid managed care programs reported fully meeting six (6) of twenty-one (21) Objectives included in the 2020-2023 CQS. Where programs were not meeting objectives, resources, capacity and timeframes were thoughtfully considered and shared with the CQS Leadership Team.

Alignment of CQS Quality Goals to Measurable Objectives

As a result of a collaborative review process, the 2020-2023 CQS Objectives were revised, and relevant performance measure(s) were identified for each of the 2023-2026 CQS Objectives. The alignment of specific CQS goals and objectives with established performance measures reflects a new process for the Michigan Medicaid managed care programs and provides an opportunity trending of program performance moving forward into the next CQS cycle.

Increased Focus on Reducing Health Disparities

MDHHS and the Medicaid managed care programs are committed to improving the access, care and services provided to Medicaid beneficiaries with the goal of reducing health disparities. Since developing the 2020-2023 CQS, the managed care programs have implemented data driven outcomes measurement and pursued efforts to identify and address social determinants of health (SDOH), health equity and disparities. Population health management strategies emphasize health promotion and disease prevention that incorporate community-based health and wellness with a focus on identifying and addressing SDOH, health equity, and supporting efforts to build more resilient communities. Examples include incorporating SDOH into the process of collecting and analyzing data; conducting clinical and non-clinical Performance Improvement Projects; establishing health equity metrics; monitoring utilization based on race/ethnicity; and requiring health plans to address disparities in measure rates. Performance Bonus Withhold programs also include measures that are stratified by race/ethnicity.

Alignment with Michigan's 2022-2024 Social Determinants of Health Strategy

MDHHS and the Medicaid managed care programs acknowledge that an individual's health is profoundly shaped by life circumstances that fall outside the traditional purview of the health care system. The ***MDHHS 2020-2023 CQS Goals and Objectives*** closely align with the ***MDHHS 2022-2024 Social Determinants of Health Strategy***. Specifically, the Medicaid managed care programs have been making significant progress in developing partnerships to advance health equity, promoting Community Health Workers, and addressing social drivers of health and chronic disease. These population health strategies require a coordinated approach, and increased collaboration and engagement among regional partners to address the burden of disease and related risk factors.

Over the course of the MDHHS 2020-2023 CQS, Michigan's managed care programs have made significant progress toward implementing strategies to meet the CQS Goals and Objectives to improve the access, quality of care and services provided to Medicaid beneficiaries.

The programs successfully conducted a process evaluation to assess progress toward meeting the 2020-2023 CQS Goals & Objectives, revised the Goals & Objectives in preparation for the 2023-2026 CQS, and identified relevant performance measures for each of the revised CQS Objectives. During this initial three-year CQS cycle, programs have implemented data driven outcomes measurement and pursued efforts to identify and address social determinants of health (SDOH), health equity and reduce health disparities. Strategies to accomplish these efforts include expanding health plan contractual requirements for collecting and analyzing race/ethnicity data, conducting health equity projects, and addressing disparity gaps in measure rates. The Medicaid managed care programs have also made significant progress in developing community partnerships to address the social drivers of health and chronic disease.

Moving forward, MDHHS and the Medicaid managed care programs will continue to work collaboratively to further integrate CQS quality improvement strategies to positively impact the lives of Michigan's Medicaid beneficiaries.

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Effectiveness Evaluation Appendix A

MDHHS 2020-2023 CQS Effectiveness Evaluation Resource Documents

1. **2020 – 2023 MDHHS Comprehensive Quality Strategy** https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder3/Folder75/Folder2/Folder175/Folder1/Folder275/Quality_Strategy_2015_FINAL_for_CMS_112515.pdf?rev=a5388738bfb9430f89dccc85b3a70f9

2. **Annual External Quality Review Technical Reports:**

CHCP: State Fiscal Year 2021 External Quality Review Technical Report for Medicaid Health Plans, March 2022 https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/MI2021_MHP_EQR-TR_Report_F1.pdf?rev=e0fb7c69e34847339c82bea0e24392e1&hash=E7CE3E1F21FB0AAF252AB562D0938044

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[Quality-Technical-Report-FINAL.pdf?rev=f435a5f4cdbc46e0948f36691156b0a6&hash=F4853A3E0533015B8053899819BC5BD8](#)

MCW: State Fiscal Year 2021 External Quality Review Technical Report for the MI Choice Waiver Program, October 2022

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PIHP: State Fiscal Year 2021 External Quality Review Technical Report for Prepaid Inpatient Health Plans, March 2022

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PIHP: State Fiscal Year 2022 External Quality Review Technical Report for Prepaid Inpatient Health Plans, February 2023

[https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Keeping-Michigan-Healthy/BH-DD/Mental-Health/Stats-and-Reports/MI2022_PIHP_EQR-TR_Report_F1.pdf?rev=2106cc0a3f224c04b3e94b244c2b9ee3&hash=537AFA53EF29DE2CFBFE7C90C76F2CA7](#)

3. ***MDHHS 2022 – 2024 SDOH Strategy: Michigan’s Roadmap to Healthy Communities***

[https://www.michigan.gov/mdhhs/inside-mdhhs/legislationpolicy/2022-2024-social-determinants-of-health-strategy](#)

Effectiveness Evaluation Appendix B

Alignment of 2023-2026 CQS with MDHHS 2023-2027 Strategic Priorities and CMS 2022 National Quality Strategy Goals

CQS Goals and Objectives	MDHHS 2023-2027 Strategic Priorities	CMS National Quality Strategy Goals
Goal #1: Ensure high quality and high levels of access to care		
<p>Objective 1.1: Monitor, track and trend the quality, timeliness and availability of care and services.</p> <p>Objective 1.2: Promote prevention, treatment, services and supports to address acute and chronic conditions in at-risk populations.</p> <p>Objective 1.3: Ensure services are delivered to maximize beneficiaries' health and safety.</p>	<ul style="list-style-type: none"> Public health investment Racial equity Address food and nutrition, housing, and other social determinants of health (SDOH) Improve the behavioral health service system for children and families Improve maternal-infant health and reduce outcome disparities Reduce lead exposure for children Reduce child maltreatment and improve rate of permanency within 12 months Expand and simplify safety net access Reduce opioid and drug related deaths Ensure all administrations are managing to outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances 	<p>Goal 1: Embed Quality into the Care Journey</p> <p>Goal 2: Advance Health Equity</p> <p>Goal 3: Promote Safety</p>
Goal #2: Strengthen person and family-centered approaches		
<p>Objective 2.1: Facilitate an environment where individuals and their families are empowered to make healthcare decisions that suit their unique needs and goals.</p> <p>Objective 2.2: Ensure referrals are made to community resources to address social determinant of health needs.—</p>	<ul style="list-style-type: none"> Racial equity Address food and nutrition, housing, and other social determinants of health Improve the behavioral health service system for children and families Ensure all administrations are managing to outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances 	<p>Goal 1: Embed Quality into the Care Journey</p> <p>Goal 2: Advance Health Equity</p> <p>Goal 4: Foster Engagement</p>
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)		
<p>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.</p> <p>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.</p>	<ul style="list-style-type: none"> Expand and simplify safety net access Address food and nutrition, housing, and other social determinants of health Integrate services, including physical and behavioral health, and medical care with long-term support services Fully implement the Families First Preservation Services Act (FFPSA) state plan Ensure all administrations are managing to outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances 	<p>Goal 4: Foster Engagement</p> <p>Goal 5: Strengthen Resiliency</p> <p>Goal 6: Embrace the Digital Age</p>
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes		

<p>Objective 4.1: Use evidence-informed approaches to address racial and ethnic disparities and health inequity.</p>	<ul style="list-style-type: none"> • Public health investment • Racial equity • Address food and nutrition, housing, and other social determinants of health (SDOH) • Improve the behavioral health service system for children and families • Improve maternal-infant health and reduce outcome disparities • Reduce lead exposure for children • Reduce child maltreatment and improve rate of permanency • Fully implement the Families First Preservation Services Act (FFPSA) state plan (collaborate with key stakeholders, families with lived experience, tribal governments and community partners) • Expand and simplify safety net access • Reduce opioid and drug related deaths • Ensure all administrations are managing to outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances (strengthen and leverage data) 	<p>Goal 2: Advance Health Equity</p> <p>Goal 4: Foster Engagement</p> <p>Goal 5: Strengthen Resiliency</p> <p>Goal 7: Incentivize Innovation and Technology Adoption to Drive Care Improvements</p>
<p>Goal #5: Improve quality outcomes through value-based initiatives and payment reform.</p>		
<p>Objective 5.1: Promote value-based payment models that improve quality of care.</p>	<p>Ensure all administrations are managing to outcomes, investing in evidence-based solutions, and ensuring program accuracy in benefit issuances (build an evidence-based and/or data lens into the budget process, grants and contracting, and direct funds toward programs that demonstrate evidence and align with strategic priorities)</p>	<p>Goal 7: Incentivize Innovation and Technology Adoption to Drive Care Improvements</p> <p>Goal 8: Increasing Alignment</p>

Effectiveness Evaluation Appendix C
Results of 2020-2023 CQS Goals & Objectives Program Evaluation Assessments

Objective	Objective Description	Number of Medicaid managed care programs Meeting Objective	Baseline 2022 Statewide Program Performance	Program Performance Target	Supporting Program Intervention()
Goal #1: Ensure high quality and high levels of access to care.					
Objective 1.1	Ensure outreach activities and materials meet the cultural and linguistic needs of the managed care populations. <i>Common Definition: All outreach activities and materials must meet the cultural and linguistic needs of the population(s).</i> <i>Comment: Ensure the Blind, Deaf & Hard of hearing populations are addressed</i>	7/7	100%	100%	<ul style="list-style-type: none"> Contractual requirements for enrollee communications to be available in alternative formats, upon request and as needed to ensure effective communication for individuals who are blind or have impaired vision; and provided in a manner, format and language that may be easily understood by persons with limited English proficiency, or for those with developmental disabilities or cognitive impairments; materials must be translated into Prevalent Languages, as specified in the Program Marketing Guidance (MHL) Contractual requirements to provide language assistance services to members including oral and written translation. Contractual requirement for Medicaid Program or CMS to review and approve member materials. CSHCS Family Center assists families with translation services/resources MDHHS Compliance Review/Audits
Objective 1.2	Assess and reduce identified racial disparities. <i>Common Definition: Identifying health inequities by race/ethnicity and using data to explore and address causes.</i>	4/7 CHCP CSHCS Dental MHL	57%	100%	<ul style="list-style-type: none"> Contractual requirements to monitor and analyze program data stratified by race/ethnicity to assess for disparities and implement performance improvement projects. Validation of MCO claims/encounter data. Implementation of projects for special populations (e.g., Foster Care timeliness of care and preventive care). Internal program committees review data and provide guidance (e.g., CSHCS Health Equity Committee, Clinical Quality Committee). Outreach and engagement with stakeholders, advocacy groups and external partners. MHL - Contractual requirement for ICOs to include a process for identifying and addressing Health Disparities in access to healthcare and health outcomes experienced by different populations. MHL - ICO Annual QI Work Plans must include a process for identifying and addressing Health Disparities in access to healthcare and health outcomes experienced by different populations of Enrollees. MHL – New Annual Report based on 12 quality measures to identify and trend health disparities at program level. MHL – ICO-specific Health Disparities Quality Improvement Projects aimed at achieving statistically significant improvement in an ICO selected quality

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					<p>measure for the disparate sub-group without a decline in performance for the comparison group.</p> <ul style="list-style-type: none"> PIHPs are contractually required to address racial/ethnic disparities on behavioral health measures including Follow-up after hospitalization for mental illness and Follow-up after ED visit for AOD. Also, Specialty Behavioral Health Services (SBHS) is working to begin collecting data by race on response rates to the National Core Indicators, a consumer experience survey for persons with IDD. The SIS assessment* may also serve as a data source on racial disparities, although it has not been used as such up to this point. An initiative to review race data on SUD service access began in 2020.
Objective 1.3	<p>Implement processes to monitor, track and trend the quality, timeliness and availability of care and services.</p> <p><i>Common Definition: Implement processes and metrics for monitoring, tracking, and trending the quality, timeliness and availability of care and services.</i></p>	<p>6/7</p> <p>CHCP CSHCS Dental MCW MHL SBHS</p>	86%	100%	<ul style="list-style-type: none"> Contractual Requirements (e.g., network adequacy for access, availability standards) Compliance Reviews/Audits/ Assessments External Quality Review (e.g., performance measure validation) Member Satisfaction Surveys Secret Shopper Surveys HEDIS & Administrative measures MHL- Annual and quarterly Core and Michigan-specific quality measures; quarterly Contract Management Team reporting tables; ad hoc reporting; and a set of performance measures specific to LTSS sub-population. Performance Improvement Projects Focused studies SBHS utilizes a quality withhold framework; performance bonus incentive pool; and a standardized quality reporting framework, that includes Michigan's Mission-Based Performance Indicators (MMBPIS). SBHS also engages in audit and quality monitoring activities that are population-specific (such as HCBS waiver oversight activities).
Objective 1.4	Ensure care is delivered in a way that maximizes consumers health and safety.	7/7	100%	100%	<ul style="list-style-type: none"> Ongoing monitoring and analysis of program data. Member Satisfaction Surveys Monitoring of member Grievances and Appeals

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	<i>Common Definition: Aim to ensure that measures, quality improvement, payment, and certification programs assess and hold accountable, health care systems and providers to keep individuals safe and reduce healthcare errors.</i>				<ul style="list-style-type: none"> • Focus study audits • Consumer Guides (CHCP/Dental) • Monitoring of provider licensing and credentialing by the Medicaid plans and OIG to ensure the safety of the consumers. • Monitoring and trending Critical Incidents reported by ICOs through the CI Reporting System. • MHL Ombudsman Program with monthly calls. • MCO/ICO adoption, dissemination and monitoring the use of clinical practice guidelines across UM decisions, member education and coverage of services. • SBHS - All member plans of service must address the health and safety of the person. This requirement is described in the Wellness and Well-Being section of SBHS Person-Centered Planning Policy. HCBS services overseen by SBHS place a special emphasis on creating healthy and safe living environments at home. The SBHS chapter of the Medicaid Provider Manual outlines safety procedures for children receiving SBHS services in especially high detail. • SBHS has Health and Welfare assurance performance measures in all BH waivers which are audited and reported on every year. <ul style="list-style-type: none"> ○ <u>Performance Indicators that revolve around health and safety:</u> <ul style="list-style-type: none"> ▪ #1 - The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours, for both the child and adult populations. ▪ #4a - The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. ▪ #4b - The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days, for the eligible population. ▪ #10 - The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. ○ The following two indicators are new, and we do not have baseline data yet:

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					<ul style="list-style-type: none"> ▪ #2 - The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. ▪ #2e – The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. ▪ #3 – the percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.
Objective 1.5	Implement evidence-based, promising, and best practices that support person-centered care or recovery-oriented systems of care. <i>Common Definition: Objective Self-explanatory.</i>	7/7	100%	100%	<ul style="list-style-type: none"> • Contractual requirements (e.g., each MCW agency is required to have a performance improvement plan) • Member needs assessments • CHCP - MCO care coordination/transitions of care policy and procedures • Member outreach – gaps in care reports • Collaboration with MDHHS Office of Medical Affairs (OMA) Physicians • MHL model of care is based on providing integrated person-centered care through individualized assessment, care planning and coordination. As participating ICOs refine their processes, the state team gathers information on emerging evidence-based, promising, and best practices within the broad program framework and shares with all ICOs within quality workgroup and operations meetings. • CMS Integrated Care Community of Practice Learning Collaborative – identifies and shares new and promising practices across state programs. • Person-centeredness is at the core of SBHS's care model. The concept is heavily integrated into provider contracts, the SBHS chapter of the Medicaid Provider Manual, standalone policy (Person-Centered Planning Policy), and legal statute (the Michigan Mental Health Code). SBHS has audit functions to review the authenticity of person-centered planning among providers. Similarly, SBHS has a strong emphasis on recovery-oriented systems of care, with an entire division dedicated to this function. • MCW is based on providing person-centered services through individualized assessment, care planning and coordination. Person-centeredness is at the core of MCW's care model. The concept is heavily integrated into provider contracts, the MI Choice chapter of the Medicaid Provider Manual, and other policies (Person-Centered Planning). MCW contracts with MPHJ to conduct

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					the clinical quality assurance reviews to verify the authenticity of person-centered planning among waiver agencies and providers.
Goal #2: Strengthen person and family-centered approaches.					
Objective 2.1	Support self-determination, empowering individuals to participate in their communities and live in the least restrictive setting as possible. <i>Common Definition: Providing the enrollee an opportunity to exercise choice and control in identifying, accessing, and managing supports and services according to their needs and personal preferences. The opportunity supports self-determination, empowers individuals to participate in their communities and encourages living in the least restrictive setting.</i>	5/7 CSHCS MHL MCW PACE SBHS	71%	100%	<ul style="list-style-type: none"> • MCW tracks self-determination as an option among program participants • MHL ICOs offer enrollees the opportunity to use arrangements that support Self-Determination for appropriate waiver services when their care plans are created or updated. • ICOs have significant flexibility to use innovative care delivery models and to provide a range of community-based services as a way to promote independent living and alternatives to high-cost institutionally based services. • LTSS Supports Coordinators complete a person-centered planning and Self-Determination training. • HCBS C-Waiver program provides services and supports to support members choice to live in the least restrictive setting and community engagement. The ICOs focus on providing services in the most integrated and least restrictive setting. • Case management and care coordination develop plans with families to empower individuals, supporting self-determination. • CSHCS Family Center – Parent Mentors, Parent Connect Calls, host self-determination webinars. • The basic premise of PACE is to keep participants living in their own home or in the community with supports. • Within Michigan's public mental health system, self-determination involves accomplishing system change to assure that services and supports for people are not only person-centered, but person- defined and person-controlled (this definition is directly from the MDHHS SBHS Self-Determination Policy & Practice Guideline. • PIHP Michigan's Mission Based-Performance Indicators (MMBPIS) monitor employment and living arrangements.
Objective 2.2	Facilitate an environment where individuals and their families are empowered to make healthcare decisions that suit their unique needs and life goals.	7/7	100%	100%	<ul style="list-style-type: none"> • Compliance Review/Audits • Provider choice (e.g., selection of primary care provider, transitions of care) • MHL's care coordination model is based on Person-Centered Planning Processes as outlined in the Three-Way Contract requirements. MHL is adding a Person-Centered Planning Practice Guideline to MHL Minimum Operating Standards to expand on the principles already included in

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	<i>Common Definition: Empower beneficiaries and their families to make decisions regarding the services they receive using person-centered approaches. The process builds on the individual's desire to engage in activities that promote community life and that honor the individual's preferences, choices, and abilities.</i>				<p>the Three-way Contract.</p> <ul style="list-style-type: none"> LTSS Supports coordinators must complete person-centered planning and self-determination training. PACE is a person-centered program which includes participant involvement in the care planning process. Within Michigan's public mental health system, self-determination involves accomplishing system change to assure that services and supports for people are not only person-centered, but person- defined and person-controlled (this definition is directly from the MDHHS SBHS Self-Determination Policy & Practice Guideline..
Objective 2.3	<p>Ensure that the social determinants of health needs and risk factors are assessed and addressed when developing person-centered care planning and approaches</p> <p><i>Common Definition: Objective Self-explanatory.</i></p>	7/7	100%	100%	<ul style="list-style-type: none"> Compliance Review/Audits to ensure SDOH assessments are being conducted and identified risks are being addressed. Contractual requirements for Population Health Strategy and program monitoring to ensure that social determinants of health are addressed when developing the person-centered approach Focus on Social Determinants of Health is built into MHL's model of care. Care coordinators evaluate enrollees' clinical risks and needs including SDOH through the comprehensive assessment process, and interventions to address identified risks and needs are included in the enrollees' care plan. ICOs must stratify as high risk, with monthly contact requirements, all Enrollees with unmet SDOH needs until these needs are addressed. PACE interdisciplinary teams (IDT) assess and address SDOH risk factors. The behavioral health care plan (called an 'IPOS') is required by policy to focus on the person's life goals, interests, desires, choices, strengths and abilities as the foundation for the PCP process. Social determinant factors will be identified in the course of exploring and documenting these items. CHCP – Population health programs offer person-centered care planning. MHPs encourage members to use PCMH's as PCP provider per the contract language. Person-centered care planning is being developed at the provider level. MHPs are required to report on SDOH screening and referral rates.
Objective 2.4	Encourage community engagement and systematic referrals among health care providers and to other needed services	7/7	100%	100%	<ul style="list-style-type: none"> Compliance Review/Audits Data analysis (e.g., Z codes are analyzed for care coordination and awarded points/payment as part of the APM strategy) Outreach to community organizations/partners and providers to establish referral networks and identify community resources.

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	<i>Common Definition: Meet a member's specific needs through a combination of community engagement, and referrals to providers and other agencies.</i>				<ul style="list-style-type: none"> The behavioral health system as it is currently set up is fundamentally community-based, with CMHs operating at the county level. This system includes directing people served to specific community resources (e.g., food, housing, social opportunities, and others). CMHs also often have well-defined relationships with local law enforcement, schools, CPS offices, and other social systems. Behavioral health has also focused on strengthening connections/referrals to primary healthcare services when appropriate and relationships with local hospital systems.
Objective 2.5	<p>Promote and support health equity, cultural competency, and implicit bias training for providers to better ensure a network-wide, effective approach to health care within the community.</p> <p><i>Common Definition: Promote, support, and encourage health equity, cultural competency, and implicit bias training for providers.</i></p>	<p>4/7</p> <p>CHCP CSHCS Dental MHL</p>	57%	100%	<ul style="list-style-type: none"> Contractual requirements for plan/provider Implicit Bias/Health Equity/Cultural training. CSHCS internal Health Equity Committee reviews policies/procedures to ensure a health equity lens. CHCS program promotes training and discusses health equity during LHD calls and during Annual meetings to provide education and information. ICO coordinators must participate in annual training specific to MHL that covers health equity, cultural competency and implicit bias. The ICO must ensure that its network providers are responsive to the linguistic, cultural, ethnic, racial, religious, age, gender and other unique needs of any minority, homeless population. PIHP contract requires Cultural Competency training for their organization. BCCHPS participated in an MDHHS Equity Impact Assessment Demonstration that examined racial equity access for children and families offered Trauma Focused Cognitive Behavioral Therapy. CHCP FY22 contract requirements indicate MHPs must implement a DEI assessment and training program for their organization. MHPs must also have requirement for implicit bias training. Dental – Department of Licensing and Regulatory Affairs (LARA) training requirement for implicit bias training effective 6/1/22. MCW is partially meeting the objective. Program has been addressing cultural competency but can do more for health equity and implicit bias training for all network providers. MCW Supports Coordinators are required to have implicit bias training for licensure as Registered Nurses or Social Workers. Other providers are not required to have implicit bias training. MHL added health equity and implicit bias provider training to FY2023 contract requirements.

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					<ul style="list-style-type: none"> • PACE is partially meeting the objective. The FY22 contract added the requirement to provide implicit bias training for all staff. PACE will assess the status of the training during on-site visits. • PIHPs are partially meeting the objective. The SBHS program could do more for health equity.
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external).					
Objective 3.1	Establish common program-specific quality metrics and definitions to collaborate meaningfully across program areas and delivery systems. <i>Common Definition: Establish quality measures that allow for reliable measurement, reporting and meaningful comparisons across Medicaid managed care programs .</i>	4/7 CHCP CSHCS Dental SBHS	57%	100%	<ul style="list-style-type: none"> • Medicaid managed care programs utilize a number of standardized quality measure sets, including HEDIS, HOS and CAHPS. • MHL metrics related to comprehensive Health Risk Assessment and Care Plan completion closely align with the CMS managed LTSS measures. • PACE National Association metrics. • Contractual requirements for care coordination, joint care planning and care management processes for ongoing coordination and integration of services (e.g., MHP/LHDs, MHP/MIHPs). • Contractual requirements for Shared Metrics (e.g., MHPs/PIHPs). • Michigan's Mission-Based Performance Indicators (MMBPIS) are used to measure quality performance in Michigan's behavioral system. Certain MMBPIS measures share some specifications with HEDIS measures, but none are fully aligned. The current joint metrics with MHPs and PIHPs are an example of meaningful collaboration across program areas. Program administrators have been working to phase in additional performance standards for the MMBPIS measure set. • The formation of the Behavioral and Physical Health and Aging Services Administration (BPHASA) may present opportunities to align quality reporting standards across Medicaid managed care programs . • Contractual requirement to use the MDHHS CC360 data sharing system for care coordination. • As part of the MI Kids Now Initiatives, the BCCHPS is working with vendor partners to create several functional dashboards. The public facing dashboard will track the behavioral health services provided to children by MDHHS, providing transparency surrounding the access, utilization, and effectiveness of these services. This dashboard will allow for an in depth look at potential behavioral health disparities through data analysis surrounding race, ethnicity, gender, and age. This will allow MDHHS to make evidence-based decisions when providing increased services or new services in a particular area.

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					<ul style="list-style-type: none"> MHL is partially meeting the objective. Medicaid does not have QI measures across all programs. MHL shares some measures with LTSS programs (HCBS CAHPS, NAV and some specific performance measures) and some measures with CHCP ((CAHPS, HEDIS, NAV). Objective could be met through identifying common quality areas, such as NAV, CAHPS, outcomes measures, etc. and then identifying how each program addresses these areas for their unique population and set of services.
Objective 3.2	<p>Support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations.</p> <p><i>Common Definition: Create a seamless system of care that meets the needs of the beneficiary and family. The person served should have a sense that they are being served by fully integrated system of care.</i></p>	<p>3/7</p> <p>CSHCS MCW MHL</p>	43%	100%	<ul style="list-style-type: none"> Contractual requirement for transitions of care policy Contractual requirement to refer all MIHP-eligible enrollees to a MIHP Provider for MIHP outreach, screening, and care coordination. Contractual requirement to maintain Coordination Agreements with all PIHPs in the plan's service area for the purpose of referrals, care coordination, Grievance and Appeal resolution and the overall continuity of care for enrollees served by PIHPs. CSHCS Interdisciplinary Clinics MHL's care delivery model is built on care coordination framework aimed at integrated delivery of Medicare and Medicaid services for physical and behavioral health, and LTSS. MHL Care Coordinators manage provision of services and supports across delivery systems and coordinate communications among involved providers through Integrated Care Team meetings and sharing of care plans. Care Coordinators are also responsible for oversight of transition of care when a change between any care settings occurs. MHL's Quality Withholds include a Care Transition Record Transmitted to Health Care Professional measure. The CMH behavioral health provider network has been making strides to increase integration with other forms of medical care over the last several years. This includes building relationships with local clinics and hospitals and having physical health staff on hand to treat the whole person. Current behavioral; health program interventions include CC360 and the SUD 1115 IT/data sharing plan. Program leaders have also begun conversations on adopting additional HEDIS measures that involve care transitions bridging payers (for example, follow up after ED visit for mental illness; child and adult populations).

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					<ul style="list-style-type: none"> • Formation of the Behavioral and Physical Health and Aging Services Administration (BPHASA) is intended to serve as a major step toward true integration across the care continuum. • Formation of the Data Monitoring and Quality Improvement section within the Bureau of Children's Coordinated Health Policy and Supports (BCCHPS) is intended to provide centralized reporting and analysis of behavioral health data for children and youth in Michigan; including related to access, utilization, and effectiveness of the children's specialized behavioral health services provided to Michigan children, youth, and families. • MCW integration of services activities are being done but not currently measures (e.g., measuring seamless coordination between settings). • CHCP – Behavioral health system and medical system makes this difficult. Shared MHP/PIHP metrics are examples of improving transitions of care among providers/systems.
Objective 3.3	<p>Promote the use of and adoption of health information technology and health information exchange to connect providers, payers and programs to optimize patient outcomes.</p> <p><i>Common Definition: Use HIT and HIE to allow for secure, easy and "in real time" exchange of information among entities involved in the provision of care and services to Medicaid beneficiaries.</i></p>	<p>4/7</p> <p>SBHS CHCP CSHCS Dental</p>	57%	100%	<ul style="list-style-type: none"> • Contractual requirement to must support MDHHS initiatives to increase the use of HIE/HIT to improve care coordination; reduce Fraud, Waste and Abuse; and improve communication Electronic Exchange of Client Level Information. • Contractual requirement to promote the benefits of electronic exchange of client information in overall treatment of patient between systems of care. • Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts • Contractual requirement to, at a minimum, receive admission, discharge, and transfer (ADT) type messages or information to improve care management and care coordination response hospital admissions and readmissions at the plan level and within its provider network. • Requirement for MHPs to report 12 Care Management and Care Coordination codes using specific measure specifications. • MHL Three-way contract requires ICOs to create an electronic care coordination platform, called Care Bridge, to manage communication and information flow regarding referrals, care transitions, and care delivery; and to facilitate timely and thorough coordination and communication among the Enrollee, ICO, PIHP, the primary care provider, LTSS Supports Coordinators and other providers.

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					<ul style="list-style-type: none"> • Use of CC360 to support the exchange of information across the plans and other programs. • CMHs and PIHPs send and receive ADTs. CareConnect 360, which supports the integration of behavioral health data with other kinds of care data, is a key feature of SBHS's data sharing paradigm. • The electronic Consent Management System (eCMS) currently being developed by MIHIN on behalf of the State of Michigan. The eCMS) use case allows behavioral health providers to participate in the statewide exchange of health information via ADT notifications by creating a two-part solution, which would allow providers to electronically check consent and would subsequently allow for a consent check by a Health Information Network (HIN) before ADT messages containing specially protected information (SPI) are sent. PIHPs participating in this pilot are SWMBH, MSHN and OCHN. While SBHS has a strong data sharing infrastructure by current standards, healthcare data integration is a nationally recognized challenge. There are many opportunities for further enhancements. • MHL – Partially meeting the objective. Development and implementation of HIT is an ongoing process. MHL would like assistance with enhancing/closing existing gaps with HIT. For example, ICOs can view historical service utilization in CareConnect360 but their access is limited. MHL would like to expand ICOs access to align it with MHPs' access. Also, MHL would like to include the ICOs' encounters into cC360 to support exchange of information across the ICOs and other programs (currently ICOs' encounters are not included in CC360).
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes.					
Objective 4.1	Use a data-driven approach to identify root causes of racial and ethnic disparities and address health inequity at its source whenever possible. <i>Common Definition: Identify health inequities by race and ethnicity using data to analyze and address causes.</i>	4/7 CHCP CSHCS Dental MHL	57%	100%	<ul style="list-style-type: none"> • Contractual requirements to incorporate Social Determinants of Health into the process of collecting and analyzing data to support reducing Health Disparities and develop interventions that identify, and address lived experiences. • Incentive programs related to reduction of measurable racial/ethnic disparities. • Establishing health equity metrics and monitoring utilization based on race/ethnicity. • Review /analysis of CAHPS data to ensure satisfaction with the program. • Contractual requirements for plans to conduct clinical and non-clinical initiatives, including initiatives to address SDOH as well as initiatives targeting populations experiencing Health Disparities.

Objective	Objective Description	Number of Medicaid managed care programs Meeting Objective	Baseline 2022 Statewide Program Performance	Program Performance Target	Supporting Program Intervention()
					<ul style="list-style-type: none"> SBHS is working to begin collecting data by race on response rates to the National Core Indicators, which is a consumer experience survey for persons with IDD. The SIS assessment may also serve as a data source on racial disparities, although it has not been used as such up to this point. FUH and FUA measures included in the PIHP Performance Bonus Withhold program are stratified by race/ethnicity and starting FY21 PIHPs are contractually required to address disparities in measure rates. MDHHS EIA toolkit was informed by our demonstration this year and will be available for MDHHS to utilize in the future. MHL – New Annual Report based on 12 quality measures to identify and trend health disparities at program level. MHL – ICO-specific Health Disparities Quality Improvement Projects aimed at achieving statistically significant improvement in an ICO selected quality measure for the disparate sub-group without a decline in performance for the comparison group. MHL – New requirement in the 2022 three-way contract: Within their Quality Management framework, ICOs must include a process for identifying and addressing Health Disparities in access to healthcare and health outcomes experienced by different populations of Enrollees. Annual QI Work Plan must include a process for identifying and addressing Health Disparities in access to healthcare and health outcomes experienced by different populations of Enrollees. MCW is participating in the Health Equity grant from the Michigan Health Endowment Foundation to better identify areas of inequity and disparities. SBHS: Partially meeting objective; the program has an opportunity to do much more in this area. SBHS has a process for MHP/PIHP Joint metrics that could be used to implement additional measures across the Program.
Objective 4.2	Gather input from stakeholders at all levels (MDHHS, beneficiaries, communities, providers) to ensure people of color are engaged in the intervention design and implementation process. <i>Common Definition: Intentionally engage a variety of stakeholders</i>	4/7 CHCP CSHCS MCW MHL	57%	100%	<ul style="list-style-type: none"> Continuous engagement of community organizations and focus on recruitment of a diverse membership. State and local/regional quality collaborations Implementation of quality activities/initiatives across plans (e.g., LBW project) Assessment of Program committee structure and recruitment of diverse memberships (e.g., Member Advisory Councils) Although SBHS has robust feedback mechanisms for our quality program, including the Quality Improvement Council and the Developmental Disabilities Performance Improvement Team, SBHS has not systematically targeted

Objective	Objective Description	Number of Medicaid managed care programs Meeting Objective	Baseline 2022 Statewide Program Performance	Program Performance Target	Supporting Program Intervention()
	<i>and seek representation from people of color to obtain feedback for the development and improvement of Medicaid quality programs.</i>				<p>people of color for participation. SBHS does have an active BH service delivery DEI workgroup which could be a platform for this work.</p> <ul style="list-style-type: none"> • Performance Improvement Projects – PIHPs were asked to base their topic around Reducing racial and ethnic disparities in healthcare and health outcomes. Eight out of ten PIHPs did their PIP around this topic. • MHL and ICOs use Member Advisory Council to engage members and gather input. • MHL: CMS and Mathematica will be conducting a Beneficiary Experience Research with a focus on racial and ethnic minorities, and rural and remote areas. Results in March 2022.
Objective 4.3	<p>Promote and ensure access to and participation in health equity training.</p> <p><i>Common Definition: Programs will ensure that staff and providers have access to and participate in health equity training.</i></p>	<p>5/7</p> <p>CHCP CSHCS Dental MHL PACE</p>	71%	100%	<ul style="list-style-type: none"> • Contractual requirements for health equity training. • Engaging subject matter experts to provide training to MDHHS, plan staff and external partners on a variety of topics related to health equity, implicit bias and cultural competency. • SBHS - There is a BH DEI training and professional development workgroup that could be used as a platform for this work. • PIHP contract requires Cultural Competency and Limited English Proficiency training for their organization. • BCCHPS participated in an MDHHS Equity Impact Assessment Demonstration that examined racial equity access for children and families offered Trauma Focused Cognitive Behavioral Therapy. • DEI Let's Talk About it – this is a department wide training available to all. Topics that have been available are Ageism, Equity vs. Equality and Cultural Biases. • MHL added health equity and implicit bias provider training to 2023 contract requirements. • PACE added contractual requirement. • Dental - Department of Licensing and Regulatory Affairs (LARA) licensing requirements for training.
Objective 4.4	Create a valid/reliable system to quantify and monitor racial/ethnic disparities to identify gaps in care and reduce identified racial disparities	<p>4/7</p> <p>CHCP CSHCS Dental MHL</p>	57%	100%	<ul style="list-style-type: none"> • Programs and plans are using the Medicaid data warehouse, CAHPS and HEDIS data to stratify by race/ethnicity to monitor disparities and gaps in care and trend over time. • PACE - CMS and state audits (use a sample to determine if necessary care is provided); CMS and state monitor grievances and service delivery requests.

Objective	Objective Description	Number of Medicaid managed care programs Meeting Objective	Baseline 2022 Statewide Program Performance	Program Performance Target	Supporting Program Intervention()
	<p>among the managed care populations.</p> <p><i>Common Definition: Systematically identify, monitor, and address health disparities in health care, services, and outcomes to reduce identified disparities experienced among the Medicaid managed care populations.</i></p>				<ul style="list-style-type: none"> PIHPs calculate some HEDIS measures, and use HEDIS specifications for some quality reporting (MMBPIS). However, this data is not always analyzed for racial disparities. The exception was the 2021 MPH report “Racial/Ethnic and Geographic Disparities in Behavioral Healthcare in Michigan Medicaid” which analyzed regional PIHP performance on 4 HEDIS measures by race. There is also analysis by race incorporated into the PIHP Performance Bonus Withhold program. MHL - New Annual Report based on 12 quality measures to identify and trend health disparities at program level. MHL is working with MPH on Expanding Health Equity in Managed Care project to meet this objective. The MHL Health Equity project collected race/ethnicity data on specified measures from the seven Integrated Care Organizations (ICOs) and submitted the first data analysis report for years 2017, 2018 and 2020 in December of 2022. (Source: accessed at MI Health Link, Health Equity Report 2017, 2018 and 2020 (michigan.gov)) MCW is participating in the Health Equity grant from the Michigan Health Endowment Foundation (MHEF) to better identify areas of inequity and disparities. MHEF awarded MDHHS a 2-year Health Equity Project grant to identify barriers to individuals using Medicaid home and community-based services. The funding was awarded in January 2022 and covers MI Choice, Home Help, Home Health, and PACE. The purpose of the project is to increase the use of home and community-based services. We are going to look at Medicaid data to see if the services offered to people differ based on race or ethnicity. The Health Equity Project will work with local communities to learn what keeps someone from using services. SBHS is partially meeting the objective with the exception of quality measures included in the PIHP Performance Bonus Withhold program. Measures currently included in this program: Follow-up within 30 days after ED visit for AOD Follow-Up after Hospitalization for Mental Illness -Adult & Child (30 days).
Objective 4.5	<p>Expand and share promising practices for reducing racial disparities.</p> <p><i>Common Definition: Identify and promote new and existing evidence-based and promising practices to reduce racial</i></p>	<p>3/7</p> <p>CHCP CSHCS MHL</p>	43%	100%	<ul style="list-style-type: none"> Programs adding objective as contractual requirement (e.g., PACE). Program evaluation of plan performance based on identified racial/ethnic disparities to identify promising and best practices. Programs intend to share information on promising practices with plans via quality meetings/workgroups and operations meetings.

Objective	Objective Description	Number of Medicaid managed care programs Meeting Objective	Baseline 2022 Statewide Program Performance	Program Performance Target	Supporting Program Intervention()
	<i>disparities among the Medicaid managed care populations.</i>				<ul style="list-style-type: none"> SBHS has a quality withhold program that targets racial disparities. SBHS has also undertaken initial research to understand potential target areas, such as disparities in SUD care. However, there are opportunities to implement additional evidence-based practices at multiple points in the care system. MHL shares promising practices through the Quality Workgroup and operations meetings.
Objective 4.6	Collaborate and expand partnerships with community-based organizations and public health entities across the state to address racial inequities <i>Common Definition: Objective Self-explanatory.</i>	5/7 CHCP CSHCS Dental MCW MHL	71%	100%	<ul style="list-style-type: none"> Contractually require plans to establish community-based partnerships and systematically address SDOH to close gaps in access to needed services and supports and reduce racial inequities. Contractual requirement that plans address and refer members to services for SDOH. Expanding CSHCS Children's Multidisciplinary Specialty (CMDS) clinic model MHL: The ICOs partner with community-based organizations within their regions to address SDOH and close gaps in access to needed services and supports and reduce racial inequities. MHL members with identified SDOH needs are required to be stratified as High risk, which increases frequency of contact, until all their needs are met. MCW is participating in the Michigan Health Endowment Foundation (MHEF) Health Equity grant to identify areas of inequity and disparity. Grant activities include local community engagement to identify racial & ethnic disparities when accessing Home and Community Based Services.
Goal #5: Improve quality outcomes and disparity reduction through value-based initiatives and payment reform.					
Objective 5.1	Promote the use of value-based payment models to improve quality of care. <i>Common Definition: Leverage available financial incentives to advance delivery system innovations, incentivize quality care, and improve health outcomes. This means promoting value-based payments using mechanisms such as contract</i>	6/7 CHCP CSHCS Dental MCW MHL SBHS	86%	100%	<ul style="list-style-type: none"> CHCP - APM strategy is part of the performance bonus withhold; target benchmarks are established for the MHPs. Performance bonus withholds CSHCS included in Medicaid quality measures used for MHP Auto-Assignment and Performance Bonus. MHL - The Three-Way Contract, requires ICOs to demonstrate use of APMs that will advance the delivery system innovations inherent in MHL model, incentivize quality care, and improve health outcomes for enrollees. The small enrollment size for some ICOs makes VBP contracting challenging. MHL surveys ICOs on VBP and encourages expansion of VBP contracts but does not make VBP mandatory. ICOs are at various stages of implementing VBPs models (e.g., Patient Centered Medical Homes).

Objective	Objective Description	Number of Medicaid managed care programs Meeting Objective	Baseline 2022 Statewide Program Performance	Program Performance Target	Supporting Program Intervention()
	<i>requirements, quality withholds, or other special quality incentive programs.</i>				<ul style="list-style-type: none"> • PACE - Incentive payment for decreasing nursing home use/payment penalty for increased use of nursing homes; established a threshold for voluntary disenrollments. • SBHS - Performance Bonus Incentive Pool (PBIP) – This is a narrative report that the PIHPs must submit summarizing prior FY efforts, activities, and achievements to increase participation in patient-centered medical homes. The specific information to be addressed is 1. Comprehensive Care 2. Patient-Centered 3. Coordinated Care 4. Accessible Services and 5. Quality & Safety. • MCW - The program has made some changes to the quality withhold. Some small contractual changes have been implemented for FY23 and there is an opportunity to make more changes in FY24. • SBHS - Performance bonus withholds included in PIHP contract.
Objective 5.2	Align value-based goals and objectives across programs. <i>Common Definition: Leverage the Learning and Action Network Alternative Payment Model framework to establish common goals across all programs.</i> https://hcp-lan.org/apm-framework/ https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf	3/7 CHCP CSHCS MHL	43%	100%	<ul style="list-style-type: none"> • CHCP - APM care coordination Z codes payment strategy aligns with other projects such as population health strategy and with the overall strategy of MDHHS for the social determinants of health strategy. • Implementation of Objective B will require coordination and planning among all Michigan Medicaid managed care programs to align value-based goals and objectives across programs. • MHL - Most MHL plans also have Medicaid Managed Care business lines; a significant portion of MHL's provider network is already engaged in VBP contracts under MHPs. Many MHL plans have APM arrangements with their PIHP and LTSS providers. • MHL implemented standardized APM reporting aligned with the framework used by CHCP.

Effectiveness Evaluation Appendix D
2023-2026 CQS Goals & Objectives Metrics Table

CQS Objective	Objective Description	Quality Measure	Program	Measure Source	LTSS Measure (X)	Statewide Baseline Performance	Statewide Performance Target (2026)
	Goal 1: Goal #1: Ensure high quality and high levels of access to care.						
1.1	Monitor, track, and trend the quality, timeliness and availability of care and services.	Well-Child Visits in the First 30 Months of Life— Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	CHCP	HEDIS Child Core Set		58.84%	National 75th Percentile
		Prenatal and Postpartum Care—Postpartum Care	CHCP	HEDIS Adult Core Set Child Core Set		73.36%	National 50th Percentile
		Childhood Immunization Status—Combination 3	CHCP	HEDIS Child Core Set		55.46%	National 50th Percentile
		MI7.3 Annual Dental Visit	MHL	State-Specific		23.40%	65%
		FUH - Follow-Up After Hospitalization for Mental Illness (30 Days)	MHL	HEDIS Adult Core Set Health Home Core Set		50.2%	56%
		COL - Colorectal Cancer Screening	MHL	HEDIS Adult Core Set		56%	72%
		The percentage of new persons, aged 0-21, during the quarter receiving a completed biopsychosocial assessment from specialty behavioral health system within 14 calendar days of a non-emergency request for service.	BCCHPS	State-Specific		N/A	TBD
		The percentage of new persons, aged 0-21, during the quarter starting any medically necessary ongoing covered service from specialty behavioral health system within 14 days of completing a non-emergent biopsychosocial assessment.	BCCHPS	State-Specific		N/A	TBD

CQS Objective	Objective Description	Quality Measure	Program	Measure Source	LTSS Measure (X)	Statewide Baseline Performance	Statewide Performance Target (2026)
		Prenatal and Postpartum dental Care—Timeliness of Prenatal Care and Postpartum Care Diagnostic visits	Dental	State-Specific		26.15	30%
		Global rating of health plan	CSHCS	CAHPS		67.4	67.98%
		Global rating of specialist seen most often	CSHCS	CAHPS		75.1	≥ 73.83%
		Global rating of health care	CSHCS	CAHPS		71.5	≥ 68.22%
		Composite measure access to specialized services	CSHCS	CAHPS		72.6	≥ 70.6%
		Composite measure for Transportation	CSHCS	CAHPS		78.8	83.3%
		Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.	MCW	Other	X	86.65%	95%
		Staff are reliable and helpful Category Mean Score	MCW	CAHPS	X	92.1%	95%
		Met Need Category Mean Score	MCW	CAHPS	X	93%	95%
		The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.	SBHS	State-Specific		N/A	TBD
		The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.	SBHS	State-Specific		N/A	TBD
		The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours - Adult	SBHS	State-Specific		98.41%	≥ 95%
		The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours - Child	SBHS	State-Specific		98.91%	≥ 95%

CQS Objective	Objective Description	Quality Measure	Program	Measure Source	LTSS Measure (X)	Statewide Baseline Performance	Statewide Performance Target (2026)
1.2	Promote prevention, treatment, services and supports to address acute and chronic conditions in at-risk populations.	Asthma Medication Ratio - Total	CHCP	HEDIS Adult Core Set Child Core Set		56.36%	National 50th Percentile
		Controlling High Blood Pressure	CHCP	HEDIS Adult Core Set Health Home Measure		56.14%	National 75th Percentile
		Comprehensive Diabetes Care (CDC) - Eye Exams	CHCP	HEDIS		54.56%	National 75th Percentile
		CBP - Controlling High Blood Pressure	MHL	HEDIS Adult Core Set Health Home Measure		60.50%	71%
		PCR - Plan All-Cause Readmission	MHL	HEDIS Adult Core Set Health Home Measure		1.18	1.00
		COL - Colorectal Cancer Screening	MHL	HEDIS Adult Core Set		56%	72%
		Diabetes Dental Care: Preventive dental visit	Dental	State-Specific		14.36%	20%
		Emergency Dental Care Utilization in Adults	Dental	Other		TBD	Lesser than 2,794 visits per 100,000 adult beneficiaries in 21-34 Lesser than 1,989 visits per 100,000 adult beneficiaries ages 35-64
		Composite measure how well doctors communicate	CSHCS	CAHPS		94.8%	≥ 94.79%
		Composite measure for Customer Service	CSHCS	CAHPS		87.9%	91.21%

CQS Objective	Objective Description	Quality Measure	Program	Measure Source	LTSS Measure (X)	Statewide Baseline Performance	Statewide Performance Target (2026)
		Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.	MCW	Other	X	94.76%	99%
		Number and percent of participants who received all of the services and supports identified in their person-centered service plan.	MCW	Other	X	90.31%	95%
1.3	Ensure services are delivered to maximize beneficiaries' health and safety.	Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	CHCP	HEDIS Adult Core Set		47.35%	National 50th Percentile
		Getting Care Quickly Composite (Adult CAHPS)	CHCP	Adult CAHPS		82%	National 75th Percentile
		Annual Flu Vaccine	MHL	CAHPS		62%	69%
		MI5.6 Medication Review – All Populations	MHL	State-Specific		78.6%	85%
		TRC - Transitions of Care - Medication Reconciliation Post-Discharge	MHL	HEDIS		44%	65%
		PM13 Number and percent of enrollees whose IICSP addressed their assessed health and safety risks (HCBS C-Waiver population)	MHL	Other	X	98.40%	≥ 86%
		PM15 Number & percent of enrollees with an individualized contingency/back-up plan addressing caregiver absences, severe weather, fire/other emergencies (HCBS C-Waiver population)	MHL	Other	X	60.30%	86%
		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.	MHL	Other	X	80.80%	86%
		Number of children and youth who received children's mobile intensive crisis stabilization services.	BCCHPS	State-Specific		NA	TBD
		Number of children and youth who received home-based services.	BCCHPS	State-Specific		N/A	TBD
		Number of children and youth who received wraparound services.	BCCHPS	State-Specific		N/A	TBD

CQS Objective	Objective Description	Quality Measure	Program	Measure Source	LTSS Measure (X)	Statewide Baseline Performance	Statewide Performance Target (2026)
		Number of children and youth who received Children's Therapeutic Foster Care services.	BCCHPS	State-Specific		N/A	TBD
		Number of children and youth who received respite care services.	BCCHPS	State-Specific		N/A	TBD
		Number of parents or caregivers who received Parent Support Partner services.	BCCHPS	State-Specific		N/A	TBD
		Number of youth who received Youth Peer Support services.	BCCHPS	State-Specific		N/A	TBD
		Access to Dental care - HKD beneficiaries	Dental	State-Specific		74.1%	80%
		Global rating of health care	CSHCS	CAHPS		71.5%	≥ 68.22%
		Composite measure access to specialized services	CSHCS	CAHPS		72.6%	≥ 70.6%
		Access to Prescription Medicines	CSHCS	CAHPS		90.3%	90.55%
		Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.	MCW	Other	X	93.19%	95%
		Number and percent of participant critical incidents for which investigations by the waiver agencies were resolved within 60 days.	MCW	Other	X	81.74%	90%
		Personal Safety and Respect Domain Category Mean Score	MCW	CAHPS	X	97.4%	99%
		No physical safety concerns: staff does not hit or hurt you	MCW	CAHPS	X	100%	100%
	Goal #2: Strengthen person and family-centered approaches.						
2.1	Facilitate an environment where individuals and their families are empowered to make healthcare decisions that suit their unique needs and goals.	Rating of Health Plan	CHCP	CAHPS		63.9%	90th Percentile
		Adults' Access to Preventive/Ambulatory Health Services – 20-44 year old	CHCP	HEDIS		75.38%	National 75th Percentile
		Access to Dental Care	CHCP	CAHPS		67.2%	71%
		Completion of Annual Health Risk Assessment	CHCP	State-Specific		7.33%	12%

CQS Objective	Objective Description	Quality Measure	Program	Measure Source	LTSS Measure (X)	Statewide Baseline Performance	Statewide Performance Target (2026)
		MI2.3 Members with documented discussions of care goals	MHL	State-Specific		99.7%	≥ 98%
		Core 9.3 Minimizing (Institutional) Length of Stay - Ratio of Observed to Expected Discharge Rates	MHL	State-Specific	X	1.27	1.50
		PM17 Number and percent of enrollee IICSPs that are updated as the enrollee's needs change.	MHL	State-Specific	X	66.70%	86%
		Recommend Dental Plan -Adults	Dental	CAHPS		85.40%	87%
		Access to Dental Care-Adults	Dental	CAHPS		67.20%	70%
		Percentage of Mobile Crisis Response Parent/Caregiver Experience Survey responses.	BCCHPS	State-Specific		N/A	TBD
		Percentage of responses of a 3 or 4 on the following Mobile Crisis Response Parent/Caregiver Experience Survey item: "Do you feel you had voice and choice in the development of the follow-up plan?"	BCCHPS	State-Specific		N/A	TBD
		Composite measure how well doctors communicate	CSHCS	CAHPS		94.8%	≥ 94.79%
		Global rating of health plan	CSHCS	CAHPS		67.4%	67.98%
		Global rating of health care	CSHCS	CAHPS		71.5%	≥ 68.22%
		Global rating of specialist seen most often	CSHCS	CAHPS		75.1%	≥ 73.83 %
		Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.	MCW	Other	X	82.72%	95%
		Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.	MCW	Other	X	91.10%	95%
		Number and percent of waiver participants whose records indicate choice was offered among waiver services.	MCW	Other	X	89.27%	95%
		Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.	MCW	Other	X	100%	100%
2.2	Ensure referrals are made to community resources to address SDOH needs.	SDOH: Total Member Screening Rate	CHCP	State-Specific		TBD	Each plan matches the previous year's statewide average or demonstrates statistically significant

CQS Objective	Objective Description	Quality Measure	Program	Measure Source	LTSS Measure (X)	Statewide Baseline Performance	Statewide Performance Target (2026)
							improvement from previous year's performance.
		SDOH: Total Member Referral Rate	CHCP	State-Specific		TBD	Each plan matches the previous year's statewide average or demonstrates statistically significant improvement from previous year's performance.
		Social Need Screening and Intervention	CHCP	HEDIS		N/A	National 50th Percentile
		SNS-E Social Needs Screening & Intervention	MHL	HEDIS		N/A	TBD
		SDOH: Total Member Screening Rate for Transportation for Adult Dental visits	Dental	State-Specific		N/A	Each plan matches the previous year's statewide average or demonstrates statistically significant improvement from previous year's performance.
		Composite measure for access to specialized services	CSHCS	CAHPS		72.6%	≥ 70.6%
		Transportation to Medical Appointments Category Mean Score	MCW	CAHPS	X	92.4%	95%
		Met need in meal preparation/eating	MCW	CAHPS	X	95.9%	99%
	Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external).						
3.1	Support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations.	Follow-up After Hospitalization for Mental Illness within 30 Days (FUH) (Adults)	CHCP	HEDIS Adult Core Set Health Home Measure		TBD	58%
		FUH - Follow-Up After Hospitalization for Mental Illness (30 Days)	MHL	HEDIS Adult Core Set Child Core Set		50%	56%

CQS Objective	Objective Description	Quality Measure	Program	Measure Source	LTSS Measure (X)	Statewide Baseline Performance	Statewide Performance Target (2026)
				Health Home Measure			
		Follow-up After Emergency dental visits in Adults	Dental	State-Specific		<50%	60%
		Coordination of Care	CSHCS	CAHPS		86%	≥ 84.65%
		Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days-Child	SBHS	Medicaid Child Core Set		58%	TBD
		Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days - Adult	SBHS	Medicaid Adult Core Set		70%	TBD
3.2	Promote the use and adoption of health information technology and health information exchange to connect providers, payers and programs	Implementation of Joint Care Management Processes	CHCP	State-Specific		All applicable plan combinations except one had at least one shared care plan in CC360 in FY22.	All applicable plan combinations to have at least one shared care plan in CC360.
		MI2.6 Timely transmission of care transition record to health care professional	MHL	State-Specific		24%	65%
		Implementation of dental visit outreach in Non-utilizers using enrollment files and CC360.	Dental	State-Specific		65.00%	At or above 65%
		Percentage of CMHSPs with access to the MichiCANS via EMR or CareConnect360 API.	BCCHPS	State-Specific		N/A	100%
		Percentage of CareConnect360 unique user IDs with access to the MichiCANS.	BCCHPS	State-Specific		N/A	TBD
		Global rating of health plan	CSHCS	CAHPS		67.4%	67.98%
		Global rating of health care	CSHCS	CAHPS		71.5%	≥ 68.22%
	Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes.						
4.1	Use evidence-informed approaches to address racial and ethnic disparities and health inequity.	Chlamydia Screening in Women - Total	CHCP	HEDIS Adult Core Set Child Core Set		African-American population: Statistically significant difference. Hispanic population: Statistically significant difference.	African-American and Hispanic populations show No statistically significant difference from white reference population (Note: Heath equity report all state data is source)

CQS Objective	Objective Description	Quality Measure	Program	Measure Source	LTSS Measure (X)	Statewide Baseline Performance	Statewide Performance Target (2026)
		Prenatal and Postpartum Care - Postpartum Care	CHCP	HEDIS Adult Core Set Child Core Set		African-American population: Statistically significant difference. Hispanic population: No statistically significant difference.	African-American and Hispanic populations show No statistically significant difference from white reference population (Note: Heath equity report all state data is source)
		Children Immunization Combo 3	CHCP	HEDIS Child Core Set		African-American population: Statistically significant difference. Hispanic population: Statistically significant difference.	African-American and Hispanic populations show No statistically significant difference from white reference population (Note: Heath equity report all state data is source)
		Lead Screening in Children	CHCP	HEDIS Child Core Set		African-American population: Statistically significant difference. Hispanic population: Statistically significant difference.	African-American and Hispanic populations show No statistically significant difference from white reference population (Note: Heath equity report all state data is source)
		Comprehensive Diabetes Care - Eye Exam	CHCP	HEDIS		African-American population: Statistically significant difference. Hispanic population: No statistically significant difference.	African-American and Hispanic populations show No statistically significant difference from white reference population (Note: Heath equity report all state data is source)

CQS Objective	Objective Description	Quality Measure	Program	Measure Source	LTSS Measure (X)	Statewide Baseline Performance	Statewide Performance Target (2026)
		Adults' Access to Preventive/Ambulatory Health Services – 20-44 year old	CHCP	HEDIS		African-American population: Statistically significant difference. Hispanic population: Statistically significant difference.	African-American and Hispanic populations show No statistically significant difference from white reference population (Note: Heath equity report all state data is source)
		Aetna - Comprehensive Diabetes Care—HbA1c Test: Decreasing the Disparity Between White and African American Members	MHL	HEDIS		77.6% vs 90.4%	statistically significant reduction in disparity
		AmeriHealth - Transitions of Care, Medication Reconciliation Post-Discharge: Black/African American vs White	MHL	HEDIS		66.2% vs 80%	statistically significant reduction in disparity
		HAP - Reducing Controlling Blood Pressure Disparity Between Black/African American and White/Caucasian Members	MHL	HEDIS		51.5% vs 72.2%	sustained significant reduction in disparity
		Meridian - Statin Therapy for Patients with Diabetes - Decreasing the Disparity Between White and African American Members	MHL	HEDIS		74.2% vs 85.8%	sustained significant reduction in disparity
		Molina - Addressing Disparities in Controlling High Blood Pressure Between Black/African American and White Members	MHL	HEDIS		36.4% vs 47.3%	sustained significant reduction in disparity
		UPHP - MI 7.3 Annual Dental Visit: AI/AN (American Indian/Alaskan Native) vs White	MHL	State-Specific		22.7% vs 34.6%	sustained significant reduction in disparity
		Diagnostic dental Visits -CMS 416-12	Dental	State-Specific		TBD	Close any disparity in relation to race and ethnicity
		Preventive Dental visits- CMS 416-12	Dental	State-Specific		TBD	Close any disparity in relation to race and ethnicity
		Diagnostic dental visits in Adults	Dental	State-Specific		TBD	Close any disparity in relation to race and ethnicity
		Preventive Dental visits in Adults	Dental	State-Specific		TBD	Close any disparity in relation to race and ethnicity

CQS Objective	Objective Description	Quality Measure	Program	Measure Source	LTSS Measure (X)	Statewide Baseline Performance	Statewide Performance Target (2026)
		Percentage of Persons of Color, aged 0-21, receiving a completed biopsychosocial assessment from specialty behavioral health system.	BCCHPS	State-Specific		N/A	TBD
		Percentage of Persons of Color, aged 0-21, starting any medically necessary ongoing covered service from specialty behavioral health system after receiving a biopsychosocial assessment.	BCCHPS	State-Specific		N/A	TBD
		Not Felt Treated Unfairly: Race and Ethnicity	CSHCS	CAHPS		97.2%	98%
		Percent of waiver agency staff that have completed DEI training	MCW	Other		N/A	TBD
		Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (Child and Adult combined)	SBHS	Medicaid Adult Core Set		NA	TBD
	Goal #5: Improve quality outcomes through value-based initiatives and payment reform.						
5.1	Promote value-based payment models that improve quality of care.	Average percentage of plan payments to providers who are in APM arrangements ("Big Numerator")	CHCP	State-Specific		42.37%	50%
		Average percentage of plan payments to providers that are tied to quality ("Small Numerator")	CHCP	State-Specific		3.78%	2.5%
		Average percentage of plan payments to providers who are in VBP arrangements ("Big Numerator")	Dental	State-Specific		25%	50%
		Average percentage of plan payments to providers that are tied to quality ("Small Numerator")	Dental	State-Specific		1.80%	2.50%

Appendix C: MDHHS 2023-2026 CQS Goals & Objectives Measures

CQS Objective	Objective Description	Quality Measure	Program	Measure Source	LTSS Measure (X)	Statewide Baseline Performance	Statewide Performance Target (2026)
	Goal 1: Goal #1: Ensure high quality and high levels of access to care.						
1.1	Monitor, track, and trend the quality, timeliness and availability of care and services.	Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	CHCP	HEDIS Child Core Set		58.84%	National 75th Percentile
		Prenatal and Postpartum Care—Postpartum Care	CHCP	HEDIS Adult Core Set Child Core Set		73.36%	National 50th Percentile
		Childhood Immunization Status—Combination 3	CHCP	HEDIS Child Core Set		55.46%	National 50th Percentile
		MI7.3 Annual Dental Visit	MHL	State-Specific		23.40%	65%
		FUH - Follow-Up After Hospitalization for Mental Illness (30 Days)	MHL	HEDIS Adult Core Set Health Home Core Set		50.2%	56%
		COL - Colorectal Cancer Screening	MHL	HEDIS Adult Core Set		56%	72%
		The percentage of new persons, aged 0-21, during the quarter receiving a completed biopsychosocial assessment from specialty behavioral health system within 14 calendar days of a non-emergency request for service.	BCCHPS	State-Specific		N/A	TBD

CQS Objective	Objective Description	Quality Measure	Program	Measure Source	LTSS Measure (X)	Statewide Baseline Performance	Statewide Performance Target (2026)
		The percentage of new persons, aged 0-21, during the quarter starting any medically necessary ongoing covered service from specialty behavioral health system within 14 days of completing a non-emergent biopsychosocial assessment.	BCCHPS	State-Specific		N/A	TBD
		Prenatal and Postpartum dental Care—Timeliness of Prenatal Care and Postpartum Care Diagnostic visits	Dental	State-Specific		26.15	30%
		Global rating of health plan	CSHCS	CAHPS		67.4	67.98%
		Global rating of specialist seen most often	CSHCS	CAHPS		75.1	≥ 73.83%
		Global rating of health care	CSHCS	CAHPS		71.5	≥ 68.22%
		Composite measure access to specialized services	CSHCS	CAHPS		72.6	≥ 70.6%
		Composite measure for Transportation	CSHCS	CAHPS		78.8	83.3%
		Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.	MCW	Other	X	86.65%	95%
		Staff are reliable and helpful Category Mean Score	MCW	CAHPS	X	92.1%	95%
		Met Need Category Mean Score	MCW	CAHPS	X	93%	95%
		The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.	SBHS	State-Specific		N/A	TBD
		The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.	SBHS	State-Specific		N/A	TBD
		The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours - Adult	SBHS	State-Specific		98.41%	≥ 95%
		The percentage of persons during the quarter receiving a pre-admission screening for	SBHS	State-Specific		98.91%	≥ 95%

CQS Objective	Objective Description	Quality Measure	Program	Measure Source	LTSS Measure (X)	Statewide Baseline Performance	Statewide Performance Target (2026)
		psychiatric inpatient care for whom the disposition was completed within three hours - Child					
1.2	Promote prevention, treatment, services and supports to address acute and chronic conditions in at-risk populations.	Asthma Medication Ratio - Total	CHCP	HEDIS Adult Core Set Child Core Set		56.36%	National 50th Percentile
		Controlling High Blood Pressure	CHCP	HEDIS Adult Core Set Health Home Measure		56.14%	National 75th Percentile
		Comprehensive Diabetes Care (CDC) - Eye Exams	CHCP	HEDIS		54.56%	National 75th Percentile
		CBP - Controlling High Blood Pressure	MHL	HEDIS Adult Core Set Health Home Measure		60.50%	71%
		PCR - Plan All-Cause Readmission	MHL	HEDIS Adult Core Set Health Home Measure		1.18	1.00
		COL - Colorectal Cancer Screening	MHL	HEDIS Adult Core Set		56%	72%
		Diabetes Dental Care: Preventive dental visit	Dental	State-Specific		14.36%	20%

CQS Objective	Objective Description	Quality Measure	Program	Measure Source	LTSS Measure (X)	Statewide Baseline Performance	Statewide Performance Target (2026)
		Emergency Dental Care Utilization in Adults	Dental	Other		TBD	Lesser than 2,794 visits per 100,000 adult beneficiaries in 21-34 Lesser than 1,989 visits per 100,000 adult beneficiaries ages 35-64
		Composite measure how well doctors communicate	CSHCS	CAHPS		94.8%	≥ 94.79%
		Composite measure for Customer Service	CSHCS	CAHPS		87.9%	91.21%
		Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.	MCW	Other	X	94.76%	99%
		Number and percent of participants who received all of the services and supports identified in their person-centered service plan.	MCW	Other	X	90.31%	95%
1.3	Ensure services are delivered to maximize beneficiaries’ health and safety.	Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	CHCP	HEDIS Adult Core Set		47.35%	National 50th Percentile
		Getting Care Quickly Composite (Adult CAHPS)	CHCP	Adult CAHPS		82%	National 75th Percentile
		Annual Flu Vaccine	MHL	CAHPS		62%	69%
		MI5.6 Medication Review – All Populations	MHL	State-Specific		78.6%	85%
		TRC - Transitions of Care - Medication Reconciliation Post-Discharge	MHL	HEDIS		44%	65%
		PM13 Number and percent of enrollees whose IICSP addressed their assessed health and safety risks (HCBS C-Waiver population)	MHL	Other	X	98.40%	≥ 86%
		PM15 Number & percent of enrollees with an individualized contingency/back-up plan addressing caregiver absences, severe weather, fire/other emergencies (HCBS C-Waiver population)	MHL	Other	X	60.30%	86%
		PM24 Number and percent of files that show enrollee/family/legal guardians (as	MHL	Other	X	80.80%	86%

CQS Objective	Objective Description	Quality Measure	Program	Measure Source	LTSS Measure (X)	Statewide Baseline Performance	Statewide Performance Target (2026)
		appropriate) received information and education on how to report abuse, neglect, exploitation, and other critical incidents within 60 days of waiver enrollment.					
		Number of children and youth who received children's mobile intensive crisis stabilization services.	BCCHPS	State-Specific		NA	TBD
		Number of children and youth who received home-based services.	BCCHPS	State-Specific		N/A	TBD
		Number of children and youth who received wraparound services.	BCCHPS	State-Specific		N/A	TBD
		Number of children and youth who received Children's Therapeutic Foster Care services.	BCCHPS	State-Specific		N/A	TBD
		Number of children and youth who received respite care services.	BCCHPS	State-Specific		N/A	TBD
		Number of parents or caregivers who received Parent Support Partner services.	BCCHPS	State-Specific		N/A	TBD
		Number of youth who received Youth Peer Support services.	BCCHPS	State-Specific		N/A	TBD
		Access to Dental care - HKD beneficiaries	Dental	State-Specific		74.1%	80%
		Global rating of health care	CSHCS	CAHPS		71.5%	≥ 68.22%
		Composite measure access to specialized services	CSHCS	CAHPS		72.6%	≥ 70.6%
		Access to Prescription Medicines	CSHCS	CAHPS		90.3%	90.55%
		Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.	MCW	Other	X	93.19%	95%
		Number and percent of participant critical incidents for which investigations by the waiver agencies were resolved within 60 days.	MCW	Other	X	81.74%	90%
		Personal Safety and Respect Domain Category Mean Score	MCW	CAHPS	X	97.4%	99%
		No physical safety concerns: staff does not hit or hurt you	MCW	CAHPS	X	100%	100%

CQS Objective	Objective Description	Quality Measure	Program	Measure Source	LTSS Measure (X)	Statewide Baseline Performance	Statewide Performance Target (2026)
	Goal #2: Strengthen person and family-centered approaches.						
2.1	Facilitate an environment where individuals and their families are empowered to make healthcare decisions that suit their unique needs and goals.	Rating of Health Plan	CHCP	CAHPS		63.9%	90th Percentile
		Adults' Access to Preventive/Ambulatory Health Services – 20-44 year old	CHCP	HEDIS		75.38%	National 75th Percentile
		Access to Dental Care	CHCP	CAHPS		67.2%	71%
		Completion of Annual Health Risk Assessment	CHCP	State-Specific		7.33%	12%
		MI2.3 Members with documented discussions of care goals	MHL	State-Specific		99.7%	≥ 98%
		Core 9.3 Minimizing (Institutional) Length of Stay - Ratio of Observed to Expected Discharge Rates	MHL	State-Specific	X	1.27	1.50
		PM17 Number and percent of enrollee IICSPs that are updated as the enrollee's needs change.	MHL	State-Specific	X	66.70%	86%
		Recommend Dental Plan -Adults	Dental	CAHPS		85.40%	87%
		Access to Dental Care-Adults	Dental	CAHPS		67.20%	70%
		Percentage of Mobile Crisis Response Parent/Caregiver Experience Survey responses.	BCCHPS	State-Specific		N/A	TBD
		Percentage of responses of a 3 or 4 on the following Mobile Crisis Response Parent/Caregiver Experience Survey item: "Do you feel you had voice and choice in the development of the follow-up plan?"	BCCHPS	State-Specific		N/A	TBD
		Composite measure how well doctors communicate	CSHCS	CAHPS		94.8%	≥ 94.79%
		Global rating of health plan	CSHCS	CAHPS		67.4%	67.98%
		Global rating of health care	CSHCS	CAHPS		71.5%	≥ 68.22%
		Global rating of specialist seen most often	CSHCS	CAHPS		75.1%	≥ 73.83 %

CQS Objective	Objective Description	Quality Measure	Program	Measure Source	LTSS Measure (X)	Statewide Baseline Performance	Statewide Performance Target (2026)
		Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.	MCW	Other	X	82.72%	95%
		Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.	MCW	Other	X	91.10%	95%
		Number and percent of waiver participants whose records indicate choice was offered among waiver services.	MCW	Other	X	89.27%	95%
		Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.	MCW	Other	X	100%	100%
2.2	Ensure referrals are made to community resources to address SDOH needs.	SDOH: Total Member Screening Rate	CHCP	State-Specific		TBD	Each plan matches the previous year's statewide average or demonstrates statistically significant improvement from previous year's performance.
		SDOH: Total Member Referral Rate	CHCP	State-Specific		TBD	Each plan matches the previous year's statewide average or demonstrates statistically significant improvement from previous year's performance.
		Social Need Screening and Intervention	CHCP	HEDIS		N/A	National 50th Percentile
		SNS-E Social Needs Screening & Intervention	MHL	HEDIS		N/A	TBD
		SDOH: Total Member Screening Rate for Transportation for Adult Dental visits	Dental	State-Specific		N/A	Each plan matches the previous year's statewide average or demonstrates statistically significant improvement from previous year's performance.

CQS Objective	Objective Description	Quality Measure	Program	Measure Source	LTSS Measure (X)	Statewide Baseline Performance	Statewide Performance Target (2026)
		Composite measure for access to specialized services	CSHCS	CAHPS		72.6%	≥ 70.6%
		Transportation to Medical Appointments Category Mean Score	MCW	CAHPS	X	92.4%	95%
		Met need in meal preparation/eating	MCW	CAHPS	X	95.9%	99%
	Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external).						
3.1	Support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations.	Follow-up After Hospitalization for Mental Illness within 30 Days (FUH) (Adults)	CHCP	HEDIS Adult Core Set Health Home Measure		TBD	58%
		FUH - Follow-Up After Hospitalization for Mental Illness (30 Days)	MHL	HEDIS Adult Core Set Child Core Set Health Home Measure		50%	56%
		Follow-up After Emergency dental visits in Adults	Dental	State-Specific		<50%	60%
		Coordination of Care	CSHCS	CAHPS		86%	≥ 84.65%
		Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days- Child	SBHS	Medicaid Child Core Set		58%	TBD
		Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days - Adult	SBHS	Medicaid Adult Core Set		70%	TBD

CQS Objective	Objective Description	Quality Measure	Program	Measure Source	LTSS Measure (X)	Statewide Baseline Performance	Statewide Performance Target (2026)
3.2	Promote the use and adoption of health information technology and health information exchange to connect providers, payers and programs	Implementation of Joint Care Management Processes	CHCP	State-Specific		All applicable plan combinations except one had at least one shared care plan in CC360 in FY22.	All applicable plan combinations to have at least one shared care plan in CC360.
		MI2.6 Timely transmission of care transition record to health care professional	MHL	State-Specific		24%	65%
		Implementation of dental visit outreach in Non-utilizers using enrollment files and CC360.	Dental	State-Specific		65.00%	At or above 65%
		Percentage of CMHSPs with access to the MichiCANS via EMR or CareConnect360 API.	BCCHPS	State-Specific		N/A	100%
		Percentage of CareConnect360 unique user IDs with access to the MichiCANS.	BCCHPS	State-Specific		N/A	TBD
		Global rating of health plan	CSHCS	CAHPS		67.4%	67.98%
		Global rating of health care	CSHCS	CAHPS		71.5%	≥ 68.22%
	Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes.						
4.1	Use evidence-informed approaches to address racial and ethnic disparities and health inequity.	Chlamydia Screening in Women - Total	CHCP	HEDIS Adult Core Set Child Core Set		African-American population: Statistically significant difference. Hispanic population: Statistically significant difference.	African-American and Hispanic populations show No statistically significant difference from white reference population (Note: Heath equity report all state data is source)
		Prenatal and Postpartum Care - Postpartum Care	CHCP	HEDIS Adult Core Set		African-American population: Statistically significant difference.	African-American and Hispanic populations show No statistically significant difference from white reference population (Note: Heath

CQS Objective	Objective Description	Quality Measure	Program	Measure Source	LTSS Measure (X)	Statewide Baseline Performance	Statewide Performance Target (2026)
				Child Core Set		Hispanic population: No statistically significant difference.	equity report all state data is source)
		Children Immunization Combo 3	CHCP	HEDIS Child Core Set		African-American population: Statistically significant difference. Hispanic population: Statistically significant difference.	African-American and Hispanic populations show No statistically significant difference from white reference population (Note: Heath equity report all state data is source)
		Lead Screening in Children	CHCP	HEDIS Child Core Set		African-American population: Statistically significant difference. Hispanic population: Statistically significant difference.	African-American and Hispanic populations show No statistically significant difference from white reference population (Note: Heath equity report all state data is source)
		Comprehensive Diabetes Care - Eye Exam	CHCP	HEDIS		African-American population: Statistically significant difference. Hispanic population: No statistically significant difference.	African-American and Hispanic populations show No statistically significant difference from white reference population (Note: Heath equity report all state data is source)
		Adults' Access to Preventive/Ambulatory Health Services – 20-44 year old	CHCP	HEDIS		African-American	African-American and Hispanic populations

CQS Objective	Objective Description	Quality Measure	Program	Measure Source	LTSS Measure (X)	Statewide Baseline Performance	Statewide Performance Target (2026)
						population: Statistically significant difference. Hispanic population: Statistically significant difference.	show No statistically significant difference from white reference population (Note: Health equity report all state data is source)
		Aetna - Comprehensive Diabetes Care—HbA1c Test: Decreasing the Disparity Between White and African American Members	MHL	HEDIS		77.6% vs 90.4%	statistically significant reduction in disparity
		AmeriHealth - Transitions of Care, Medication Reconciliation Post-Discharge: Black/African American vs White	MHL	HEDIS		66.2% vs 80%	statistically significant reduction in disparity
		HAP - Reducing Controlling Blood Pressure Disparity Between Black/African American and White/Caucasian Members	MHL	HEDIS		51.5% vs 72.2%	sustained significant reduction in disparity
		Meridian - Statin Therapy for Patients with Diabetes - Decreasing the Disparity Between White and African American Members	MHL	HEDIS		74.2% vs 85.8%	sustained significant reduction in disparity
		Molina - Addressing Disparities in Controlling High Blood Pressure Between Black/African American and White Members	MHL	HEDIS		36.4% vs 47.3%	sustained significant reduction in disparity
		UPHP - MI 7.3 Annual Dental Visit: AI/AN (American Indian/Alaskan Native) vs White	MHL	State-Specific		22.7% vs 34.6%	sustained significant reduction in disparity
		Diagnostic dental Visits -CMS 416-12	Dental	State-Specific		TBD	Close any disparity in relation to race and ethnicity
		Preventive Dental visits- CMS 416-12	Dental	State-Specific		TBD	Close any disparity in relation to race and ethnicity
		Diagnostic dental visits in Adults	Dental	State-Specific		TBD	Close any disparity in relation to race and ethnicity

CQS Objective	Objective Description	Quality Measure	Program	Measure Source	LTSS Measure (X)	Statewide Baseline Performance	Statewide Performance Target (2026)
		Preventive Dental visits in Adults	Dental	State-Specific		TBD	Close any disparity in relation to race and ethnicity
		Percentage of Persons of Color, aged 0-21, receiving a completed biopsychosocial assessment from specialty behavioral health system.	BCCHPS	State-Specific		N/A	TBD
		Percentage of Persons of Color, aged 0-21, starting any medically necessary ongoing covered service from specialty behavioral health system after receiving a biopsychosocial assessment.	BCCHPS	State-Specific		N/A	TBD
		Not Felt Treated Unfairly: Race and Ethnicity	CSHCS	CAHPS		97.2%	98%
		Percent of waiver agency staff that have completed DEI training	MCW	Other		N/A	TBD
		Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (Child and Adult combined)	SBHS	Medicaid Adult Core Set		NA	TBD
	Goal #5: Improve quality outcomes through value-based initiatives and payment reform.						
5.1	Promote value-based payment models that improve quality of care.	Average percentage of plan payments to providers who are in APM arrangements ("Big Numerator")	CHCP	State-Specific		42.37%	50%
		Average percentage of plan payments to providers that are tied to quality ("Small Numerator")	CHCP	State-Specific		3.78%	2.5%
		Average percentage of plan payments to providers who are in VBP arrangements ("Big Numerator")	Dental	State-Specific		25%	50%
		Average percentage of plan payments to providers that are tied to quality ("Small Numerator")	Dental	State-Specific		1.80%	2.50%

Appendix D: Guide to Michigan Medicaid Health Plan Ratings Measures

Domain	Subdomain	Measure
Overall Rating	Overall Rating	Adult Medicaid—Rating of Health Plan (CAHPS® Global Rating)
Overall Rating	Overall Rating	Child Medicaid—Rating of Health Plan (CAHPS® Global Rating)
Overall Rating	Overall Rating	Adult Medicaid—Rating of All Health Care (CAHPS® Global Rating)
Overall Rating	Overall Rating	Child Medicaid—Rating of All Health Care (CAHPS® Global Rating)
Overall Rating	Overall Rating	Adult Medicaid—Customer Service (CAHPS® Composite)
Doctor's Communication and Services	Satisfaction With Providers	Adult Medicaid—How Well Doctors Communicate (CAHPS® Composite)
Doctor's Communication and Services	Satisfaction With Providers	Child Medicaid—How Well Doctors Communicate (CAHPS® Composite)
Doctor's Communication and Services	Satisfaction With Providers	Adult Medicaid—Rating of Personal Doctor (CAHPS® Global Rating)
Doctor's Communication and Services	Satisfaction With Providers	Child Medicaid—Rating of Personal Doctor (CAHPS® Global Rating)
Doctor's Communication and Services	Satisfaction With Providers	Adult Medicaid—Rating of Specialist Seen Most Often (CAHPS® Global Rating)
Doctor's Communication and Services	Patient Engagement	Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit
Doctor's Communication and Services	Patient Engagement	Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications
Doctor's Communication and Services	Patient Engagement	Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies
Getting Care	Access	Child Medicaid—Getting Needed Care (CAHPS® Composite)
Getting Care	Access	Child Medicaid—Getting Care Quickly (CAHPS® Composite)
Getting Care	Access	Adult Medicaid—Getting Needed Care (CAHPS® Composite)
Getting Care	Access	Adult Medicaid—Getting Care Quickly (CAHPS® Composite)
Getting Care	Access	Adults' Access to Preventive/Ambulatory Health Services (ages 20-44 years)
Getting Care	Access	Adults' Access to Preventive/Ambulatory Health Services (ages 45-64 years)
Getting Care	Access	Adults' Access to Preventive/Ambulatory Health Services (ages 65+ years)
Keeping Kids Healthy	Immunizations and Screenings for Young Children	Childhood Immunization Status (Combo 3)
Keeping Kids Healthy	Immunizations and Screenings for Young Children	Lead Screening in Children
Keeping Kids Healthy	Immunizations for Adolescents	Immunizations for Adolescents (Combo 2)
Keeping Kids Healthy	Preventive Care	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile
Keeping Kids Healthy	Preventive Care	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Nutrition

Keeping Kids Healthy	Preventive Care	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Physical Activity
Keeping Kids Healthy	Preventive Care	Well-Child Visit in the First 15 Months of Life (6 or More Visits)
Keeping Kids Healthy	Preventive Care	Well-Child Visit for Ages 15 Months-30 Months (2 or More Visits)
Keeping Kids Healthy	Preventive Care	Child and Adolescent Well-Care Visits (Ages 3-11 Years)
Keeping Kids Healthy	Preventive Care	Child and Adolescent Well-Care Visits (Ages 12-17 Years)
Keeping Kids Healthy	Preventive Care	Child and Adolescent Well-Care Visits (Ages 18-21 Years)
Living with Illness	Diabetes	Blood Pressure Control for Patients With Diabetes
Living with Illness	Diabetes	Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)
Living with Illness	Diabetes	Comprehensive Diabetes Care - HbA1c Control (<8.0%)
Living with Illness	Diabetes	Eye Exam for Patients with Diabetes
Living with Illness	Cardiovascular	Controlling High Blood Pressure
Living with Illness	Respiratory	Asthma Medication Ratio - Total
Taking Care of Women	Screenings for Women	Breast Cancer Screening
Taking Care of Women	Screenings for Women	Cervical Cancer Screening
Taking Care of Women	Screenings for Women	Chlamydia Screening in Women (Combined Rate)
Taking Care of Women	Maternal Health	Prenatal and Postpartum Care - Postpartum Care
Taking Care of Women	Maternal Health	Prenatal and Postpartum Care - Timeliness of Prenatal Care

Appendix E: Performance Improvement Projects (PIP) AIMS and Interventions

PIP Topic	PIP AIM	Performance Indicators	PIP Interventions
CHCP: Medicaid Health Plans (MHPs)			
Addressing Disparities in Timeliness of Prenatal Care	There will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (rural population) will demonstrate a significant increase over the baseline rate without a decline in performance for the comparison subgroup (urban population) or achieve clinically or programmatically significant improvement as a result of an intervention.	<ol style="list-style-type: none"> 1. Timeliness of prenatal care in rural designated ZIP Codes. 2. Timeliness of prenatal care in urban designated ZIP Codes. 	<ul style="list-style-type: none"> • Deployed racial and culturally concordant mailings and text message campaigns to pregnant mothers that included QR [quick response] codes on the mailings and links in the text messages to take members to “Every Mother Counts: Choices in Childbirth” resources and videos on the importance of advocating for themselves during appointments, asking questions at every visit, and that mothers have the right to make informed choices in their pregnancy, birth, and as a parent with physicians. • Contracted with Health Intelligence Platform to offer pregnant members solutions to improve their quality of care and engagement in the healthcare system. The platform allows pregnant individuals access to the Baby Smart coaching program that supports appointment and transportation scheduling, pregnancy and parenting education, pregnancy monitoring and postpartum health goals, quick connections to any needed critical resources for social risks/social determinants of health as well as virtual doula pairing for high-risk pregnant individuals.
Reducing Racial Disparities Within Timeliness of Prenatal Care.	There will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black women) will demonstrate a statistically significant increase over the baseline rate without a decline in performance for the comparison subgroup (White women), or achieve clinically or programmatically significant improvement as a result of an intervention.	<ol style="list-style-type: none"> 1. Black women residing in Region 10 (disparate group). 2. White women residing in Region 10 (comparison group). 	MHP had not progressed to initiating improvement strategies and interventions for the PIP. Interventions will be reported in the next annual EQR technical report.
Improving the Timeliness of Prenatal Care.	Demonstrate statistically significant improvement over the baseline for the remeasurement periods or achieve clinically or programmatically significant improvement as the result of an intervention.	Measuring the percentage of Black/African-American pregnant individuals who have a prenatal visit within 42 days of enrollment or	<ul style="list-style-type: none"> • Outreached to members engaged in MHP case management program for maternity utilizing monthly pregnancy reports. • Implemented a maternity-focused care management program powered by ProgenyHealth. Progeny also outreaches to engage members and refers to the Maternal Infant Health Program (MIHP). • Increased member incentive amount for prenatal care in 2021. Continued outreach strategies to engage members and educate on incentive program.

PIP Topic	PIP AIM	Performance Indicators	PIP Interventions
		within the first trimester.	
Addressing Disparities in Timeliness of Prenatal Care.	Demonstrate a significant increase over the baseline rate without a decline in performance for the comparison subgroup (White women), or achieve clinically or programmatically significant improvement as a result of an intervention.	<p>1. The percentage of deliveries that received a prenatal care visit as a member of an organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization for Black members.</p> <p>2. The percentage of deliveries that received a prenatal care visit as a member of an organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization for White members.</p>	<ul style="list-style-type: none"> Targeted outreach to members in Regions 6 and 7 (highest population and disparate areas) upon notification of pregnancy to facilitate timeliness of prenatal care. Providers received a \$100 incentive for completing timely prenatal and postpartum care. Providers received monthly gaps-in-care reports with disparity information for this measure. Members received a \$10 gift card incentive upon notification of pregnancy to the MHP.
Addressing Disparities for Timeliness of Prenatal Care: Addressing Racial Health Disparities.	There will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black women) will demonstrate a significant increase over the baseline rate without a decline in performance for the comparison subgroup (White women) or achieve clinically or programmatically significant improvement as a result of an intervention.	<p>1. Improve the PPC [Prenatal and Postpartum Care]-Timeliness of Prenatal Care rate for the Black (non-Hispanic) population residing in Region 6 in order to reduce the disparity to the comparison subgroup.</p> <p>2. Maintain the performance of the HEDIS®PPC-Timeliness of Prenatal</p>	<ul style="list-style-type: none"> Member Services telephonic outreach to members due for HEDIS®PPC-Timeliness of Prenatal Care services to provide education and awareness, and offer care coordination assistance. Member Services assists members connect to care by helping members locate providers, schedule appointments, and [arrange for] transportation when needed or requested by members. Incentivized providers for successful completion of HEDIS®PPC Timeliness of Prenatal Care measure. PPC HEDIS®care gap reports and education for members due for measure completion. Referral of pregnant members due for prenatal care visits to CHWs for intensive outreach and engagement. Offered member gift card incentive to members due for prenatal care visits after the member satisfactorily meets measure compliance. Start Smart for Baby evidence-based maternity case management program that leverages advanced analytics to identify and engage members to

PIP Topic	PIP AIM	Performance Indicators	PIP Interventions
		Care performance result for eligible White (non-Hispanic) members residing in Region 6.	<p>improve obstetrical and pediatric care services, reduce pregnancy-related complications, premature deliveries, low birth weight deliveries, and infant disease.</p> <ul style="list-style-type: none"> Incentivized members for self-reporting pregnancies to plan for care coordination and SDOH needs assessment. Referred pregnant members to a group-based care program.
Addressing Disparities for Timeliness of Prenatal Care.	There will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black women) will demonstrate a statistically significant increase over the baseline rate without a decline in performance for the comparison subgroup (White women), or achieve clinically or programmatically significant improvement as a result of an intervention.	<p>1. Timeliness of Prenatal Care—Black.</p> <p>2. Timeliness of Prenatal Care—White.</p>	MHP had not progressed to initiating improvement strategies and interventions for the PIP. Interventions will be reported in the next annual EQR technical report.
Improving Timeliness of Prenatal Care for African-American Women.	There will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African-American women) will demonstrate a statistically significant increase over the baseline rate without a decline in performance for the comparison subgroup (Caucasian women), or achieve clinically or programmatically significant improvement as a result of an intervention.	<p>1. The percentage of African-American women that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment.</p> <p>2. The percentage of Caucasian women that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment.</p>	MHP had not progressed to initiating improvement strategies and interventions for the PIP. Interventions will be reported in the next annual EQR technical report.

PIP Topic	PIP AIM	Performance Indicators	PIP Interventions
Addressing Disparities in Timeliness of Prenatal Care.	Achieve statistically significant improvement over the baseline performance for the subsequent remeasurement periods or achieve clinically or programmatically significant improvement as a result of an intervention.	Timeliness of prenatal care for African-American/Black members in Region 10.	MHP had not progressed to initiating improvement strategies and interventions for the PIP. Interventions will be reported in the next annual EQR technical report.
Reducing Racial Disparities in Adult Ambulatory and Preventive Access to Care in Members Ages 20–44.	There will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black members) will demonstrate a significant increase over the baseline rate without a decline in performance for the comparison subgroup (White members) or achieve clinically or programmatically significant improvement as a result of an intervention.	1. Annual Ambulatory or Preventative Visit for Black members. 2. Annual Ambulatory or Preventative Visit for White members.	<ul style="list-style-type: none"> • Outreached to members of the target population to perform a survey to identify barriers to completing care, along with education and coordination of care as needed. • Offered an alternative payment method to select provider clinic systems to address and eliminate existing racial disparities for the performance indicator. • Worked with provider relations staff to increase provider reported race.
Dental Prepaid Ambulatory Health Plans (PAHPs)			
Increasing the Number of Members Ages 0–5 Accessing Dental Services.	Demonstrate a statistically significant improvement over the baseline for the remeasurement periods or achieve clinically or programmatically significant improvement as a result of an initiated intervention(s).	The percentage of BCBSM HKD member visits to a dental provider in the selected federal fiscal year based on data.	<ul style="list-style-type: none"> • Healthy Beginnings Program: age specific education, anticipatory guidance and call to action mailer educated parent/guardian of member on importance of dental visit no later than age 1. • Live outreach calls to members educating on importance of routine dental visits to prevent dental problems and assistance with scheduling preventive visit.
Increasing Dental Utilization in Ages One and Two.	Demonstrate a statistically significant improvement over the baseline for the remeasurement periods or achieve clinically or programmatically significant improvement as a result of an initiated intervention(s).	1. Providers Rendering Treatment 2. Increase Ages One and Two Dental Utilization Percentages	<ul style="list-style-type: none"> • Offered members access to a special clinic, outside of normal scheduling, supported by grant funds. • Offered an incentive to providers to see members 1–2 years of age. • Offered a year-end bonus to top performing providers who see the most members 1–2 years of age by provider type or clinic type: large group, small group, solo practitioner, and pediatric dentist. • Developed a text messaging campaign to dispel fears of visiting the dentist and contracting COVID-19 (coronavirus disease 2019) by detailing safety measures in place at dental offices.
MI Health Link: Integrated Care Organizations (ICOs)			
Comprehensive Diabetes Care—	There will no longer be a statistically significant rate	1. Comprehensive Diabetes Care—	<ul style="list-style-type: none"> • Directed member outreach call campaign targeting members with no PCP visit in the last year and a diagnosis of diabetes.

PIP Topic	PIP AIM	Performance Indicators	PIP Interventions
HbA1c [Hemoglobin A1c] Test: Decreasing the Disparity Between White and African American Members.	difference between the two subgroups, and the disparate subgroup (Black or African American) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White) or achieve clinically or programmatically significant improvement as a result of initiated intervention(s).	HbA1c Test: Black or African American (Non-Hispanic or Latino). 2. Comprehensive Diabetes Care—HbA1c Test: White (Non-Hispanic or Latino).	<ul style="list-style-type: none"> Conducted outreach to PCPs who have treated members who do not have a completed HbA1c test for the year; and reminded providers of those with a gap in care for an HbA1c test. Care management 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.
Addressing Race and Ethnic Disparities in Transitions of Care, Medication Reconciliation Post-Discharge.	There will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black/African American) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White) or achieve clinically or programmatically significant improvement as a result of initiated intervention(s).	1. Medication Reconciliation Post-Discharge for Disparate Group: Members Identified as Black/African American. 2. Medication Reconciliation Post-Discharge for Comparison Group: Members Identified as White.	<ul style="list-style-type: none"> Revised internal processes to include MRP [Medication Reconciliation Post-Discharge] as a required step. Nurse Care Coordinators to complete process with every transition of care, utilizing functionality within the ICO's medical record system, forwarding MRP to primary care providers, and including it in HEDIS® data abstraction. Notified providers that they will receive a \$25 payment for submission of Current Procedural Terminology II codes. Implemented automated fax notifications to providers of admission and discharge dates based on a daily report. Requested new text campaign to remind members who have experienced TOC to follow up with the provider within 30 days.
Reducing Controlling Blood Pressure Disparity Between Black/African American and White/Caucasian Members.	There will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African American) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (Caucasian) or achieve clinically or programmatically significant improvement as a result of initiated intervention(s).	1. The percentage of African American members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year. 2. The percentage of Caucasian members 18–85 years of age who had a diagnosis of	<ul style="list-style-type: none"> Created an adherence report to ensure providers are monitoring members who have uncontrolled blood pressure readings. Members who require supportive education on hypertension can have a scheduled appointment with the pharmacist to review medications and measures to help get their blood pressure under control. Specific goals will be added, in partnership with the member, to the Individual Integrated Care and Support Plan (IICSP) if it is determined that a member has uncontrolled blood pressure. 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. Updated its internal customer service resource tool which shows member-facing staff which HEDIS® measures the members need. This enabled staff to discuss the member's gaps in care when the member calls HAP and update contact information as well.

PIP Topic	PIP AIM	Performance Indicators	PIP Interventions
		hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.	<ul style="list-style-type: none"> Developed a data collection improvement project, including building the ability for providers to document blood pressure readings (and supportive medical records) into the provider portal. Additionally, the ICO modified supplemental data HEDIS® extracts to include at-home and telehealth visit blood pressure readings.
Addressing Race and Ethnic Health Disparities: Statin Therapy for Patients With Diabetes.	There will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African American/Black) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White) or achieve clinically or programmatically significant improvement as a result of initiated intervention(s).	<ol style="list-style-type: none"> HEDIS® statin therapy for patients with diabetes adherence performance—African American/Black population—all regions. HEDIS®SPD adherence performance—White population—all regions. 	<ul style="list-style-type: none"> Identified members who were not seen by their PCP in 2021 or 2022 and conducted member outreach to assist with appointment scheduling and/or transportation needs. Offered a member incentive program for annual wellness visits. Identified members who have not received cardiovascular testing (minimum LDL test). Conducted member outreach and offered to assist with appointment scheduling and/or transportation needs. Utilized provider-facing staff for communication with providers about members in need of cardiovascular testing (minimum LDL test). 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. Developed and distributed culturally sensitive education material to the African American/Black population. Addressed unable-to-reach members for education 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. Developed a provider pay-for-performance bonus for HEDIS®SPD adherence at 80 percent compliance. Identified low-performing PCPs and utilized provider-facing staff to promote evidence-based guidelines, Provider HEDIS® Quick Reference Guide, and pay-for performance program.
Addressing Disparities in Controlling Blood Pressure	There will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White) or achieve clinically or programmatically	<ol style="list-style-type: none"> Controlling high blood pressure—Black. Controlling high blood pressure—White. 	<ul style="list-style-type: none"> Provided digital blood pressure monitors to members with a diagnosis of hypertension and who are assigned to the Michigan Community Health Network or the United Outstanding Physicians Network. Provided medical sites with two blood pressure monitor units to use to teach patients with hypertension the method they should use to take an accurate blood pressure reading at home. Conducted hypertension education during Quarters 1 and 2, followed by a Quarter 3 medical record audit, scoring each site for compliance related to documentation and member blood pressure level compliance.

PIP Topic	PIP AIM	Performance Indicators	PIP Interventions
	significant improvement as a result of initiated intervention(s).		<ul style="list-style-type: none"> 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. 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. 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. Provided hypertension education to members electronically by email.
Addressing Race and Ethnic Disparities in Annual Dental Care.	There will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (American Indian/Alaskan Native) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White) or achieve clinically or programmatically significant improvement as a result of initiated intervention(s).	<p>1. Annual dental visit for UPHP American Indian/Alaskan Native MI Health Link (MHL) members.</p> <p>2. Annual dental visit for UPHP White MHL members.</p>	<ul style="list-style-type: none"> Provided specific education 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. General education was provided to members on the importance of preventive dental care and benefit availability. Members were provided education on the provider network and connection with the ICO transportation service. The ICO collected data during member outreach to determine any impact of out-of-network dental providers for 2023 interventions.
Behavioral Health: Prepaid Inpatient Health Plans (PIHPs)			
Increase the Percentage of Individuals Who Are Diagnosed with a Co-Occurring Disorder and Are Receiving Integrated Co-Occurring [COD] Treatment from a Network Provider.	Demonstrate statistically significant improvement over the baseline for the remeasurement periods or achieve clinically or programmatically significant improvement as a result of implemented intervention(s).	The percentage of individuals ages 12 years and older who are diagnosed with a co-occurring disorder that are receiving co-occurring treatment from a member CMHSP.	THE PIHP had not progressed to initiating improvement strategies and interventions for the PIP. Interventions will be reported in the next annual EQR technical report.
The Percentage of Individuals Who are Eligible for OHH Services,	Demonstrate statistically significant improvement over the baseline for the remeasurement periods or achieve clinically or	Client Enrollment.	PIHP had not progressed to initiating improvement strategies and interventions for the PIP. Interventions will be reported in the next annual EQR technical report.

PIP Topic	PIP AIM	Performance Indicators	PIP Interventions
Enrolled in the Service, and are Retained in the Service.	programmatically significant improvement as a result of implemented intervention(s).		
FUH [Follow-up After Hospitalization for Mental Illness] Metric: Decrease in Racial Disparity Between Whites and African Americans/Black.	There will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African American/Black) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White) or achieve clinically or programmatically significant improvement as a result of implemented intervention(s).	<p>1. FUH Metric for Adults and Children Combined Who Identify as African American/Black.</p> <p>2. FUH Metric for Adults and Children Combined Who Identify as White.</p>	PIHP had not progressed to initiating improvement strategies and interventions for the PIP. Interventions will be reported in the next annual EQR technical report.
Reducing Racial Disparities in Follow-Up After Emergency Department [ED] Visit for Alcohol and Other Drug Abuse or Dependence	There will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African American/Black) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White) or achieve clinically or programmatically significant improvement as a result of implemented intervention(s).	<p>1. The percentage of African-American/Black beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence.</p> <p>2. The percentage of White beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence.</p>	PIHP had not progressed to initiating improvement strategies and interventions for the PIP. Interventions will be reported in the next annual EQR technical report.
Improving the Rate of New Persons Who Have Received a Medically Necessary Ongoing Covered Service Within 14 Days of	There will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black/African American) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White) or	1. The percentage of new persons who are Black/African American and have received a medically necessary ongoing covered service within 14 days of completing	PIHP had not progressed to initiating improvement strategies and interventions for the PIP. Interventions will be reported in the next annual EQR technical report.

PIP Topic	PIP AIM	Performance Indicators	PIP Interventions
Completing a Biopsychosocial Assessment and Reducing or Eliminating the Racial Disparities Between the Black/African American Population and the White Population.	achieve clinically or programmatically significant improvement as a result of implemented intervention(s).	a biopsychosocial assessment. 2. The percentage of new persons who are White and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.	
Reduction of Disparity Rate Between Persons Served who are African American/Black and White and miss their appointment for an initial Biopsychosocial (BPS) Assessment and Assist Individuals in scheduling and keeping their initial assessment for services.	There will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African American) will demonstrate a significant decrease over the baseline rate without an increase in performance to the comparison subgroup (White) or achieve clinically or programmatically significant improvement as a result of implemented intervention(s).	1. Initial assessment no-show rate for African American consumers. 2. Initial assessment no-show rate for White consumers.	PIHP had not progressed to initiating improvement strategies and interventions for the PIP. Interventions will be reported in the next annual EQR technical report.
Reducing the Racial Disparity of African Americans Seen for Follow-Up Care within 7-Days of Discharge from a Psychiatric Inpatient Unit.	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	1. Follow-Up within 7 Days After Hospitalization for Mental Illness for the Black or African-American Population. 2. Follow-Up within 7 Days After	PIHP had not progressed to initiating improvement strategies and interventions for the PIP. Interventions will be reported in the next annual EQR technical report.

PIP Topic	PIP AIM	Performance Indicators	PIP Interventions
	subgroup (White) or achieve clinically or programmatically significant improvement as a result of implemented intervention(s).	Hospitalization for Mental Illness for the White Population.	
Improving Antidepressant Medication Management—Acute Phase.	There will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African-American adult members) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White adult members) or achieve clinically or programmatically significant improvement as a result of implemented intervention(s).	<p>1. The rate for White adult members who maintained antidepressant medication management for 84 days.</p> <p>2. The rate for African-American adult members who maintained antidepressant medication management for 84 days.</p>	<ul style="list-style-type: none"> Educated providers on the World Health Organization’s technical report on medication safety in polypharmacy which highlights guidelines and best practices. Educated provider staff annually on updated acute care discharge protocols developed by the PIHP to include best practices for medication psychoeducation and medication reminders to members leaving acute care settings. Educated and encouraged providers to use shared decision-making skills to support adherence.
Increase Percentage of Adults Receiving and a Reduction in Racial Disparity Between Caucasian and African Americans Served Post Inpatient Psychiatric Hospitalizations.	There will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African Americans) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (Caucasian Americans) or achieve clinically or programmatically significant improvement as a result of implemented intervention(s).	<p>1. The percentage of Caucasian adults discharged from a psychiatric inpatient unit who are seen for follow-up care within seven calendar days.</p> <p>2. The percentage of African-American adults discharged from a psychiatric inpatient unit who are seen for follow-up care within seven calendar days.</p>	<ul style="list-style-type: none"> The PIHP will pull data, broken down by provider, on providers’ compliance rates for seeing members seven days after being discharged from a psychiatric unit. Follow-up will occur with certain providers to assess whether additional support is needed. The PIHP will meet with providers to reiterate the importance of follow-up after an inpatient stay and provide space to discuss any specific challenges providers may be facing. The PIHP will review project compliance rates on the performance indicators, with consideration to race and ethnicity, against other PIHPs for comparison. The PIHP will issue a memorandum (memo) to the provider network to remind providers of the importance of the performance indicator standard and detail expectations moving forward. The PIHP will explore issuing incentive payments for providers who consistently meet the follow-up after inpatient stay standard. The PIHP will hold a follow-up meeting with providers 30 days after the initial meeting to discuss reported improvements and review persisting challenges. The PIHP staff will contact the plan hospital liaison team for coordination of discharging members who do not have a scheduled follow-up appointment.

PIP Topic	PIP AIM	Performance Indicators	PIP Interventions
			<ul style="list-style-type: none"> The PIHP hospital liaison team will meet with members discharging from an inpatient stay and unable to secure a follow-up appointment to provide necessary services and coordination.
Reducing Racial/Ethnic Disparities in Access to SUD Services.	There will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black/African American) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White) or achieve clinically or programmatically significant improvement as a result of implemented intervention(s).	<p>1. The percentage of new persons (Black/African American) receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders.</p> <p>2. The percentage of new persons (White) receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders.</p>	PIHP had not progressed to initiating improvement strategies and interventions for the PIP. Interventions will be reported in the next annual EQR technical report.
MI Choice (Prepaid Ambulatory Health Plans – PAHPs)			
Prevalence of Falls.	Decrease the percentage of participants that report a fall within the last 90 days, post initial assessment to be at or below the statewide goal of 23%.	<p>Numerator = The number of participants who recorded a fall on a follow-up assessment.</p> <p>Denominator = All participants excluding those completely dependent in bed mobility.</p>	<ul style="list-style-type: none"> Quarterly review the iHC QI Summary and Detailed Reports for tracking and trending of members. Identifying the prevalence of falls at the management team meeting the following month of the quarter. When trends are discovered, additional education will be provided to waiver staff on fall prevention and in home safety. The clinical educator will be utilizing the contracted occupational therapist to request she speak at an upcoming local consumer quality council meeting about safe transfers and fall prevention. All supports coordinators have completed the Model of Care certification and will utilize the resources obtained from the program as individuals with fall risks are identified.

PIP Topic	PIP AIM	Performance Indicators	PIP Interventions
Prevalence of Any Injuries.	Reduce the prevalence of any injury to be at or below the statewide goal of 3.0%.	Numerator = Participants with fractures or major skin problems, excluding current pressure or status ulcers. Denominator = All participants	<ul style="list-style-type: none"> Quarterly review the iHC QI Summary and Detailed Reports for tracking and trending of members Identifying the prevalence of any injury at the management team meeting the following month of the quarter. Quality Team completes a 5-10% randomized audit on the individual members reporting injuries to identify trends and possible solutions to decrease the prevalence of any injury. All results will be presented to the management team at the month following the quarter. When trends are discovered, additional education will be provided to waiver staff on the prevalence of injuries. Training/discussions surrounding internal and external audit findings and monthly one-on-one coaching provided to supports coordinators.
Prevalence of Neglect/Abuse.	Decrease the percentage of participants reporting being neglected/abused, have poor hygiene, are fearful of family member, or have been restrained to be equal to or below the statewide goal of 3.0%	Numerator = Participants who have been neglected or abused, have poor hygiene, are fearful of family member, or have been restrained Denominator = All participants	<ul style="list-style-type: none"> Continued reporting of critical incidents involving neglect/abuse via the critical incident portal within the contract designated time frames. Quarterly review of the InterRAI Home Care Assessment] Quality Improvement Summary. Detailed Reports for tracking and trending of members identifying the prevalence of neglect/abuse to identify trends. Annual training to all supports coordinators about abuse, neglect, and exploitation. Increased frequency of monitoring calls to participants, due to decrease in home visits and increase in telehealth services due to COVID-19. Provider agency audits to ensure abuse and neglect policies are in place. Quality Improvement peer review with supports coordinators and new enrollments to ensure any members reporting neglect/abuse, poor hygiene, are fearful of a family member, or have been restrained receive appropriate follow-up and person-centered care planning to address identified issues.
Prevalence of Pain With Inadequate Pain Control.	Decrease the percentage of participants that report pain with inadequate pain control to be equal to or below the statewide goal of 20%	Numerator = Participants who experience pain - AND- experience inadequate pain control on regimen or breakthrough pain or sometimes severe or excruciatingly intense pain Denominator = All participants	<ul style="list-style-type: none"> Monitors a separate WellSky (Harmony) report that identifies members in pain with inadequate pain control and breaks down the reason why the individual pulled to the report. Identified need for additional training to improve accuracy in coding of the iHC. Training completed with all program staff in Quarter 1 of SFY 2021. Conducted peer reviews at least bi-annually with supports coordinators and new enrollments are thoroughly audited (based on a tiered schedule) by the quality department to ensure pain issues receive appropriate follow-up and person-centered care planning to address, if necessary. Chart audits of enrolled members utilizing the full or targeted CQAR Record Review protocol (based on SFY 2020 CQAR Corrective Action Plan) and added to the CQAR portal for review.

PIP Topic	PIP AIM	Performance Indicators	PIP Interventions
			<ul style="list-style-type: none"> Adding additional questions to the iHC assessment to ensure sufficient information is collected regarding pain, including, baseline pain, description of pain, location, physician involvement (regarding unaddressed and breakthrough pain), current pain control methods.
Prevalence of Dehydration	Decrease the percentage of participants that report dehydration to be at or below the statewide goal of 1.5%	Numerator = Participants who report insufficient fluid intake Denominator = All participants	<ul style="list-style-type: none"> Quarterly review the iHC QI Summary and Detailed Reports for tracking and trending of members after identifying the prevalence of dehydration. When trends are identified, provide additional education to waiver staff on the prevalence of dehydration. Clinical Educator quarterly audits of the identified members, per the iHC QI Detailed report, to ensure identified member's fluid needs are within their normal, medically prescribed limits. Conduct presentations on dehydration and the effect it has on members. The focus of the education is to decrease the prevalence of dehydration.

Appendix F: Comprehensive Health Care Program 2021 National Committee for Quality Assurance (NCQA) Deemable Standards

MDHHS' contracted Medicaid Health Plans (MHPs) must hold and maintain accreditation as a managed care organization by the NCQA or URAC Accreditation for Health Plans. As such, MDHHS is committed to the nonduplication of activities through the use of information from private accreditation reviews as allowed in CFR §438.360. Since all MHPs are NCQA accredited, MDHHS uses the most current NCQA Medicaid Managed Care Toolkit as a guide to compare the NCQA Health Plan Accreditation standards to the standards established through the EQR protocols, and specifically for the mandatory compliance review activity described in 42 CFR §438.358(b)(iii), to identify those areas that are fully or partially comparable to federal and state-specific contract requirements and, therefore, eligible for deeming. MDHHS then assesses the most current MHP-specific accreditation reports and findings to determine the extent of nonduplication for each MHP.

On an annual basis, MDHHS publishes a list of the standards and elements that will be deemed in the current compliance review activity. Further, the MHPs contract with an NCQA certified HEDIS® vendor annually to undergo a full audit of their HEDIS® reporting processes. As such, the results of each MHP's HEDIS® audit is used for the external quality review in lieu of completion of the mandatory validation of performance measures activity described in 42 CFR §438.358(b)(ii).

NCQA NETWORK MANAGEMENT STANDARDS:
(2.17) PROVIDER SITE PERFORMANCE STANDARDS AND THRESHOLDS Authority: 1.1.V. A. 2. D.; CMS 438.206(C)(3)
NCQA: MED 3, Element A: Performance Standards and Thresholds Submit documentation that shows MHP sets site performance standards and thresholds for: <ol style="list-style-type: none"> 1. Accessibility equipment. 2. Physical accessibility. 3. Physical appearance. 4. Adequacy of waiting and examining room space. 5. Adequacy of medical/treatment record keeping.
NCQA MEMBERS' RIGHTS AND RESPONSIBILITIES:
(3.14) SECOND OPINIONS Authority: 1.1V.A.12.; CMS 438.206(b)(3)
NCQA: MED 1, Element C: Second Opinions Submit processes and handbook language showing that MHP provides for a second opinion from qualified health care professional within the network or arrange for the Enrollee to obtain one Out-of-Network at no cost to the Enrollee if not available in-network.
(3.15) OUT OF NETWORK SERVICES Authority: 1.1V.D.1.; CMS 438.206(b)(4)
NCQA: MED 1, Element D: Out-of-Network Services Submit policies and procedures showing if the organization is unable to provide a necessary and covered service to a member in-network, the organization must adequately and timely cover these services out of network for as long as the organization is unable to provide them.

(3.16) OUT OF NETWORK COST TO MEMBER Authority: CMS 438.206(b)(5)
<i>NCQA: MED 1, Element E: Out-of-Network Cost to Member</i> Submit policies and procedures showing if the organization approves a member to go out of network because it is unable to provide a necessary and covered service in-network, the organization: <ol style="list-style-type: none"> 1. Coordinates payment with the out-of-network practitioner. 2. Ensures that the cost to the member is no greater than it would be if the service was provided in-network.
(3.17) CARE COORDINATION Authority: 1.1. Q.; CMS 438.208(b)(1), 438.208(b)(3)
<i>NCQA: MED 5, Element A: Coordinating Health Care Services for Members;</i> <i>MED 6, Element A: Initial Screening of Member Needs</i> Submit policies and procedures for care coordination process including provisions for all members, including: <ol style="list-style-type: none"> 1. Having a person or entity formally assigned to coordinate health care services provided to members. 2. Providing the contact information of the individuals coordinating healthcare services to members.
(3.18) INITIAL SCREENING OF MEMBER NEEDS Authority: 1.1. Q.; 438.208(b)(3)
<i>NCQA: MED 6, Element A: Initial Screening of Member Needs</i> Submit policies and procedures explaining how organization conducts an initial screening of the health care needs of all new members within 90 calendar days of enrollment.
(3.19) SHARING IDENTIFICATION AND ASSESSMENT RESULTS Authority: 1.1. Q.; 438.208(b)(4)
<i>NCQA: MED 6, Element A: Sharing Identification and Assessment Results</i> Submit policies and procedures that show MHP shares the results of its identification and assessment of members with: <ol style="list-style-type: none"> 1. The state. 2. Other organizations serving the member.
(3.20) MAINTAINING AND SHARING MEMBER HEALTH RECORDS Authority: 1.1. Q.; 438.208(b)(5)
<i>NCQA: MED 5, Element B: Maintaining and Sharing Member Health Records</i> Submit policies and procedures that show MHP requires: <ol style="list-style-type: none"> 1. Practitioners to maintain member health records, as appropriate and in accordance with professional standards. 2. Practitioners to share member health records, as appropriate and in accordance with professional standards. 3. Providers to maintain member health records, as appropriate and in accordance with professional standards. 4. Providers to share member health records, as appropriate and in accordance with professional standards.
(3.21) PRIVACY AND CONFIDENTIALITY Authority: 1.1. Q.; 438.208(b)(6)
<i>NCQA: MED 4, Element A: Adopting Written Policies for Privacy and Confidentiality</i> Submit written policies and procedures that address: <ol style="list-style-type: none"> 1. Information included in notification of privacy practices. 2. Access to PHI.

<ol style="list-style-type: none"> 3. The process for members to request restrictions on use and disclosure of PHI. 4. The process for members to request amendments to PHI. 5. The process for members to request an accounting of disclosures of PHI. 6. Internal protection of oral, written, and electronic information across the organization.
<p>NCQA: MED 4, Element B: Authorization</p> <ol style="list-style-type: none"> 7. The organization has policies and procedures that address members' right to authorize or deny the release of PHI beyond uses for treatment, payment, or health care operations.
<p>(3.22) DELEGATION AGREEMENTS Authority: 438.230(c)(1)(i-iii)</p>
<p>NCQA: MED 15: Element A: Delegation Agreement</p> <p>Submit written delegation agreement which must meet the following:</p> <ol style="list-style-type: none"> 1. Is mutually agreed upon. 2. Describes the delegated activities and the responsibilities of the organization and the delegated entity. 3. Requires at least semiannual reporting of the delegated entity to the organization. 4. Describes the process by which the organization evaluates the delegated entity's performance. 5. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.
<p>NCQA QUALITY MANAGEMENT AND IMPROVEMENT STANDARDS:</p>
<p>(4.1) ADOPTION OF CLINICAL PRACTICE GUIDELINES Authority: 1.1XI(A); CMS 438.236(b)(1-4)</p>
<p>NCQA: MED 2: Element A: Adoption of Practice Guidelines</p> <p>Submit policies and procedures that demonstrate MHP adopts at least four evidence-based clinical practice guidelines, approved by its QI committee, that:</p> <ol style="list-style-type: none"> 1. Are based on valid and reliable clinical evidence or a consensus of practitioners in the particular field. 2. Consider the needs of the organization's members. 3. Are adopted in consultation with contracted health care professionals. 4. Are reviewed and updated at least every two years, as applicable.
<p>(4.2) POLICY/PROCEDURE FOR CLINICAL PRACTICE GUIDELINES Authority: 1.1XI(A); CMS 438.236(c)</p>
<p>NCQA: MED 2: Element B: Distribution of Practice Guidelines</p> <p>Submit documentation that shows MHP distributes the evidence-based guidelines it adopted in 4.1 (MED 2, Element A), to the appropriate practitioners and to members and potential members, upon request.</p>
<p>(4.21) COMPENSATION FOR UTILIZATION MANAGEMENT ACTIVITIES Authority: XI. I. 6.; 438.210(e)</p>
<p>NCQA: MED 9: Element D: Affirmative Statement About Incentives</p> <p>Submit policies and procedures that demonstrated MHP distributes a statement to all members and to all practitioners, providers and employees who make UM decisions, affirming the following:</p> <ol style="list-style-type: none"> 1. UM decision making is based only on appropriateness of care and service and existence of coverage. 2. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage. 3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.
<p>(4.22) BASIC ELEMENTS OF QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAMS</p>

Authority: 438.330(b)(1-5)

NCQA: MED 7: Element A: Quality Assessment and Performance Improvement Program

Submit documentation that demonstrate MHP's comprehensive quality assessment and performance improvement program includes:

1. Mechanisms to detect underutilization and overutilization.
2. Mechanisms to assess the quality and appropriateness of care provided to members with special health care needs.

Appendix G: Specialty Network Access Fee (SNAF) Program Quality Performance Measures

To better understand the quality performance of the SNAF program and determine the improvement areas, **MDHHS identified 16 quality measures for analysis.** The quality measures chosen to explore the care provided by SNAF providers were based on several factors: access to health care, the prevalence of chronic conditions seen in the Michigan Medicaid population and suggested measures by CMS.

HEDIS® Access to Care Measures (5): <ul style="list-style-type: none"> • <i>Well-Child Visits in the First 15 Months</i> assesses the percentage of children who turned 15 months old during the measurement year for six or more well-child visits. • <i>Well-Child Visits for Age 15 Months–30 Months</i> assesses the percentage of children who turned 30 months old during the measurement year for two or more well-child visits. • <i>Child and Adolescent Well-Care Visits</i> assess the percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. <ul style="list-style-type: none"> ○ Ages 3 to 11 years, ○ Ages 12 to 17 years, and ○ Ages 18 to 21 years
Chronic Care Set of three (3) HEDIS® and four (4) AHRQ – Prevention Quality Indicators (PQIs) Measures.
Diabetes HEDIS® Measures: <ul style="list-style-type: none"> • <i>Comprehensive Diabetes Care—HbA1c Testing</i> assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had HbA1c testing. • <i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i> assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had screening or monitoring for diabetic retinal disease. • <i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i> assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who received medical attention for nephropathy.
AHRQ Prevention Quality Indicator (PQI) Measures: <ul style="list-style-type: none"> • <i>PQI 01: Diabetes short-term complications admission rate</i> includes admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 member months, ages 18 years and older. Excludes obstetric admissions and transfers from other institutions. • <i>PQI 05: Chronic obstructive pulmonary disease or Asthma in older adults' admission rate</i> includes admissions with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma per 100,000 member months, ages 40 years and older. Excludes obstetric admissions and transfers from other institutions. • <i>PQI 08: Congestive heart failure admission rate</i> includes admissions with a principal diagnosis of heart failure per 100,000 member months, ages 18 years and older. Excludes cardiac procedure admissions, obstetric admissions, and transfers from other institutions • <i>PQI 15: Asthma in younger adults' admission rate</i>
Three (3) Women—Adult Care Measures and one (1) Pregnancy Care Measure.
Women-Adult Care Measures: <ul style="list-style-type: none"> • <i>Breast Cancer Screening</i> assesses the percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer on or after October 1 two years prior to the measurement year. Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2019 and prior years. • <i>Cervical Cancer Screening</i> assesses the percentage of women 21 to 64 years of age who were screened for cervical cancer using either of the following criteria: <ul style="list-style-type: none"> ○ Women 21 to 64 years of age who had cervical cytology performed every three years.

- Women 30 to 64 years of age who had cervical cytology/human papillomavirus co-testing performed every five years.
- *Chlamydia Screening in Women–Total* assesses the percentage of women 16 to 24 years of age who were identified as sexually active and had at least one test for chlamydia during the measurement year.

Pregnancy Care Measure:

- *Postpartum Care* assesses the percentage of deliveries of live births that had a postpartum visit on or between 21 and 56 days after delivery.

Specialty Network Access Fee (SNAF) Program: Quality Performance and Targets

Measure	Measure Steward/ Developer	Baseline Year	Baseline Statistic	FY 2020 Performance	FY 2021 Performance	FY 2022 Performance	Future Performance Target
HbA1c Testing	NCQA/HEDIS	FY 2019	88.84%	85.83%	87.96%	88.41%	89.00%
Eye Exam (Retinal) Performed	NCQA/HEDIS	FY 2019	61.19%	53.78%	56.22%	57.28%	62.00%
Medical Attention for Nephropathy	NCQA/HEDIS	FY 2019	92.85%	91.08%	91.40%	90.78%	93.00%
Breast Cancer Screening	NCQA/HEDIS	FY 2019	69.02%	65.72%	62.73%	64.37%	70.00%
Cervical Cancer Screening	NCQA/HEDIS	FY 2019	53.92%	54.00%	53.36%	53.15%	55.00%
Chlamydia Screening in Women–Total	NCQA/HEDIS	FY 2019	70.33%	66.53%	65.67%	65.08%	71.00%
Postpartum Care	NCQA/HEDIS	FY 2019	56.60%	65.31%	67.56%	68.51%	66.00%
Well-Child Visits in the First 30 Months of Life – First 15 Months	NCQA/HEDIS	FY2021	N/A	N/A	54.25%	59.62%	62.00%
Well-Child Visits in the First 30 Months of Life – 15 to 30 Months	NCQA/HEDIS	FY2021	N/A	N/A	66.13%	67.86%	68.00%
Child and Adolescent Well-Care Visits – 3 to 11 years	NCQA/HEDIS	FY2021	N/A	N/A	75.41%	72.72%	75.41%
Child and Adolescent Well-Care Visits – 12 to 17 years	NCQA/HEDIS	FY2021	N/A	N/A	64.88%	61.61%	64.88%
Child and Adolescent Well-Care Visits – 18 to 21 years	NCQA/HEDIS	FY2021	N/A	N/A	42.98%	40.54%	42.98%
PQI 01: Diabetes short-term complications admission rate	CMS Core Set	FY 2019	23.18	41.31	37.17	32.56	Michigan will continue to monitor this measure

PQI 05: COPD or Asthma in older adults' admission rate	CMS Core Set	FY 2019	74.14	91.29	67.16	48.95	Michigan will continue to monitor this measure
PQI 08: Congestive heart failure admission rate	CMS Core Set	FY 2019	28.79	60.10	56.51	49.59	Michigan will continue to monitor this measure
PQI 15: Asthma in younger adults' admission rate	CMS Core Set	FY 2019	11.56	11.99	8.14	6.17	Michigan will continue to monitor this measure

Comparison of SNAF Participating Providers to Non-Participating Providers:

Diabetic HEDIS Measures

	SNAF Numerator	SNAF Denominator	SNAF Rate	Non-SNAF Numerator	Non-SNAF Denominator	Non-SNAF Rate
<i>HbA1c Testing</i>	37,637	42,569	88.41%	41,506	47,156	88.02%
<i>Eye Exam (Retinal) Performed</i>	24,383	42,569	57.28%	22,887	47,156	48.53%
<i>Medical Attention for Nephropathy</i>	38,646	42,569	90.78%	40,697	47,156	86.30%

Women- Adult Care & Pregnancy Measures

	SNAF Numerator	SNAF Denominator	SNAF Rate	Non-SNAF Numerator	Non-SNAF Denominator	Non-SNAF Rate
<i>Breast Cancer Screening</i>	30,922	48,041	64.37%	19,022	37,048	51.34%
<i>Cervical Cancer Screening</i>	119,365	224,578	53.15%	82,128	196,488	41.80%
<i>Chlamydia Screening in Women--Total</i>	29,733	45,685	65.08%	25,391	43,576	58.27%
<i>Postpartum Care</i>	22,666	34,955	64.84%	2,224	3,417	65.09%

Appendix H: Hospital Reimbursement Adjustment (HRA) Program Quality Performance Measures

To better understand the quality performance of the Hospital Reimbursement Adjustment (HRA) program and determine the improvement areas, MDHHS generates quality measure rates, some of which include demographic stratification to expand our efforts and focus on population health and health equity. The quality measures chosen to explore the care provided by hospitals in the HRA program were based on hospital specific related measures and those measures suggested by CMS.

HEDIS® Access to Care Measures (5):
<ul style="list-style-type: none"> • <i>Ambulatory Care—Total</i> (Per 1,000 Member Months) measure summarizes use of ambulatory care for ED Visits—Total and Outpatient Visits—Total • <i>Inpatient Utilization—General Hospital/Acute Care—Total</i> measure summarizes use of acute inpatient care and services in four categories: <ul style="list-style-type: none"> ○ Total Inpatient, ○ Medicine, ○ Surgery, and ○ Maternity. • <i>Well-Child Visits in the First 15 Months</i> assesses the percentage of children who turned 15 months old during the measurement year for six or more well-child visits. • <i>Well-Child Visits for Age 15 Months–30 Months</i> assesses the percentage of children who turned 30 months old during the measurement year for two or more well-child visits. • <i>Child and Adolescent Well-Care Visits</i> assess the percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. <ul style="list-style-type: none"> ○ Ages 3 to 11 years, ○ Ages 12 to 17 years, and ○ Ages 18 to 21 years • <i>Adults' Access to Preventive/Ambulatory Health Services—Total</i> (Ages 20 to 64 Years) assesses the percentage of members 20 years of age and older who had an ambulatory or preventive care visit during the measurement year. • <i>Plan All-Cause Readmissions</i> measures the number of acute inpatient discharge events for beneficiaries 18 and older, excluding discharges for pregnancy/perinatal conditions and discharges that had planned readmissions, such as rehab, chemotherapy, and transplant. Beneficiaries in hospice are excluded.*
AHRQ Prevention Quality Indicators (PQI) Measures (3):
<ul style="list-style-type: none"> • <i>PQI 05: Chronic obstructive pulmonary disease or Asthma in older adults admission rate</i> includes admissions with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma per 100,000 member months, ages 40 years and older. Excludes obstetric admissions and transfers from other institutions. • <i>PQI 08: Congestive heart failure admission rate</i> includes admissions with a principal diagnosis of heart failure per 100,000 member months, ages 18 years and older. Excludes cardiac procedure admissions, obstetric admissions, and transfers from other institutions • <i>PQI 15: Asthma in younger adults' admission rate</i> includes admissions for a principal diagnosis of asthma per 100,000 member months, ages 18 to 39 years. Excludes admissions with an indication of cystic fibrosis or anomalies of the respiratory system, obstetric admissions, and transfers from other institutions.
Pregnancy Care Measure (1):
<ul style="list-style-type: none"> • Cesarean Section This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section. To be included in this measure, a woman must be nulliparous, greater than eight years of age and less than 65 years of age, have a length of stay less than 120 days, and not be enrolled in a clinical trial. She must have completed at least 37 weeks of gestation, this must be a singleton pregnancy, the fetus must be in the vertex position and the infant must be liveborn. The measure's numerator is the number of nulliparous women with a singleton, vertex fetus at ≥ 37 weeks of gestation who deliver a

liveborn infant by c-section. The denominator is the number of nulliparous women with a singleton, vertex fetus at ≥ 37 weeks of gestation who deliver a liveborn infant.

*A risk adjusted ratio is also calculated to determine performance on this measure. The intent of the risk adjustment is to take into consideration how the disease burden of the population might influence hospital readmission rates, to allow for more accurate performance comparisons. Risk adjustment accounts for age, gender, inpatient surgeries, discharge condition and comorbidities. This is then used to calculate an “expected” readmission rate. A ratio can then be calculated between the observed/expected readmission rate. A ratio of 1.00 means that the observed and expected rates were equal. A ratio that is higher than 1.00 means that more readmissions occurred than were expected, and a ratio that is less than 1.00 means less readmissions occurred than were expected.

Hospital Reimbursement Adjustment (HRA) Program: Quality Performance and Targets

Measure Name	Measure Steward/ Developer	Baseline Year	CY2018	CY2019	CY2020	CY 2021	Future Performance Target
Adults' Access to Preventative/Ambulatory Services: Total	NCQA/HEDIS	CY 2018	81.95%	82.49%	78.22%	78.58%	83.00%
Ambulatory Care: Outpatient Visits and Emergency Department Visits: ED Visits per 1,000 MM	NCQA/HEDIS	CY 2018	66.87	66.05	48.10	50.94	Michigan will continue to monitor this measure
Ambulatory Care: Outpatient Visits and Emergency Department Visits: Outpatient Visits per 1,000 MM	NCQA/HEDIS	CY 2018	389.77	433.13	361.46	402.05	Michigan will continue to monitor this measure
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits ¹	NCQA/HEDIS	CY 2018	N/A	N/A	61.88%	58.84%	Michigan will continue to monitor this measure
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits ²	NCQA/HEDIS	CY 2018	N/A	N/A	67.71%	60.99%	Michigan will continue to monitor this measure
Child and Adolescent Well-Care Visits - Ages 3 to 11 Years ¹	NCQA/HEDIS	CY 2018	N/A	N/A	50.92%	58.13%	Michigan will continue to monitor this measure
Child and Adolescent Well-Care Visits - Ages 12 to 17 Years ¹	NCQA/HEDIS	CY 2018	N/A	N/A	42.35%	49.93%	Michigan will continue to monitor this measure
Child and Adolescent Well-Care Visits - Ages 18 to 21 Years ¹	NCQA/HEDIS	CY 2018	N/A	N/A	27.36%	29.01%	Michigan will continue to monitor this measure
Inpatient Utilization: General Hospital/Acute Care, Average length of Stay (Maternity)	NCQA/HEDIS	CY 2018	2.66	2.54	2.49	2.54	Michigan will continue to monitor this measure

¹ Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between MY 2020 and prior years; therefore, prior years' rates will not be displayed and comparisons to benchmarks will not be performed for this measure.

² This measure was new in 2020; therefore, prior years' rates cannot be displayed and comparisons to benchmarks cannot be performed for this measure as benchmarks are not yet available.

Inpatient Utilization: General Hospital/Acute Care, Average length of Stay (Medicine)	NCQA/HEDIS	CY 2018	3.87	4.00	4.33	4.57	Michigan will continue to monitor this measure
Inpatient Utilization: General Hospital/Acute Care, Average length of Stay (Surgery)	NCQA/HEDIS	CY 2018	6.89	7.00	7.62	8.22	Michigan will continue to monitor this measure
Inpatient Utilization: General Hospital/Acute Care: Total Inpatient Days							
Inpatient Utilization: General Hospital/Acute Care: Total Inpatient Average Length of Stay	NCQA/HEDIS	CY 2018	4.33	4.43	4.65	4.99	Michigan will continue to monitor this measure
Inpatient Utilization: Total Inpatient Discharge per 1,000 Member Months	NCQA/HEDIS	CY 2018	7.93	8.63	7.31	6.78	Michigan will continue to monitor this measure
Measures Based on Claims & Encounters							
Measure Name	Measure Steward/ Developer	Baseline Year	Baseline Statistic	FY 2020 Performance	FY 2021 Performance	FY 2022 Performance	Future Performance Target
Cesarean Section		FY 2019	26.45%	27.73%	28.59%	28.54%	26.00%
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	CMS Core Set	FY 2019	74.14	54.87	41.23	31.17	Michigan will continue to monitor this measure
PQI 08: Heart Failure Admission Rate	CMS Core Set	FY 2019	28.79	28.29	27.17	23.31	Michigan will continue to monitor this measure
PQI 15: Asthma in Younger Adults Admission Rate	CMS Core Set	FY 2019	11.56	6.48	5.20	3.95	Michigan will continue to monitor this measure
Retired Measures							
Readmissions among Medicaid Beneficiaries	NCQA/HEDIS	FY 2019	14.73	15.39	15.46	Measure Retired	
New Measures							
Plan All-Cause Readmissions	NCQA/HEDIS	FY 2019	N/A	9.09%	9.65%	9.21%	Michigan will continue to monitor this measure

¹ Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between MY 2020 and prior years; therefore, prior years' rates will not be displayed and comparisons to benchmarks will not be performed for this measure.

¹ This measure was new in 2020; therefore, prior years' rates cannot be displayed and comparisons to benchmarks cannot be performed for this measure as benchmarks are not yet available.

Appendix I: MDHHS 2023-2026 Comprehensive Quality Strategy (CQS) Public Comment

The Michigan Medicaid CQS is developed collaboratively with input from health care providers, stakeholders, advocates, and multiple state agencies with an interest in improving access, clinical quality, and service quality received by Medicaid enrollees.

In compliance with federal and state public comment requirements, MDHHS follows all applicable processes for public comment across managed care programs. Regulatory requirements 42 CFR 438.340(c)(1)(i), 438.340(c)(1)(ii), and 42 CFR 457.1240(e) require states to make the CQS available for public comment before submission to CMS for review. The public comment process includes obtaining input from the state's Medicaid Medical Care Advisory Committee, beneficiaries, and other stakeholders. In addition, the state must consult with Tribes in accordance with the state's Tribal consultation policy established pursuant to 1902(a)(73) of the Social Security Act, if the state enrolls American Indians and Alaska Natives (AI/ANs) in any of its MCPs.

A draft of the MDHHS 2023-2026 CQS was finalized in August 2023 and presented to the MDHHS Medical Care Advisory Council (MCAC) and Tribal Health Directors. In addition, the MDHHS 2023- 2026 CQS final draft was posted on the MDHHS website for a 30-day public comment period beginning August 16, 2023 (<https://www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/reports>), with comment due to MDHHS by Friday, September 15, 2023.

Comments were shared with the CQS Leadership and Core teams for consideration and to determine whether CQS revisions were warranted prior to submission to CMS in October 2023. The comments and MDHHS feedback are outlined in the table below.

MDHHS 2023-2026 Comprehensive Quality Strategy Public Comment

Public Comment Feedback
Comment: CalAIM has been a leader in transitional housing. Is there an opportunity to look beyond referrals for SDOH and look at funding. CalAIM uses Medicaid dollars for 6 months for transitional housing vs Michigan has 1 month – is this something the Department can think about this in the coming years?
MDHHS Response: MDHHS is committed to investing in Social Determinants of Health (SDOH). The Department's SDOH strategy for 2022-2024 can be found here . We will continue to look for ways to deepen this engagement and will assure this feedback is incorporated into future conversations and strategy development in this space.
Comment: When the Team references incorporating SDOH metrics into the process and collecting and using data - is there more to extrapolate on? Does it fit into the Departments' conversation in Community Information Exchange (CIE) to close loop referrals, and do the collection and aggregation, referral/follow up data.

<p>MDHHS Response: As noted above, MDHHS has laid out a vision for focusing Departmental efforts on addressing SDOH. As part of the of the 2022-2024 strategy, closed-loop referral policy and statewide recommendations will be developed through engagement across MDHHS and with statewide stakeholders. While CQS metrics for SDOH did not go as far as closing referral loops at this time, this feedback will help to inform continued conversations on this topic.</p>
<p>Comment: What is the timeline to submit comments?</p>
<p>MDHHS Response: Comments are due by September 15, 2023.</p>
<p>Comment: Many of the areas of performance improvement envisioned in the plan will require provider and community efforts that are not currently paid by Medicaid because they take place before a covered service is delivered and they incorporate "risk" in the sense that efforts are pursued with a much larger number of people than will ultimately result in a paid service. What is the vision for investing in those efforts for 2023-2026? For example, access to services that focus on engagement in preventive care in order to have impact there needs to be outreach activities on a very targeted basis, which takes a lot of time and resources. Ultimately when there are 1000 members in given area that need engagement, but we only receive 100 contacts, means that we have a lot of staff time towards the targeted group that results in a smaller number of interactions. Whereas health plans receive capitative rate per member. What is the vision for how to reduce that gap between the two?</p>
<p>MDHHS Response: MDHHS values provider and community efforts to improve performance and increase access to care. The Department's FY2024 budget includes \$6M to support the implementation of a Medicaid alternative payment methodology for FQHCs. The Department will be working in partnership with the Michigan Primary Care Association to design this payment model, which provides a unique avenue to test an approach to reducing the gap noted and supporting providers in investing in outreach and engagement that happens outside of a billable service.</p>
<p>Comment: Is there a process to look at bandwidth of the CQS?</p>
<p>MDHHS Response: Respondent feedback was shared with the CQS Leadership and Core Teams regarding CQS resources and support. MDHHS notes that not all metrics apply to all programs. There will be ongoing review of the CQS and if substantial changes are made, the revised CQS will be shared, including a public comment period.</p>
<p>Comment: On page 18, the PACE Directors meetings are listed as part of the Quality Strategy. This seems more like an opportunity for MDHHS to announce programmatic and policy changes and for directors to have a forum to ask questions and gain clarification on issues they are facing. There is no apparent connection to quality measurement or quality improvement in these meetings. The PACE Directors Meetings seem out of place in the Quality Plan.</p> <p>Other provider types also have meetings with MDHHS (e.g. MI Choice Directors) that deal with program issues, but are not really part of the quality plan. What makes the PACE Directors meeting different and how does it fit into the Quality Plan? Commenter recommends removing PACE Directors meetings from the draft.</p>

MDHHS Response: The PACE Directors meetings include MDHHS PACE program staff and representatives from the 13 PACE organizations. In 2023, the meeting agenda has implemented a “Best Practice” item with each meeting. The sharing of best practices will assist PACE programs improve the quality and services to PACE participants.

Comment:

While the Commenter acknowledges and appreciates the various input mechanisms in place related to the MI Choice program, we recommend more easily understandable/plain language briefs be created and published in an easy to find location on the MDHHS website. The MI Choice Quality Management Collaboration (QMC), noted on page 17, is an important part of MI Choice quality oversight, yet information about what issues it has addressed or any recommendations it has made are not readily available to the public. Likewise, information about who the current QMC members are; whether the membership includes appropriate representation of people with disabilities and older adults; and whether diverse racial, ethnic, gender, and other identities are represented among the membership should be made public. We recommend MDHHS compile information about the structure and membership of the QMC and what issues or recommendations have been addressed by the QMC and post this information in a prominent place on the MDHHS website.

The MI Choice Steering Committee is noted as part of the Quality Strategy, but the membership, charge and authority of the committee are not detailed. If this committee is to be named as part of the Quality Strategy, its duties, membership, charge, and authority should all be detailed to clarify their role in the strategy.

Similarly, on page 18, the PACE Participant Advisory Committee is included in the strategy but there are no details about the group’s membership, charge, or authority. It also appears that participant input to the PACE program exists only at the PACE organization level and not at the state level. Is there a statewide endeavor that includes PACE participants and/or family or caregivers?

MDHHS Response:

MDHHS does not post Statewide MI Choice Quality Management Collaborative (QMC) membership due to member privacy concerns. The QMC is a consumer led committee and members have requested that personal information not be disclosed (e.g., that they are Medicaid beneficiaries or receiving home and community-based services). MDHHS respects their confidentiality and privacy wishes. MDHHS will consider posting QMC meeting agendas and summary notes in the future.

Similarly, MDHHS does not post the MI Choice Steering Committee membership due to member privacy concerns. The Steering Committee is charged with developing the agenda, finding presenters, doing additional research on topics of interest, and discussing the quality indicators selected for the MI Choice Quality Strategy for the QMC meetings.

The PACE Participant Advisory Committee (PAC) is required by federal regulation. A PACE Board member must also participate in the PAC meetings. These meetings are usually led by the quality director. Any concerns/problems are then shared at the PACE Board Meeting. Usually, the PACE Executive Director attends this meeting or a representative. CMS/State/PACE program discusses this on their monthly/bimonthly or quarterly CMS scheduled meeting. This (attendees and content) is monitored on CMS and State audits by reviewing PAC minutes as well as reviewing the PACE Board Meeting agenda.

Comment:

On page 33, there are the six MI Choice performance measurements: participant access and LOC determination; patient centered service planning; service delivery; provider capacity and capabilities; participant safeguards related to health and welfare, rights and responsibilities, outcomes, and satisfaction; and system performance. We recommend that the percentage of nursing facility to community transition referrals to which the agency responded in a timely fashion, the number of successful transitions to the community compared to a benchmark set by MDHHS for each waiver agency, the percentage of care plans (authorized services/hours) that match actual care provision (services/hours), and the number and disposition of grievances and complaints be included as quality measures for MI Choice agencies.

On page 36, the Administrative Quality Assurance Review (AQAR) and the Clinical Quality Assurance Review (CQAR) are described. We believe that in addition to the items already reviewed in the AQAR and the CQAR, a review of network adequacy be included. There is a requirement that MI Choice (like other managed care entities) must maintain a provider network adequate to serve 125% of their enrollment capacity. We have received multiple reports of potential MI Choice participants remaining on long waiting lists and some current participants not receiving all authorized hours because of a shortage of in-home caregivers or service providers. We therefore recommend that a specific measure be added to either the AQAR or CQAR regarding network adequacy.

For the MI Health Link program, on page 33, the strategy states that quality of life, person-centered planning, and enrollee/caregiver experience are measured. We understand that the CAHPs tool captures enrollee and caregiver experience, but the strategy does not include any information about what tools are used and where results are posted or quality of life or person-centered planning performance. We recommend that the strategy specify how these two items are measured and that the results be posted along with the CAHPs results.

A set of CMS Quality Measures for PACE organizations exists but is not mentioned in the Quality Strategy. We recommend that these quality measures be included in the Quality Strategy. Additionally, we recommend that PACE organization performance on these measures be posted on the MDHHS website in an understandable format for public viewing.

MDHHS Response: MI Choice waiver agencies are not charged with facilitating transitions from the nursing facility to the community. Therefore, MDHHS has not defined a timely response time for addressing such referrals (that would differ from waiting list policy), nor set any benchmarks for the activity. The state-wide Comprehensive Quality Strategy applies only to managed care programs, and it would not be appropriate to include the suggested information on transitions since Community Transition Services are not managed care services. MDHHS shares monthly statistics related to Community Transition Services provided by Transition Agencies and the number of individuals who transition out of the nursing facility and enroll in MI Choice without using Community Transition Services.

MDHHS is working on obtaining data for the percentage of authorized services that are delivered. However, this data collection is in the beginning stages and not ready to be included within the CQS at this point. Starting in FY 2023, the information on grievances is gathered with the required MCPAR report and submitted to CMS annually.

MDHHS began gathering and analyzing provider network adequacy in depth during FY 2023. We do not have enough information yet to develop reportable statistics, but plan to do so in the future as this too will be required by CMS.

The publicly available Medicare-Medicaid Plan performance data, including certain Medicare Parts C and D quality measures, such as select HEDIS, HOS and Medicare Adult CAHPS measures, as well as certain CMS core measures, is shared by CMS on the CMS.gov website and can be accessed here: <https://www.cms.gov/medicaid-chip/medicare-coordination/financial-alignment/capitated-model>. MDHHS administers Home and Community Based Services (HCBS) CAHPS surveys with the findings published on the MI Health Link website annually and accessible here: [MHL Resources Toolkit \(michigan.gov\)](https://mhlresources.michigan.gov) under the Quality section. Additionally, quality performance evaluation for each ICO and MI Health Link as a whole can be found in annual EQRO Technical Reports accessible here: [MHL Resources Toolkit \(michigan.gov\)](https://mhlresources.michigan.gov) under the Quality section.

MDHHS is unable to provide this data currently. However, the National PACE Association (NPA) indicates they are working with CMS on providing a more collaborative quality approach which will be considered for future quality strategies.

Comment:

On page 38, provider network adequacy for MI Choice is discussed. It is not clear, however, how MI Choice performance maintaining adequate provider networks is measured. Critical issues like enrolled participants not getting all authorized hours of care due to lack of providers and MI Choice applicants waiting for admission to services because there are insufficient providers should be measured. If a MI Choice agency is granted an exception to the requirement to “reasonably deliver covered services to enrollees” and to the network adequacy requirement, the criteria for exceptions, the exceptions granted to particular MI Choice agencies, any required actions the waiver agency needs to take, and the timeline for the exception should all be made publicly available.

The MI Choice requirement to have network provider capacity at 125% of anticipated service utilization, noted on page 39, is apparently often not met since there are multiple instances when a MI Choice agency cannot enroll new clients because of a lack of providers. Additionally, advocates get reports of providers being counted in more than one waiver agencies’ list of available providers, thus artificially inflating both waiver agencies’ networks. MI Choice network adequacy for each waiver agency, any findings of inadequate provider networks, and any corrective action plans from the department should be made publicly available.

MDHHS Response: MDHHS began gathering and analyzing provider network adequacy in depth during FY 2023. We do not have enough information yet to develop reportable statistics, but plan to do so in the future. Additionally, there is a nationwide shortage of direct care workers, so the issue described above is not unique to MI Choice. MDHHS is attempting to address the direct care worker shortage in many ways.

Comment:

This section on page 41 only addresses transitions from one MI Choice entity to another. We recommend that specific measures for Transition of Care from FFS to Managed Care Entity (e.g. nursing home to MI Choice) be added to the strategy and that the performance of MI Choice agencies on transition activities be measured and published.

On page 56, Community Health Workers' (CHW) availability to MI Choice participants is described as follows: "may use this service after a hospitalization or nursing facility discharge to assure the enrollee understands and follows discharge plans, makes follow-up appointments as recommended, and understands any medication changes resulting from the hospitalization or nursing facility admission. This service also helps any enrollee access community resources, understand their disease process and how to manage it, find self-determined workers, increase independence, find housing or employment, and assures the enrollees supports coordinator is informed of the enrollee's progress toward meeting goals identified in the person-centered service plan." We recommend that specific measures for the actual availability and use of CHWs by MI Choice participants be created and MI Choice agency performance on provision of CHW services be publicly reported.

MDHHS Response: MI Choice waiver agencies are not charged with facilitating transitions from the nursing facility to the community. Therefore, MDHHS has not defined a timely response time for addressing such referrals (that would differ from waiting list policy), nor set any benchmarks for the activity. The state-wide Comprehensive Quality Strategy applies only managed care programs, and it would not be appropriate to include the suggested information on transitions since Community Transition Services are not managed care services.

MDHHS is working on adding a state-plan CHW service that would be available to all Medicaid beneficiaries that qualify for the service. MDHHS will continue to explore performance measures related to CHW services.

Comment:

The plan effectively describes the work of the Medicaid Health Plans to address health disparities through data collection and reporting, contractual incentives, etc. However, the programs that provide long-term supports and services (primarily MI Choice and PACE) do not report comparable efforts. The Effectiveness Evaluation, Appendix C, Goal #4, Reduce racial and ethnic disparities in healthcare and health outcomes (page 134) shows which managed care programs are meeting the goals for each of six objectives. The MI Choice waiver is listed as meeting two of the six objectives and PACE is listed as meeting one. We recommend that MDHHS increase its investment in health equity efforts in LTSS programs to achieve comparable data collection, reporting, and outcomes.

On page 103, a Michigan Health Endowment Fund supported project on measures for health equity is mentioned. We recommend that the specific measures for MI Choice and PACE performance identifying and addressing participants' SDOH needs and other project results be publicly

available. It appears there are no current measures of SDOH performance for MI Choice or PACE and new measures developed in this project should be published for public comment. The MHL program has existing measures for some aspects of health equity and disparities. We recommend that the results of these measures and any changes stemming from the Michigan Health Endowment Fund supported project be published for public review.

The MI Choice Effectiveness Evaluation for 2020-2023, referenced on page 107, lists items to be measured for MI Choice: 1. Prevalence of Neglect/Abuse; 2. Prevalence of Pain with Inadequate Pain Control; 3. Prevalence of Falls; 4. Prevalence of Any Injuries; and 5. Prevalence of Dehydration. We recommend that specific elements and methods for measuring these items be added.

MDHHS Response: MDHHS is in the middle of a Michigan Health Endowment Fund grant that is looking at health equity in HCBS programs, including MI Choice. Once the data collection and analysis are completed through that grant, MDHHS will develop performance measures that are informed by the data gathered through this Health Equity Grant.

The specific elements and methods for measuring these items, 1. Prevalence of Neglect/Abuse; 2. Prevalence of Pain with Inadequate Pain Control; 3. Prevalence of Falls; 4. Prevalence of Any Injuries; and 5. Prevalence of Dehydration, can be found in Appendix E of the CQS document on page 171.

Comment:

Finally, as an overarching comment, we recommend that MDHHS use existing data to create dashboards or reports for each entity participating in the long term supports and services Medicaid programs (MI Choice, MI Health Link, and PACE) that are easy to understand and publicly available on the MDHHS website. These dashboards or reports should be made at the program level and at the managed care entity level to give the public a much more complete view of the quality performance of these various publicly funded programs and organizations.

MDHHS Response: MDHHS will explore existing data to determine what reports and/or dashboards could be added to the MDHHS website in the future.

Comment:

Thank you for the opportunity to review the Comprehensive Quality Strategy for 2023-2026 (the Quality Strategy Plan). This is a helpful guide for Medicaid Health Plans (MHP) to use as they continue to develop and expand on their existing programs to ensure that Medicaid beneficiaries receive timely, comprehensive, and quality care regardless of their physical or behavioral health needs. A core point of emphasis in the Quality Strategy Plan is access standards described in Section III, beginning on page 38. For nearly 20 years, the MDHHS has ensured that a Medicaid recipient has access to the critical services offered at every Michigan hospital, including hospitals unwilling to contract with a specific MHP through Hospital Access Agreements (HAA). While Section III does address the important role the Hospital Reimbursement Adjustment (HRA) program has played in incentivizing hospitals to participate in the Medicaid program regardless of whether or not they are contracted with an MHP, Section III needs to emphasize the continued use of Hospital Access Agreements (HAA). The reason is to ensure that Medicaid

beneficiaries have access to vital hospital emergency and inpatient services regardless of whether the hospital is directly contracted with an MHP. We believe it's important for MDHHS to continue the use of HAAs and consider them an essential part of ensuring access for Medicaid beneficiaries, along with allowing their use as a tool to demonstrate network adequacy consistent with the federal regulations (i.e., 42 CFR Parts 438.68 and 457.1218).

It is also recommended that MDHHS's strategy includes early identification of quality measures included in the Medicaid health plan contract. Timing of identification of metrics should be at least 12 months before the reporting period of each measure. This will allow health plans time to implement initiatives to impact plan performance in MDHHS's focused areas positively.

We further recommend MDHHS continue to provide Medicaid Health Plans opportunities to review and comment on any changes to quality metrics before finalization and implementation.

MDHHS Response: The network adequacy and network exception provisions are appropriately described in the current text of the CQS. Related to the timing for identification of measures and consideration for the MCEs to review and provide input on those measures; MDHHS considers these operational details that need not be documented in the CQS.