Michigan Department of Health and Human Services

Comprehensive Quality Strategy

2020 - 2023

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Executive Summary

The Michigan Department of Health and Human Services (MDHHS) is united by a common desire to improve the health and welfare of the people of the State of Michigan and address the challenges facing the state. 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 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.

Michigan's 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 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.

Development of the 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. Fundamental to the concept of population health improvement is a commitment to health equity and addressing health disparities. To meet this goal, Michigan Medicaid collaboratively identified and agreed upon CQS goals and objectives that pursue an integrated framework for both overall population health improvement and a commitment to eliminating unfair outcomes within subpopulations in Medicaid managed care. The CQS also strives to align with the Centers for Medicare and Medicaid Services (CMS) Quality Strategy which is built on the National Quality Strategy (NQS) aims and priorities.

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.

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 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 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 women, most categories of foster children, Children's Special Health Care Services).

In Michigan, management of these programs is spread across two different administrations, and four separate divisions within the MDHHS. Physical health, children's and adult dental services, and mild-to-moderate behavioral health services are managed by the Managed Care Plan Division (MCPD) in the Medical Services Administration (MSA). Long-term services and supports (LTSS) are implemented by three different MDHHS program areas: The Long-Term Care Services Division (MI Choice Program); the Integrated Care Division (MI Health Link Medicaid/Medicare Dual Eligible Demonstration, Program of All-Inclusive Care for the Elderly); and the Behavioral Health and the Developmental Disabilities Administration (BHDDA) Quality Division. BHDDA also administers Medicaid Waivers for people with intellectual/developmental disabilities, mental illness, serious emotional disturbance, and it administers prevention and treatment services for substance use disorders.

All of these programs have developed and implemented quality monitoring and improvement strategies to ensure their beneficiaries' experience of care is positive, appropriate, and timely. The quality strategies, however, have remained separate from one another.

Table 1 outlines the Medicaid managed care programs administered by the Michigan Department of Health and Human Services (MDHHS).

The intent of this **Comprehensive Quality Strategy** is to begin 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.

Table 1: Michigan Medicaid Managed Care Programs

Medicaid Managed Care Program	Date Initiated	MDHHS Lead
Comprehensive Health Care Program (CHCP)		
Medicaid Managed Care (Medicaid Health Plans, MHPs)	July 1997	Medical Services Administration (MSA)
• MIChild	January 2016	
• Children's Special Health Care Services	October 2012	
• Foster Children	November 2010	
• Pregnant Women	October 2008	
Healthy Michigan Plan (Medicaid Expansion)	April 2014	
Flint Medicaid Expansion (FME) Waiver	March 2016	
Long-term services and supports (LTSS)		
MI Health Link Demonstration (Integrated Care Organizations, ICOs)	March 2015	Medical Services Administration (MSA)
MI Choice Waiver Program (Prepaid Ambulatory Health Plans, PAHPs)	1992 (available in all counties October 1998)	
Program of All-Inclusive Care for the Elderly (Waiver Agencies)	BBA 1997	
Dental Programs		
• Healthy Kids Dental (Pre-paid Ambulatory Health Plan, PAHP)	October 2016	Medical Services Administration (MSA)
• Healthy Michigan Plan (Pre-paid Ambulatory Health Plan, PAHP)	April 2014	
• Pregnant Women (Pre-paid Ambulatory Health Plan, PAHP)	July 2018	
Behavioral Health Managed Care		
• Pre-Paid Inpatient Health Plans (PIHPs) /Community Mental Health Service Programs (CMHSPs)	March 2019 1115 Demonstration Waiver, 1915(i); April 2014 1115 Healthy Michigan Plan; Flint 1115 Waiver or Community Block Grant; October 2019 1915(c) Habilitation Supports Waiver; 1915(c) Children Waivers (SEDW and CWP)	Behavioral Health and Developmental Disabilities Administration (BHDDA)

To assist in this endeavor, over the course of the last several 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 addressing social determinants of health, health equity and disparities, and advanced payment methodologies. One example is the integration of medical and behavioral health services among the MHP and PIHPs for mutually served beneficiaries. MDHHS contractually required the MHPs/PIHPs to work collaboratively on shared performance metrics and establishing processes to improve care coordination and case management across programs.

Description of Michigan Medicaid Managed Care Programs
As previously described, managed care programs in Michigan are administered by the MDHHS, Medical Services Administration (MSA) and the Behavioral Health and Developmental Disabilities Administration (BHDDA).

The Medical Services Administration (MSA) administers the Medicaid program, providing health care services to eligible Michigan residents. Those include families enrolled in the Family Independence Program, other low-income families, Supplemental Security Income recipients, pregnant women, children, elderly, disabled, blind and the medically needy, who except for income, would qualify for regular Medicaid. MSA administers many other programs including the Healthy Michigan Plan and MIChild, which serves children whose families have incomes up to twice the federal poverty level. MSA also includes the Bureau of Medicaid Long Term Care Services and Supports and exercises 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 Behavioral Health and Developmental Disabilities Administration (BHDDA) administers Medicaid Waivers for people with intellectual/developmental disabilities, mental illness, serious emotional disturbance, and it administers prevention and treatment services for substance use disorders. The administration establishes the policy directions and standards for the statewide system including Community Mental Health Services Programs (CMHSP) services to children and adults, substance use prevention and treatment, autism services to children and families, problem gambling addictions services and coordinates with State Hospital Centers. BHDDA services and supports in Michigan are delivered through a county-based community mental health services programs (CMHSPs) which includes regional Community Mental Health Services Programs (CMHSPs) and 10 Pre-paid Inpatient Health Plans (PIHPs).

Mandatory and Special Health Care Needs Populations
Since 2008, the following populations, formerly voluntary or excluded are mandatorily enrolled in managed care: pregnant women (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.

Children and Youth with Special Health Care Needs
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 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 CSHCS Population is a subset of the CYSHCN population and includes children and some adults who are medically eligible for CSHCS. CSHCS provides coverage for medical/physical conditions, and typically does not cover behavioral or developmental conditions.

Defining Disability Status
Individuals who qualify for Medicaid on the basis of disability (Aged, Blind, and Disabled Group) meet 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.[1]

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.

The following Michigan Medicaid managed care programs are included in this Comprehensive Quality Strategy:

Comprehensive Health Care Program (CHCP): Medicaid Health Plans
As of January 1, 2020, MDHHS contracts with ten (10) managed care plans in targeted geographical service areas comprised of 83 counties (divided into 10 regions) and provides services to approximately 1.7 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.

1. Exhibit I - Disability, Substantial Gainful Activity And Blindness https://dhhs.michigan.gov/OLMWeb/ex/BP/Mobile/BEM/BEM%20Mobile.pdf)

MDHHS 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. See Appendix A.

Michigan's Children's Health Insurance Program (CHIP): MIChild

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 quality 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.

Children's Special Health Care Services Program

Children's Special Health Care Services (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 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.

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. See Appendix B.

Healthy Michigan Plan (Medicaid Expansion)

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.

The State began accepting applications for the Healthy Michigan Plan on April 1, 2014. Michigan has continued to experience higher than anticipated enrollment and as of July 13, 2020, managed care enrollment for the HMP population was 622,189. August 10, 2020 HMP enrollment numbers of 770,280 reflect an increase of 4,321 from the previous week. The HMP program has seen an increase of 4,000-5,000 new enrollees per week as a result of maintaining enrollment during the COVID-19 pandemic.

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. See Appendix C.

Flint Medicaid Expansion Waiver

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.[2] 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 women) and pregnant women (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 women in households with higher income levels; eliminating cost sharing and Medicaid premiums for eligible enrollees; and permitting eligible children and pregnant women above the 400% FPL and served by the Flint water system to buy into Medicaid benefits by paying premiums.

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 women) and pregnant women (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 women served by the Flint water system to gain access to needed medical, social, educational, 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. See Appendix D.

Managed Long-Term Services and Supports

Long-term services and supports (LTSS) is assistance with an individual's activities of daily living to help them remain as independent as possible. 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 plans, 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 waiver, the Program of All-Inclusive Care for the Elderly (PACE) and the MI Health Link demonstration project.

2. United State Census Bureau. *QuickFacts Flint city, Michigan.* Accessed February 1, 2019, https://www.census.gov/quickfacts/flintcitymichigan

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.

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; 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.[3] Descriptions of the MI Choice home and community-based waiver, the MI Health Link demonstration project, and the Program of All-Inclusive Care for the Elderly (PACE) are below.

MI Choice Waiver Program

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. The program allows individuals to live independently while receiving LTSS in their home or a community-based setting.

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. See Appendix E.

3. Brian Barrie, *Managed Long Term Supports and Services in Michigan Medicaid.* Michigan Department of Health and Human Services. August 1, 2017.

MI Health Link Demonstration
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.

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, 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.[4] See Appendix F.

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 thirteen PACE organizations who operate twenty-one (21) centers in lower Michigan. (Note: PACE is not a statewide service; and currently PACE services are not offered in the Upper Peninsula.) 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. See Appendix G.

4. Edith G. Walsh. RTI International. *Financial Alignment Initiative Michigan MI Health Link First Evaluation Report.* August, 2019. https://www.michigan.gov/documents/mdhhs/MI_FAI_EvalReport1_666833_7.pdf

Dental Managed Care Programs

MDHHS operates and oversees multiple managed care dental programs.

Healthy Kids Dental

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.

Pregnant Women Dental

Effective July 1, 2018, MDHHS began providing expanded access to managed care dental services for pregnant women who are eligible for the Medicaid Dental Fee-for-Service benefit and enrolled in a Medicaid Health Plan (MHP). Beneficiaries are eligible to receive managed care dental services when beneficiaries: become pregnant, are enrolled in Medicaid Dental FFS; and are enrolled in a Medicaid Health Plan (MHP).

Pregnant beneficiaries enrolled in the Healthy Kids Dental program continue to receive services through the Healthy Kids Dental program. Beneficiaries are eligible for the managed care dental benefit for the duration of their pregnancy and three months postpartum. The managed care dental benefit is administered through a contracted MHP dental vendor in the beneficiary's service area.

Healthy Michigan Plan Dental

The Healthy Michigan Plan (HMP) provides dental benefits including preventive services, x-rays, fillings, tooth extractions, dentures and partial dentures to beneficiaries. HMP dental services are provided through Medicaid Fee-for-Service dental providers and after enrollment in a MHP, dental services are provided by dental providers in the plan network. As of April 2020, 538,346 individuals were enrolled in the HMP dental program. See Appendix H.

Behavioral Health Managed Care

The Behavioral Health and Developmental Disabilities Administration (BHDDA) 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). It also administers Medicaid Waivers for people with intellectual or developmental disabilities, mental illness, serious emotional disturbance, and it administers prevention and treatment services for substance use disorders. BHDDA establishes the policy directions and standards for the statewide system including Community Mental Health Services Programs (CMHSP) services to children and adults, substance use prevention and treatment, Autism Services to Children and families, problem gambling addictions services and coordinates with State Hospital Centers.

BHDDA 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. Through a combination of different PIHP/CMHSP management and service delivery models, CMHSPs are normally contracted to directly provide or contract for the majority of direct service including evaluation, service plan development/ authorization, and certain quality improvement activities related to clinical service delivery. See Appendix I.

Medicaid Fee-for Service

While the majority of Michigan's Medicaid populations are enrolled in managed care programs, approximately twenty percent 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 MSA is responsible for the oversight of the fee-for-service populations.

Purpose of Comprehensive Quality Strategy

The 2020 - 2023 Michigan Department of Health and Human Services (MDHHS) 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 MDHHS Medicaid managed care programs. The CQS document is intended to meet the required Medicaid Managed Care and Children's Health Insurance Program (CHIP) Managed Care Final Rule (Final Rule), at 42 Code of Federal Regulations (CFR) 438.340.

To develop a comprehensive and integrated strategic quality plan, MDHHS convened a team of internal MDHHS staff representing all of the Medicaid managed care programs referenced Table 1.

A representative from the MDHHS Office of Equity and Minority Health (OEMH) 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 OEMH 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. The planning team met routinely throughout the development of this CQS and conducted multiple visioning and planning sessions.

This CQS report describes the MDHHS process for developing and maintaining a coordinated quality strategy to assess the quality of care and services that all Michigan beneficiaries receive, regardless of managed care delivery system. The CQS defines measurable goals to assess, track and trend quality improvement efforts and outcomes for all Michigan Medicaid managed care programs and their community partner organizations while adhering to managed care regulatory requirements.

Michigan's CQS strives to incorporate each managed care program's individual accountability, population characteristics, provider network, and prescribed authorities into a common strategy with the intent of guiding all Medicaid managed care programs toward aligned goals that address equitable, quality health care and services.

Michigan's CQS also strives wherever applicable to align 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. Michigan's CQS is 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).

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) for review and comment and then submitted to CMS for final approval.

Vision and Strategic Priorities
The 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, including traditionally marginalized populations. As such, Medicaid managed care programs in Michigan have been aware of the improvement needs of their populations for years. The CQS will integrate the various data-driven improvement processes across Medicaid managed care programs into commonly defined activities that pursue common goals. These data served as valid and reliable starting points for supporting the development of the MDHHS vision.

In accordance with the new gubernatorial leadership, the MDHHS vision and priorities were updated in early 2020. The new vision, key pillars and strategic priorities are outlined below.

The vision of MDHHS is to deliver health and opportunity to all Michiganders, reducing intergenerational poverty and health inequity.

This vision is supported by four strategic priorities:

1. Give all kids a healthy start
   - Improve maternal-infant health and reduce outcome disparities
   - Become a national leader in reducing lead exposure for children
   - Create a child welfare system that reduces maltreatment and becomes a model for prevention
2. Provide families with stability to escape poverty

- Expand and simplify safety net access
- Protect the gains of the Healthy Michigan Plan in implementation of work requirements

3. Serve the whole person
   - Address food and nutrition, housing, and other social determinants of health
   - Integrate services, including physical and behavioral health, and medical care with long-term support services
   - Reduce opioid and drug-related deaths
4. Use data to drive outcomes
   - Drive value in Medicaid
   - Ensure we are managing to outcomes and investing in evidence-based solutions

Although the MDHHS vision is supported by these four strategic priorities, the CQS activities align primarily with MDHHS's commitment to give all kids a healthy start and to serve the whole person. In accordance with State and Federal laws and regulations, the CQS follows the principles of quality measurement, monitoring, and improvement. Therefore, the CQS is functionally aligned with MDHHS's commitment to being data-driven and evidence-based.

MDHHS is united by a common desire to improve the health and welfare of the people of the State of Michigan and address the challenges facing the state. Michigan Medicaid has chosen to forge a path toward population health improvement on behalf of the people they serve. Fundamental to the concept of population health improvement is a commitment to health equity. Overall population health cannot be measured in a positive light unless and until disparities experienced by subpopulations are addressed. To meet this goal, Michigan Medicaid has collaboratively identified and agreed upon CQS goals and objectives within this document that pursue an integrated framework for both overall population health improvement as well as commitment to eliminating unfair outcomes within subpopulations in Medicaid managed care.

In alignment with the MDHHS vision, all Medicaid managed care programs in Michigan are committed to health equity. While each program area has been committed to providing Michigan residents with access to affordable, integrated, high-quality health care and services including medical, dental, mental health, substance use treatment services and long-term care, this commitment is being broadened to incorporate a focus on health equity.

Michigan strives to align the state's CQS with the National Quality Strategy (NQS). The CMS Quality Strategy is built on the NQS and pursues and aligns with the NQS three aims and six priorities. Aligning with the NQS enables Michigan to develop the CQS with a purposeful approach, focusing on population health and engaging in continuous improvement consistent with national efforts. It also allows Michigan to mindfully improve health and increase quality improvement efforts for special populations, drive disparities reduction, support integrated care, foster value-based delivery models, and identify gaps in areas such as community engagement.

As a result, 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.

Michigan Comprehensive Quality Strategic Plan Aims, Goals, and Objectives
Michigan Medicaid managed care programs are committed to continuous quality improvement and is dedicated to supporting the health and well-being of Michigan residents.

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

- 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 opportunities and improve outcomes.

The Office of Equity and Minority Health (OEMH) is actively engaged in the development of the CQS goals and objectives to ensure a persistent and continued focus on health equity and eliminating health disparities among Michigan's populations of color. OEMH activities support programs and policies to address social determinants of health that contribute to health inequities for racial and ethnic minority populations in Michigan. This includes development of MDHHS prevention and health service delivery strategies to improve health outcomes for minority populations. OEMH also facilitates implementation of culturally and linguistically appropriate health services throughout MDHHS and has launched online health equity training for MDHHS staff to enhance understanding of health equity and health disparities, factors that contribute to health inequities, populations that are most affected, the impact of health inequities.

The MDHHS CQS goals are to:

Goal #1: Ensure high quality and high levels of access to care.
Objectives:

1.1 Ensure outreach activities and materials meet the cultural and linguistic needs of the managed care populations.
1.2 Assess and reduce identified racial disparities.
1.3 Implement processes to monitor, track and trend the quality, timeliness and availability of care and services.
1.4 Ensure care is delivered in a way that maximizes consumers health and safety.
1.5 Implement evidence-based, promising, and best practices that support person-centered care or recovery-oriented systems of care.

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

2.1 Support self-determination, empowering individuals to participate in their communities and live in the least restrictive setting as possible.

2.2 Facilitate an environment where individuals and their families are empowered to make healthcare decisions that suit their unique needs and life goals.
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.
2.4 Encourage community engagement and systematic referrals among health care providers and to other needed services
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.

Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external).
Objectives:
3.1 Establish common program-specific quality metrics and definitions to collaborate meaningfully across program areas and delivery systems.
3.2 Support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations.
3.3 Promote the use of and adoption of health information technology and health information exchange to connect providers, payers and programs to optimize patient outcomes.

Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes.
Objectives:
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.
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.
4.3 Promote and ensure access to and participation in health equity training.
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.
4.5 Expand and share promising practices for reducing racial disparities.
4.6 Collaborate and expand partnerships with community-based organizations and public health entities across the state to address racial inequities.

Goal #5: Improve quality outcomes and disparity reduction through value-based initiatives and payment reform.
Objectives:
5.1 Promote the use of value-based payment models to improve quality of care.
5.2 Align value-based goals and objectives across programs.

Michigan's CQS goals align with the **NQS three aims: *better care, healthy people and communities, and affordable care*.**

Table 2: **Alignment with National Quality Strategy**

MI Medicaid CQS Managed Care Program Goals	MDHHS Strategic Priorities	Objectives
Goal #1: Ensure high quality and high levels of access to care		
NQS Aim #1 Better Care MDHHS Pillar #1: Give all kids a healthy start.	Expand and simplify safety net access	**Objective 1.1:** Ensure outreach activities and materials meet the cultural and linguistic needs of the managed care populations.
		Objective 1.2: Assess and reduce identified racial disparities.
		Objective 1.3: Implement processes to monitor, track and trend the quality, timeliness and availability of care and services.
		Objective 1.4: Ensure care is delivered in a way that maximizes consumers health and safety.
		Objective 1.5: Implement evidence-based, promising, and best practices that support person-centered care or recovery-oriented systems of care.
Goal #2: Strengthen person and family-centered approaches		
NQS Aim #1 Better Care MDHHS Pillar #3: Serve the whole person.	Address food and nutrition, housing and other social determinants of health Integrate services, including physical and behavioral health, and medical care with long-term support services	**Objective 2.1:** Support self-determination, empowering individuals to participate in their communities and live in the least restrictive setting as possible.
		Objective 2.2: Facilitate an environment where individuals and their families are empowered to make healthcare decisions that suit their unique needs and life goals.
		Objective 2.3: Ensure that the social determinants of health needs and risk factors are assessed and addressed when developing person-centered care planning and approaches.
		Objective 2.4: Encourage community engagement and systematic referrals among health care providers and to other needed services.
		Objective 2.5: Promote and support health equity, cultural competency, and implicit bias training for providers to better ensure a network-wide, effective approach to health care within the community.
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external)		
NQS Aim #1 Better Care MDHHS Pillar #3: Serve the whole person.	Address food and nutrition, housing and other social determinants of health	**Objective 3.1:** Establish common program-specific quality metrics and definitions to collaborate meaningfully across program areas and delivery systems.
		Objective 3.2: Support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations.

	Integrate services, including physical and behavioral health, and medical care with long-term support services	**Objective 3.3:** Promote the use of and adoption of health information technology and health information exchange to connect providers, payers and programs to optimize patient outcomes.
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes		
NQS Aim #1 Better Care MDHHS Pillar #1: Give all kids a healthy start. MDHHS Pillar #3: Serve the whole person.	Improve maternal-infant health and reduce outcome disparities Address food and nutrition, housing and other social determinants of health Integrate services, including physical and behavioral health, and medical care with long-term support services	**Objective 4.1:** Use a data-driven approach to identify root causes of racial and ethnic disparities and address health inequity at its source whenever possible.
		Objective 4.2: Gather input from stakeholders at all levels (MDHHS, beneficiaries, communities, providers) to ensure people of color are engaged in the intervention design and implementation process.
		Objective 4.3: Promote and ensure access to and participation in health equity training.
		Objective 4.4: Create a valid/reliable system to quantify and monitor racial/ethnic disparities to identify gaps in care and reduce identified racial disparities among the managed care populations.
		Objective 4.5: Expand and share promising practices for reducing racial disparities.
		Objective 4.6: Collaborate and expand partnerships with community-based organizations and public health entities across the state to address racial inequities.
Goal #5: Improve quality outcomes and disparity reduction through value-based initiatives and payment reform		
NQS Aim #3 Affordable Care MSHHS Pillar #4: Use data to drive outcomes.	Drive value in Medicaid Ensure we are managing to outcomes and investing in evidence-based solutions	**Objective 5.1:** Promote the use of value-based payment models to improve quality of care.
		Objective 5.2: Align value-based goals and objectives across programs.

Establishing Comprehensive Quality Strategy Performance Measures

During the development of the CQS, the MDHHS internal visioning team of Medicaid managed care program staff (Table 1) discussed establishing a common set of performance measures to address the required Medicaid Managed Care and CHIP Managed Care Final Rule, (CFR) § 438.340. Although each of the Medicaid programs

have established performance metrics and monitoring, they are specific to the individual program and the populations served. After discussion and review of existing program measures, the team identified four common domains:

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

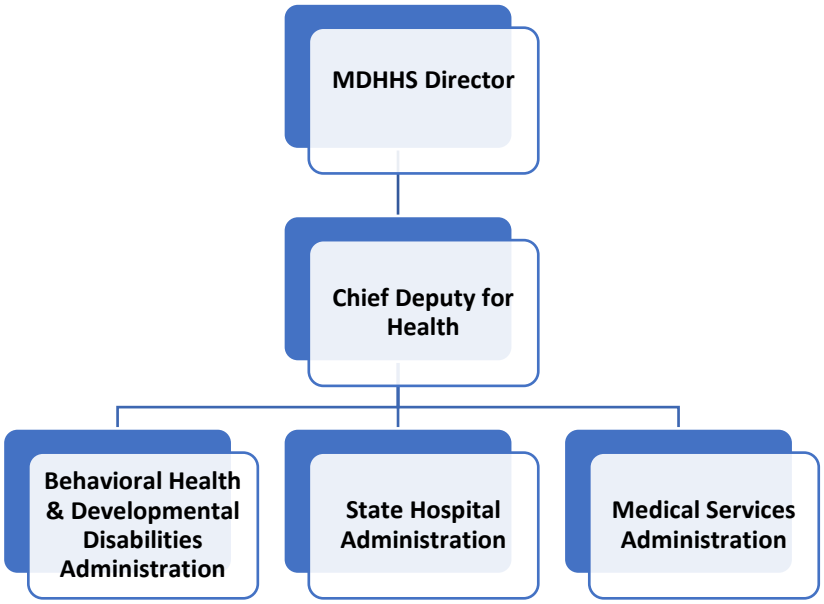
These domains address the required State-defined network adequacy and availability of services standards and take into consideration the health status of all populations served by the MCOs, PIHPs, and PAHPs in Michigan.

While conversations were initiated to identify a set of common performance measures, the team acknowledged that this work has only just begun, and the team will need to exert continued and persistent efforts moving forward to accomplish this goal. Team members agreed that a key priority is to identify key metrics across all programs that will drive quality of care and services for Michigan Medicaid managed care program beneficiaries.

Individual program measures and standards are outlined in the managed care program Fact Sheets which are appendices to this document, and described in Sections IV and V.

MDHHS Quality Management and Improvement Structure

Managed care programs in Michigan are administered by the MDHHS, Medical Services Administration (MSA), the Behavioral Health and Developmental Disabilities Administration (BHDDA) and the State Hospital Administration. MSA, BHDDA and the State Hospital Administration are under the direction of the Chief Deputy for Health who directly reports to the MDHHS Director.



MSA and BHDDA are comprised of bureaus and divisions that have a direct impact on the care and services provided to Medicaid beneficiaries. In addition, each division has an administrative director and associated staff.

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.

Committees

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., Medicaid Health Pans, Integrated Care Organizations, CMHPs, PIHPs) and senior leadership from both MDHHS and the organization/entity in addition to health plan participants and families and community stakeholders/partners. Refer to Table 3 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, Office of Equity and Minority Health (OEMH), Department of Human Services, Michigan Department of Education/Part C/Early On, and Public Health.

Table 3: 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 Advisory Committee (MHP-CAC)	The MHP-CAC oversees the development and implementation of the 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	The MHP-CAC is comprised of medical or quality improvement 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.	Quarterly

	priorities and addresses common areas of clinical and service delivery.		
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	The Local Consumer Advisory Teams are comprised of participants and waiver agencies.	

	discuss opportunities and program improvement.		
MI Choice Steering Committee	The Steering Committee establishes the agenda and work of the QMC.	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 MSA, 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 MSA.	
Program for All-Inclusive Care for the Elderly (PACE)			
PACE Directors Meetings	PACE Program oversight is conducted by both CMS and MDHHS.	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	Local PACE organizations establish one or more committees, with community input. Participants include representatives from each PACE organization.	

	end-of-life issues and implement the Patient Self-Determination Act.		
Participant Advisory Committee	The Participant Advisory Committee provides advice to the governing body on matters of concern to participants. Participants and representatives of participants must constitute a majority of the membership of this committee.	The Participant Advisory Committee includes participants and representatives of participants; these individuals must constitute a majority of the membership of this committee.	
Behavioral Health & Developmental Disabilities Administration (BHDDA)			
BHDDA Quality Improvement Council	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
Recovery-Oriented System of Care Transformation Steering Committee	The Recovery-Oriented Systems of Care Transformation Steering Committee assists in the develop of expectations for systems change. The recovery-oriented system of care supports an individual's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports.	The Transformation Steering Committee includes representatives from OROSC, the PIHPs, provider organizations, universities, community stakeholders and individuals with lived experience.	

Quality Strategy Effectiveness Review and Evaluation

To support ongoing collaboration and continued integration of the CQS goals and objectives across Medicaid managed care programs, the internal MDHHS team of key program staff will continue to meet quarterly under the direction of key MDHHS leadership. The CQS MDHHS team will review progress toward established CQS goals and objectives, continue the visioning and integration process, and identify opportunities for improvement and collaboration across programs.

In addition, managed care program staff will assess progress toward meeting both individual program performance and the CQS goals and objectives at least annually. These reviews are based on interim program data at a plan, state and federal level.

MDHHS intends to conduct a formal comprehensive assessment of performance against CQS performance objectives on an annual basis. Findings will be summarized in the Michigan Medicaid Comprehensive Quality Strategy Annual Effectiveness Review, which drives program activities and priorities for the upcoming year and identifies modifications to the CQS. The CQS Annual Effectiveness Review will be submitted to the **Medical Care Advisory Council (MCAC)** for formal review and approval. If significant changes are required (which Michigan defines as changes to program priorities, goals, or objectives), the CQS will be updated, reapproved at the state level, and resubmitted to CMS.

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 MSA and BHDDA committees (referenced above in Table 3) serve as the point of integration for quality improvement activities. Managed care programs are also integrated with other state programs and departments including but not limited to the Department of Human Services, MI Children's Services Agency, Division of Maternal & Infant Health, Child and Adolescent Health Center Program, Housing and Homeless Services Division, Public Health and the Department of Corrections.

MDHHS also 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 4**. Defined metrics and applicable performance goals are established by each managed care program.

Table 4: 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 Visits
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 HMP Dental

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

Definition of Special Health Care Needs

The Children's Special Health Care Services (CSHCS) population has been enrolled in managed care since October 2012. 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 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 CSHCS population is a subset of the CYSHCN population and includes children and some adults who are medically eligible for CSHCS. CSHCS provides coverage for medical/physical conditions, and typically does not cover behavioral or developmental conditions.

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

The requirement to reduce disparities is codified in federal and state law[5,6,7,8.] Michigan Medicaid is required to monitor the quality and appropriateness of the healthcare services delivered by participating Medicaid health plans. 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." Disparities assessment, identification, and reduction have been priorities for Michigan Medicaid for several years.

MDHHS has a longstanding history of addressing racial and ethnic disparities. As early as 2005 the Medicaid Managed Care Plan Division participated in initiatives to identify racial and ethnic disparities for a number of measures. In 2008, Michigan Medicaid was awarded a grant by the Center for Health Care Strategies (funded by the Robert Wood Johnson Foundation) to participate in the three-year initiative, Reducing Disparities at the Practice Site Project focused on six high-volume Medicaid practices in Southeast Michigan where diabetes-related HEDIS® measures were tracked by race and ethnicity across time at the participating practices. In addition, between 2008 and 2010, the Medicaid Health Plans were required to conduct an annual Performance Improvement Project (PIP) specifically aimed at reducing a disparity in a population using a quality measure.

As a continuation of previous efforts to ensure compliance with federal and state laws and to provide high-quality healthcare for all Medicaid Health Plan enrollees, the Medicaid Managed Care Plan Division developed the Medicaid Health Equity Project. In early 2010, an initial set of measures was agreed upon and specifications were developed. The purpose of the Medicaid Health Equity Project is to promote health equity by establishing a system to monitor racial and ethnic disparities within the managed care population. The Project allows MDHHS to identify priority areas for quality improvement initiatives related to health disparities. Over the past five years, the set of measures and data analysis has evolved and currently includes fourteen (14) HEDIS® measures in the areas of women's adult and pregnancy care, child and adolescent care, access to care, living with illness and health plan (race/ethnicity) diversity of membership.

Efforts or Initiatives to Address Determinants of Health

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 into quality assessment and improvement processes.

5. Balanced Budget Act of 1997. 42 CFR 438.206(e)(2). Cultural Considerations
6. Patient Protection and Affordable Care Act, PUBLIC LAW 111–148, Sec. 1557
7. Patient Protection and Affordable Care Act, PUBLIC LAW 111–148, Sec. 4302
8. Michigan Compiled Laws, 2006 PA 653. Signed by Gov. Jennifer M. Granholm on January 8, 2006

Analysis of social determinants of health 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.

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).

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. This legislation called for the Secretary of the U.S. Department of Health and Human Services (HHS) to identify and publish an initial core set of children's health care quality measures for voluntary use by state programs administered under Titles XIX and XXI, health insurance issuers, managed care entities, and providers of items and services under Medicaid and CHIP.

Michigan Medicaid began voluntarily reporting the national Child and Adult Core Set Measures in 2013. Michigan was also one of twenty-six states selected by CMS to participate in the Adult Medicaid Quality (AMQ) Grant Program: *Measuring and Improving the Quality of Care in Medicaid*. This two-year grant program was designed to support state Medicaid agencies in developing staff capacity to collect, report, and analyze data on the Initial Core of Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Initial Core Set). Michigan used Year 1 and 2 grant funds to support the development, collection, analysis, and reporting of the Adult Core Set measures enabling MDHHS Medicaid staff to extract real-time data from the warehouse to drive performance improvement. Michigan continues to successfully extract, stratify, and report administrative data for the Adult and Child Core Set Measures. MDHHS coordinated this component of the grant reporting with the Medicaid Health Equity Project described earlier this section in which data were stratified by Medicaid managed care and Fee-for-Service, Healthy Michigan Plan, and by health plan. MDHHS continues to strengthen internal capacity to generate and report the Child and Adult Core Set Measures.

The MI Health Link Integrated Health Organizations (ICOs) collect and submit timely data or a subset of the Adult Core Quality Measures under the 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.

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.

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/subpopulations 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 operations contractual requirements.

Member and provider surveys

Medicaid managed care programs either contractually require and/or conduct beneficiary satisfaction surveys (Table 4). Beneficiary feedback may also be obtained through focus groups, interviews and through community partner organizations such as town halls.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a set of survey tools developed to assess patient satisfaction with their health plan. Developed jointly by the Agency for Healthcare Research and Quality (AHRQ) and the National Committee for Quality Assurance (NCQA), the CAHPS surveys are the most comprehensive tool available for assessing consumers' experiences with their health plans. The survey results are an important component of Medicaid program management and oversight.

To better understand consumer perception of quality, MDHHS and the managed care programs or individual health plans contract with a certified CAHPS® vendor, Health Services Advisory Group, Inc. (HSAG), to administer the CAHPS® survey to their respective populations.

The MI Choice program contracts with a third-party vendor to conduct participant satisfaction and quality of life surveys. The CAHPS Home and Community-Based Services Survey (HCBS) survey is used to assess enrollee satisfaction with the MI Choice program. The vendor assures a statistically significant sample from each waiver agency and analyzes the data for any trends or possible system improvements that can be made locally or statewide. The analysis is provided to MDHHS and waiver agencies to use for quality improvement initiatives.

MI Health Link uses CAHPS surveys and RTI International focus groups and stakeholder interviews to garner enrollee satisfaction with the program. MI Health Link administers both the Medicare Advantage Prescription Drug and Adult Medicaid CAHPS surveys for its general population; the CAHPS Home and Community-Bases Services (HCBS) Survey; and the Medicare Health Outcomes Survey (HOS). Qualitative research regarding the experience of MI Health Link beneficiaries is also conducted by Alan Newman Research on behalf of CMS in June of 2019.

Managed care programs administering CAHPS® surveys are outlined in Table 5.

Table 5: Medicaid Managed Care Programs Administering CAHPS

Medicaid Managed Care Plan	Population	Survey Instrument	Report Year
Medical Services Administration			
Comprehensive Health Care Program (CHCP)	Adult and Child members in an MHP or FFS	Standardized CAHPS 5.0 Adult and Child Medicaid Health Plan Survey with the HEDIS® supplemental item set	August 2019
Healthy Michigan Plan (HMP)	Adult HMP members	Standardized CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS® supplemental item set	October 2019
Children's Special Health Care Services (CSHCS)	CSHCS Fee-for-Service (FFS) and Medicaid Health Plan	Modified version CAHPS® 5.0 Child Medicaid Health Plan Survey with the HEDIS® supplemental item set and the Children with Chronic Conditions (CCC) measurement set	October 2019
Dental Programs	Healthy Kids Dental (HKD); and Healthy Michigan Plan (HMP)	FY20 was the first year the CAHPS Dental Plan Survey was administered for the HKD and HMP Dental programs. The standardized survey instrument selected for the Adult Healthy Michigan Plan (HMP) was the Dental Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The CAHPS® Adult Dental Survey was modified for the HKD Dental program Child Dental Survey.	2020
Managed Long-Term Services and Supports			
MI Choice	MI Choice participants	CAHPS Home and Community-Based Services (HCBS) Survey	2019
Mi Health Link	Adult Medicare/ Medicaid members	Medicare Advantage Prescription Drug CAHPS with 10 supplemental questions (added by RTI)	2019
		CAHPS 5.0 Adult Medicaid Health Plan Survey with HEDIS® supplemental item set	2019

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, HSAG 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.[9] Other managed care programs conduct member satisfaction surveys using a similar CAHPS survey format including the Flint Waiver evaluation.

National Core Indicators (NCI)Adult Consumer Survey
Michigan participates in the National Core Indicators (NCI) survey, a nationally recognized set of performance and outcome indicators to measure and track performance of public services for people with intellectual or developmental disabilities. Implementation of the NCI survey is done in collaboration with the PIHPs who provide the information/demographics needed to schedule and conduct the face to face surveys for the identified participants. The NCI survey, which includes approximate 60 consumer outcome indicators, provides comprehensive and statistically reliable information based on a random sample of adult service recipients.

BHDDA uses 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 BHDDA managed care performance dashboard. The indicators summarize the survey results from personal interviews with individuals with intellectual/developmental disabilities (I/DD) and the background information provided by the community mental health system. Performance indicators assess individual outcomes, health, welfare and rights (e.g., safety and personal security; health and wellness; and protection of and respect for individual rights.); and system performance (e.g., service coordination; family and individual participation in provider-level decisions; the utilization of and outlays for various types of services and supports; cultural competency; and access to services).

Integrated Satisfaction Measurement for PACE (I-SAT™) Survey
PACE centers must 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. In addition, 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). The HOS-M design is based on a randomly selected sample of individuals from each participating PACE organization. The HOS–M is a cross–sectional survey, measuring the physical and mental health functioning of beneficiaries at a single point in time. This differs from the HOS, which has a follow-up component.[10]

9. Michigan Department of Health and Human Services. Quality Checkup January 2020. https://www.michigan.gov/documents/QualityCheckupJan03_59423_7.pdf
10. Medicare Health Outcomes Survey. *Medicare Health Outcomes Survey-Modified (HOS-M) Overview.* June 25, 2020. https://www.hosonline.org/en/hos-modified-overview

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 plan performance relative to national Medicaid percentiles.

The managed care programs use the majority or a subset of HEDIS® measures when implementing quality oversight and engaging plans in performance improvement activities. The following managed care programs utilizing the HEDIS® process include the CHCP Medicaid Health Plans, CSHCS, Healthy Michigan Plan, PIHP/CMHSPs, Flint Medicaid Expansion (FME) Waiver, and MI Health Link (Table 4).

MDHHS requires plans 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 reviews, analyzes, trends, and reports HEDIS® rates internally, publicly, and to the health plan based on managed care program specifications and contractual requirements. 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).

MDHHS establishes performance levels that are specific, attainable, and are based on HEDIS® national percentiles or the Michigan Medicaid weighted average, where applicable. The PIHPs/CMHSPs are evaluated on a subset of HEDIS® measures, some jointly with the Medicaid Health Plans.

For FY 20 these joint measures include: Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence (FUA); Follow-up After Hospitalization for Mental Illness within 30 Days (FUH); Plan All-cause Readmission (PCR); and Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET).

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."* 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 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 health plan is accredited (e.g., National Committee for Quality Assurance).

Publicly Available Managed Care Program Data

The Comprehensive Health Care Program (CHCP) publishes Medicaid reports on the MDHHS web site. The publicly available reports include the Michigan Medicaid Health Equity Reports, CAHPS and HEDIS® Statewide Aggregate Reports, and the External Quality Review.

MI Choice agency information, which allows for comparison of agency performance is also available on the MDHHS web site. The information includes agency accreditation status, Compliance Determination results, beneficiary satisfaction and CAHPS survey results.

MI Health Link data is available on the Centers for Medicare & Medicaid Services (CMS) website. 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 HEDIS® and the results of surveys; state weighted averages are provided for each measure.

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 CHAPS scores, results of focus studies, submission of required reporting (e.g., financials, encounters, etc.) and shared PIHP/MHP metrics.[11]

11. Catalyst, N. E. J. M. "What Is Pay for Performance in Healthcare?." *NEJM Catalyst* 4, no. 2 (2018).

BHDDA utilizes a two-pronged approach in assessing CMHP/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.

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 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 Michigan specific measures.

Performance Monitoring Metrics/Standards

Michigan Medicaid monitors individual plan 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 on a yearly basis. Medicaid managed care contracts require plans to incorporate the performance monitoring standards into required written quality improvement plans. Performance measurement is shared with the plans during the fiscal year and may be used to compare plan performance over time to other health plans 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 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 on a year-to-year basis. 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. The purpose of the Auto Assignment Algorithm is to assign beneficiaries to plans using performance-based criteria using a defined methodology. The primary goal of the Auto Assignment 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, CAHPS performance, and new metrics developed by MDHHS uniquely for MI Health Link.

BHDDA 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 and Supporting report 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 *c*ontribute to all applicable MDHHS and CMS data quality assurance processes, that 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.

Required MCO Reporting on Performance Improvement Projects

Many of the Michigan Medicaid Health Plan contracts require health plans 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 4.) 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 plans 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, (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. Recent examples of topics covered in PIPs include addressing disparities in timeliness of prenatal care, integration of physical and behavioral health, and increased satisfaction with homecare services.

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. The technical report describes 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. To meet the External Quality Review (EQR) requirement, MDHHS contracts with the Health Status 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 4 outlines the managed care plans that conduct External Quality Review activities. Currently the Comprehensive Health Care Program (CHCP) and MI Health Link (ICO) do not exempt managed care organizations from participating in the EQR.

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.

On-Site Compliance Reviews

MDHHS conducts annual or biennial on-site compliance reviews of the Medicaid managed care plans. The compliance review includes both a desk audit and an on-site focus 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 on-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 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 compliance reviews for the ten (10) contracted Medicaid Health Plans (MHPs). The MHP annual on-site compliance review includes at least one focused study based on identified priorities such as Community Health Workers, the Maternal Infant Health Program (MIHP) home visiting program, and CSHCS. A review of dental programs was added to the FY2020 compliance review and there will be separate focus study reviews for the HKD Dental and HMP Dental programs. The dental compliance review will also assess Provider Directory Network Adequacy (accuracy, timeliness for submissions, website updates). Additionally, Secret Shopper Calls are being conducted.

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. The MDHHS BHDDA Quality Management and Planning (QMP) Site Review team 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 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. CQAR reviewers also evaluate the waiver agency's enrollment, assessment, care planning, backup plans, reassessment activities, and Critical Incident reporting.

A comprehensive compliance review is conducted on the seven MI Health Link ICOs on a three-year cycle. The review includes eleven standards: 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 Sanctions

MDHHS utilizes a variety of means to assure compliance with contractual requirements and will pursue 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 plan 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.

Section III: STATE STANDARDS

Access

MDHHS requires all managed care plans 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 plans 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 plans 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, plans 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.

Specific to the Comprehensive Health Care Program (CHCP), the Medicaid Health Plans (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. MDHHS has the sole authority to determine whether an exception will be granted. Consideration must be given to the geographic location of providers and enrollees, including distance, travel time and available means of transportation and whether the provider location provides access for enrollees with physical or developmental disabilities. To ensure adequate appointment access, plans are required to develop and comply with established standards for appointment availability and appointment wait time.

The CHCP contract also states that 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 if the health plan documents that no other network or non-network provider is accessible within the 30-minute or 30-mile travel time. Services may be authorized out of the plan's service area or out of the plan's network of providers.

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. MHPs must also 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 her choice.

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 contract with enough providers to have capacity within their network to serve 125% of anticipated service utilization. Provider lists and files are reviewed during the biennial Administrative Quality Assurance Review (AQAR). In some cases, MDHHS may grant provider network rural exceptions requests based on program requirements.

The MI Health Link Integrated Care Organizations (ICOs) must maintain a provider network sufficient to provide all Enrollees with access to the full range of Covered Services. The ICO must provide or arrange accessible care twenty-four (24) hours per day, seven (7) days per week. The ICO must guarantee that Emergency Services are available twenty-four (24) hours per day, seven (7) days per week. Each ICO's region-

specific network offers a choice of at least two providers for each provider type with sufficient capacity to accept enrollees and coverage that requires the ICO enrollee to not travel more than a 30-mile radius or for no more than 30 minutes. MI Health Link enrollees must also have a choice of at least two providers for in-home services. ICOs annually submit a list of its participating LTSS network providers that provide Medicaid related services; and must demonstrate annually that its Medicare Provider Network meets the stricter of the following Medicare standards.[12]

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.

If MDHHS grants a network exception, the plan must submit a description of how it will reasonably deliver covered services to enrollees who may be affected by the exception and how the plan will work to increase access to the provider type in the designated county or counties. Plans 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 plans to ensure reasonable accommodation for enrollees related to physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities. Plans 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).

12. United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with the State of Michigan. January 1, 2018. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MIContract01012018.pdf

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.

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.

As previously indicated, MDHHS has established provider capacity requirements for contracted health plans to maintain a network of qualified providers in sufficient numbers, mix, and geographic locations. MDHHS requires health plans to ensure adequate capacity of specialty services, ancillary services (such as durable medical equipment services) and home health services. Plans 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, plans are required to submit provider files that provide a description of the plan's 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.

Access to Care During Transitions of Coverage

Transition of care requirements for Medicaid Managed Care are defined under 42 CFR, Section (§) § 438.62 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 plan or transition from one plan 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 plans. The coverage periods for continuity of care may vary by managed care program.

Managed care plans 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.[13] The MI Health Link program is in the process of developing a formal transition of care policy.

13. Memorandum of Understanding (MOU) Between The Centers for Medicare & Medicaid Services (CMS) And The Michigan Department of Community Health Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees Demonstration to Integrate Care for Persons Eligible for Medicare and Medicaid. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MIMOU.pdf

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. Plans 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 on-site compliance visits. In addition, continuity and coordination of care are components of the mandatory Medicaid Health Plan accreditation process that requires plans to meet or exceed established standards to maintain accreditation status. In general, plans 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. Plans 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/PHIP 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. The MI Choice program utilizes Supports Coordinators to develop person-centered care plans. A written person-centered service plan (PCSP) documents issues, concerns, conditions, and specific supports and interventions needed.

14. United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with the State of Michigan. January 1, 2018. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-

and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MIContract01012018.pdf

The person-centered planning process involves families and professionals, utilizes the PCP process, promotes community living, and honors individual preferences, choices and abilities. MDHHS defines performance standards for Supports Coordination within MDHHS policy which is reviewed and amended as necessary.

Support coordinators also 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. MDHHS includes a Supports Coordination Performance Standards document as an attachment to all waiver agency provider contracts. The document prescribes acceptable standards and protocols for the provision of supports coordination services. It is reviewed and amended as necessary.

In general, Medicaid managed care programs utilize multiple technology tools such as CC360 to enable care coordination and continuity of care.

Providing Care Management Services and Other Targeted Interventions
Managed care program contracts also address Care Management Services for populations and subpopulations. For example, the Comprehensive Health Care Program (CHCP) Medicaid Health Plan contract stipulates plans must offer a robust care management program that meets NCQA and/or URAC accreditation standards to enrollees who qualify for these services, and other subpopulations 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 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.

Coverage and Authorization of Services
Managed care contracts require plans 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 plan 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 plan Authorization policy must establish timeframes for standard and Expedited Authorization Decisions. Plans 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 plan 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 plans 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. Plans 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 plans 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 health plans to be in compliance 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 plans 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. Plans 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 plans 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 plans 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. Plans 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 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]

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.

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.

Clinical Practice Guidelines

Managed care plans 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 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 plan'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.

15. United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with the State of Michigan. January 1, 2018. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MIContract01012018.pdf

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 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). MDHHS and all CHCP contracted MHPs endorse the Michigan Quality Improvement Consortium (MQIC) guidelines. MQIC is 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. In clinical areas where no MQIC guideline has been developed, MDHHS and the Medicaid Health Plans 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 health plans 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.

MDHHS or its designee (Enrollment Broker) may develop generic materials to assist potential enrollees in choosing whether to enroll in the MI Health Link Demonstration. MDHHS may collaborate with the ICO in developing ICO-specific materials including presenting information in an unbiased manner related to enrollment and/or to help enrollees seeking to transfer from one ICO to another. The information must ensure potential enrollees are informed prior to enrollment or transfer of their rights and responsibilities of participation in the Demonstration and the nature of the ICO's care delivery system, including disenrollment, and process opt-out requests. MDHHS and CMS monitor the performance of the MDHHS Enrollment Broker.

MI Choice waiver agencies assess medical/functional eligibility during an in-person interview using the Nursing Facility Level of Care (NFLOC) determination. MDHHS requires waiver agencies to put NFLOC results for all enrollments 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.

Confidentiality
Managed care programs contractually require that plans 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 plan must provide safeguards that restrict the use or disclosure of information concerning enrollees in accordance with HIPAA privacy 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 plan adherence to security and privacy standards during compliance visits.

Grievance and Appeals Systems
Contracted Medicaid managed care plans 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 plan. When a plan 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 on-site compliance visits, which includes review 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 plans are responsible for subcontractor adherence to all provisions of the plan contract. Plans 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. Plans 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) 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
Michigan's Health Information Technology strategy has included plan participation and in effect has furthered statewide adoptions and interoperability.

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 (e.g., CSHCS and behavioral health services); and receiving 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.
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/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 EHR technology through the Medicare and Medicaid Electronic Health Record (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 enrollees' 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 being used to improve the health and safety of children in foster care.[16]

The MI Health Link ICO's 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.

16. Optum. *CareConnect360 helps Michigan focus health and human services efforts on people, not programs.* https://www.optum.com/content/dam/optum3/optum/en/resources/case-studies/michigan-cc360.pdf

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 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. On an annual basis, MDHHS publishes a list of the standards and elements that will be deemed in the current compliance review activity. Refer to Appendix J for the list of the 2020 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.

In addition, MI Health Link Integrated Care Organizations (ICOs) may seek NCQA accreditation and a majority of the 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.

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

In 2017, Michigan recorded more than 2,000 opioid-related overdose deaths and more than 7,000 Michiganders have lost their lives to the opioid epidemic in the last five years. The total number of overdose deaths involving opioids has increased and prescription drug misuse is a serious problem. Neonatal Abstinence Syndrome (NAS) is also a critical concern significantly impacting the health and well-being of women and infants across the State. 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. The Medical Services Administration (MSA) actively participates in and supports Michigan's opioid efforts.

MDHHS is utilizing 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. The purpose of the SOR project is to increase access to Medication-Assisted Treatment (MAT) for the three FDA-approved medications; reduce unmet treatment need; and reduce opioid overdose-related deaths through the provision of prevention, treatment and recovery activities for Opioid Use Disorders (OUD).[17,18] In Michigan, the funding supports services for individuals at the highest risk of overdose, including offering medications to treat opioid use disorder, as well as naloxone within the criminal justice system, as well as in the Emergency Department following an overdose. The SOR project is intended to help meet the State's goal of cutting opioid overdose deaths in by half within five years.

Michigan increased funding to support interventions and implement legislative and administrative initiatives. Key activities include increasing the use of Medication Assisted Treatment (MAT), Prescription Drug Monitoring through provider use of Michigan's Automated Prescription System (MAPS) and expanding prevention and recovery programs. Prevention and recovery interventions support an expanded recovery housing and 24-hour Peer Support, Inter-Tribal Council Peer Recovery Support, statewide education and anti-stigma campaigns, and distributing Naloxone statewide.

17. MDHHS Assistance Application. Rev (1-20). https://www.michigan.gov/documents/mdhhs/Michigan_SOR_Project_Narrative_Final_648408_7.pdf
18. HHS Press Office. March 20, 2019. https://www.hhs.gov/about/news/2019/03/20/hhs-releases-additional-487-million-to-states-territories-to-expand-access-to-effective-opioid-treatment.html

Michigan also 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)

The OHH functions as the central point of contact for directing patient-centered care across the broader health care system and utilizes an interdisciplinary team of providers to work with beneficiaries to develop an individualized recovery care plan. The OHH 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 with a goal of attending to a beneficiary's complete health and social needs.

The MI Care Team primary care health homes program began in July 2016. The MI Care Team model focuses on individuals with mild-to-moderate behavioral health and physical conditions. MDHHS is currently seeking federal approval to authorize a Behavioral Health Home (BHH) model to provide comprehensive care management and coordination services to Medicaid beneficiaries with a serious mental illness or serious emotional disturbance. Similar to the other models, the BHH will function as the central point of contact for directing patient-centered care, and beneficiaries will work with an interdisciplinary team of providers to develop a person-centered health action plan. This model will elevate the role and importance of Peer Support Specialists and Community Health Workers to foster direct empathy and address the individual's health, well-being and social needs. The anticipated start date is October 2020.

The MSA Opioid Workgroup key accomplishments in 2019 include removing prior authorization requirements from buprenorphine; lowering Morphine Equivalent Daily Dose (MEDD) limit on claims; implementing contract changes to make sure managed care plans are tracking and monitoring Opioid Use Disorder; monitoring opioid use trends, and conducting Academic detailing for outlier prescribers and providing them with an opioid prescribing toolkit. MSA goals for 2020 include but are not limited to removing the copay on naloxone; lowering the limit on claims to 90 MEDD; developing joint substance use disorder care plans; and issuing an L-Letter to encourage providers to use Screening, Brief Intervention, and Referral to Treatment (SBIRT) and Medication Assisted Treatment (MAT) services for beneficiaries with indications of a substance use disorder. There are also plans for the Michigan Automated Prescription System (MAPS) to be added to the Michigan Data Warehouse. MAPS is Michigan's prescription drug monitoring program that allows prescribers to help identify patients that may be improperly seeking medication.

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.

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.

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 requires 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. 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. A brief description of plan

performance bonus information is included in the Managed Care Program Fact Sheets attached to this document.

Health Equity Reporting and Tracking

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
Both federal and state laws address the need to reduce racial/ethnic disparities in healthcare and outcomes. Federal regulations require that Medicaid plans provide services "in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds." [19] The Affordable Care Act (ACA) includes language that prohibits discrimination under any health program or activity that is receiving federal financial assistance.[20] The ACA also includes improved federal data collection efforts by ensuring that federal health care programs collect and report data on race, ethnicity, sex, primary language, and disability status.[21] 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.[22]

Disparities assessment, identification, and reduction are priorities for the Medicaid managed care programs although MDHHS acknowledges that programs are at various stages of implementation. The CQS MDHHS Visioning Team identified Goal #4.

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

- 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.
- 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.
- 4.3 Promote and ensure access to and participation in health equity training.
- 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.
- 4.5 Expand and share promising practices for reducing racial disparities.
- 4.6 Collaborate and expand partnerships with community-based organizations and public health entities across the state to address racial inequities.

19. Balanced Budget Act of 1997. 42 CFR 438.206(e)(2). Cultural Considerations
20. Patient Protection and Affordable Care Act, PUBLIC LAW 111–148, Sec. 1557
21. Patient Protection and Affordable Care Act, PUBLIC LAW 111–148, Sec. 4302
22. Michigan Compiled Laws, 2006 PA 653. Signed by Gov. Jennifer M. Granholm on January 8, 2006

Efforts or Initiatives to Reduce Disparities in Health Care

As early as 2005, Michigan Medicaid participated in grant funded projects where participating Medicaid Health Plans identified racial/ethnic disparities in a number of measures at the plan and provider level. Results were disseminated to health plans and to providers for their information. Between 2008 and 2010, MHPs were required to conduct an annual Performance Improvement Project (PIP) specifically aimed at reducing a disparity in a population using a quality measure. As a continuation of these efforts to ensure compliance with federal and state laws and to provide high-quality healthcare for all MHP enrollees, the CHCP Quality Improvement and Program Development Section of the Medicaid Managed Care Plan Division developed the *Medicaid Health Equity Project*. The purpose of the *Medicaid Health Equity Project* is to promote health equity by establishing a system to monitor racial and ethnic disparities within the managed care population. The Project also allows MDHHS to identify priority areas for quality improvement initiatives related to health disparities. As a means of measuring quality consistently across plans and to facilitate comparison across states, audited Health Effectiveness Data and Information Set (HEDIS®) data was utilized. The following subset of HEDIS® measures broken down by race/ethnicity are included in the Health Equity Project (Table 6).

Table 6: Medicaid Health Equity Project Metrics

<table>
<tr>
<td rowspan="3">Women-Adult Care and Pregnancy
• Breast Cancer Screening
• Cervical Cancer Screening
• Chlamydia Screening (Total)
• Post-Partum Care

Child and Adolescent Care
• Childhood Immunizations Combo 3
• Adolescent Immunizations Combo 1
• Lead Screening in Children
• Well Child Visits 3-6 years</td>
<td>Access to Care
• Children and Adolescents’ Access to Care (25 months to 6 years)
• Adult Access to Preventive/Ambulatory Health Services (20-44 years)

Living with Illness
• Comprehensive Diabetes Care- HbA1c
• Comprehensive Diabetes Care - Medical Attention for Nephropathy
• Comprehensive Diabetes Care - Eye Exams</td>
</tr>
<tr>
<td>Health Plan Diversity</td>
</tr>
<tr>
<td>Race/Ethnicity Diversity of Membership</td>
</tr>
</table>

The MHPs are required to fully participate in the Medicaid Health Equity Project and any associated initiatives, and report all required information to MDHHS within specified timelines.

Targeted Interventions for Subpopulations Experiencing Health Disparities
Managed care programs encourage and/or contractually require plans to offer evidence-based interventions that have a demonstrated ability to address Social Determinants of Health and reduce health disparities to all individuals who qualify for those services. Plans should collaborate with high volume primary care and specialty practices to develop, promote and implement targeted evidence-based interventions. 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. The MHPs must measure and report annually to MDHHS 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 such as transportation, housing, food access, unemployment, or education level, number enrollees participating in additional in-person support services such as Community Health Worker, patient navigator, the Maternal Infant Health Program (MIHP), or health promotion and prevention program delivered by a community-based organization.

Managed care plans have also begun to initiate contractual requirements to incorporate social determinants of health into processes for analyzing data to support population health management. Data analysis may utilize available information such as claims, pharmacy, and laboratory results; supplemented by utilization data, health risk assessment (HRA) results and eligibility status (e.g., children in foster care, persons receiving Medicaid for the blind or disabled, CSHCS). 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, 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 a community-based organization (adult/family shelters, schools, foster homes).

Healthy Living/Population Health Strategies
An individual's health is shaped profoundly 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.

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.

The CHCP requires the Medicaid Health Plans to participate in formal population health initiatives. Most recently, housing stability was identified as a concern associated with high and super Emergency Department utilizers; and homelessness was the focus of a 2016 engagement between MDHHS and the National Governor's Association (NGA) to determine the relationship between housing stability and healthcare costs. In 2018, MDHHS launched a pilot project to address the integration between healthcare, housing, and Medicaid. The purpose of the housing population health management intervention is to improve the health of the Michigan Medicaid population and to address Social Determinants of Health.

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.

Healthy behaviors are a key components of the Healthy Michigan Plan (HMP). MDHHS in consultation with stakeholders, developed a Healthy Behaviors Incentives Program specific to the Healthy Michigan Plan managed care population. The purpose of the Healthy Behaviors Incentives Program is to encourage beneficiaries to maintain and implement healthy behaviors as identified in collaboration with their health care provider primarily via a standardized health risk assessment (HRA). The MDHHS HMP HRA, which can be used with all plan populations, assesses a broad range of health issues and behaviors including, but not limited to, physical activity, nutrition, alcohol, tobacco, and substance use, mental health and Influenza vaccination. Members are encouraged to complete the HRA at an annual primary care preventive visit where identified risks, and member health concerns and readiness to change health behaviors are discussed. MHPs are required to identify and conduct outreach and education to members who have identified healthy behaviors goal(s) and provide ongoing support in accordance with MDHHS policy. Health plans must also have at least two wellness and/or population health management programs to meet the contractual requirements of the Healthy Behaviors Incentive Program.

Integration with Public Health

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. 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.

The 2015 merger of the former departments of Community Health and Human Services creating the MDHHS, promoted more effective and efficient protections to assure and strengthen Michigan's families. The merger aligned family and health-related services and administrative functions, and integrated service delivery programs. The re-organization further advanced Michigan's goal to integrate medical and public health priorities, including physical and behavioral health, and medical care with long-term support services.

In September 2019, MDHHS announced the release of the **2020-2023 Mother Infant Health & Equity Improvement Plan (MIHEIP).** 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. This work follows several Infant Mortality Plans, building off years of successful work across Michigan, and addressing the gaps which have persistently left behind the most vulnerable groups of women and infants across our state. The Plan is intended to address the underlying causes of maternal and infant mortality and acknowledge the underlying drivers of inequity, including poverty, racism, and discrimination. 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.

Examples of Medicaid and public health program intersection include the Medicaid Health Plan Low Birth Weight (LBW) project. The multi-year LBW Pay for Performance initiative supports and aligns MDHHS efforts to promote health equity in maternity care and infant care. It also aligns with the Medicaid Health Equity Project to promote health equity and monitor racial and ethnic disparities within the managed care population. 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.[23] 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.

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.

Managed care program contracts also 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.

23. Michigan Department of Health and Human Services. *Mother and Infant Health and Equity Improvement Plan.* https://www.michigan.gov/documents/infantmortality/FINAL_MIHEIP_665052_7.pdf

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.

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.

Enhancements to the data warehouse as a result of the CMS Adult Medicaid Quality (AMQ) grant have allowed MDHHS staff to query the system at the desk level enhancing data analysis and the identification of opportunities for improvement. In addition, the AMQ grant allowed MDHHS to create the infrastructure to move forward with the development of a data mart for the purpose of implementing a Dashboard.

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 new 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 more 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.

Additionally, MDHHS has continued 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.

State Innovation Model (SIM) and the Patient-Centered Medical Homes (PCMH)Initiative

In 2015, the Centers for Medicare and Medicaid Services (CMS) awarded the State of Michigan funding to test and implement an innovative model for delivering and paying for health care in the state. The award, made through the CMS State Innovation Model (SIM) initiative, was based on a plan submitted by the state in 2014, "Reinventing Michigan's Health Care System: Blueprint for Health Innovation."

MDHHS organized the work of implementing its SIM initiative under three main umbrellas: Population Health, Care Delivery, and Technology. The Population Health component has at its foundation community health innovation regions, or CHIRs (pronounced "shires"), which are intended to build community capacity to drive improvements in population health. The Care Delivery component encompasses a patient-centered medical home (PCMH) initiative and the promotion of alternative payment models. The Technology component is where the state is leveraging its statewide infrastructure and related health information exchange initiatives to enable and support advances in population health and payment and care delivery strategies.

Recognizing that 20 percent of the factors that influence a person's health outcomes are related to access and quality of care while socioeconomic, environmental, and behavioral factors account for 80 percent; the state has focused efforts in each of these areas on developing and strengthening connections among providers of clinical care (e.g., physician offices, health systems, and behavioral health providers) and community-based organizations that address social determinants of health. Clinical-community linkages are emphasized heavily in the state's guidance for both CHIRs and PCMHs participating in the SIM initiative. Alternative payment models can provide a way for clinical providers to receive financial support for connecting patients to community resources, and the state's technology solutions support the exchange of health information among partners.

The SIM PCMH Initiative was executed as a demonstration that ran in parallel to other Michigan Medicaid operations as opposed to being embedded within a specific operational area, such as Michigan's managed care program. While participation in a demonstration afforded MDHHS the ability to drive administrative oversight of the program in a comprehensive manner and ensure limited administrative burden on the provider community, there were consequences in operationalizing in such a manner. Direct oversight required diligent coordination across many Medicaid program activities such as enrollment and eligibility, claims processing, managed care oversight, and actuarial. It

additionally added in all aspects of provider program oversight such as the design and implementation of a program model, compliance activities, training and technical assistance, the development of direct communication pathways, and administrative reporting functions. Therefore, as MDHHS approached transitioning the program into daily operations, it was apparent that it would not be possible to maintain all operational practices considering functional responsibilities would cross many operational areas with limited opportunities for coordinated oversight and management. Therefore, MDHHS identified key aspects of the program that were integral to sustaining the momentum of transformed primary care in Michigan and aligned those functionalities with the most appropriate operational area for future program oversight. The operational transition has meant that many of the successful practices established within the SIM PCMH Initiative have been replaced by existing functional practices and alternative mechanisms for oversight, such as leveraging Medicaid health plans as operational and administrative partners to manage provider relations and contracting through value-based purchasing agreements.

Post SIM, PCMH Sustainability

MDHHS recognizes that provider-delivered care management and care coordination (CMCC) services are foundational to healthcare transformation efforts and whole-person care. Understanding that Care Management and Care Coordination (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 SIM 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.

Beyond the positive impact for patients, MDHHS recognizes the value CMCC programs can bring to the Medicaid provider community. Whether the draw is to provide opportunities to extend the care team, offer greater insight to patient progress, expand opportunities to engage patients, improve patient outcomes, or create opportunities to leverage reimbursement to deliver efficient care, the provider community is essential to Michigan's CMCC progress.

Leveraging both the evidence of Medicaid costs savings from the MiPCT demonstration and the experience of addressing wholistic needs of the Medicaid population within SIM, MDHHS has committed to maintain a method of supporting provider delivered care management. Therefore, in 2020, MDHHS has established a process within the Michigan Managed Care program to sustain capacity in care management, enhanced access, and continued care transformation. This has been accomplished through close partnership with Michigan's Medicaid Health Plans (MHPs) by building upon the foundational elements of the PCMH model implemented within the past demonstrations and integrating within Alternative Payment Models (APMs) that focus on both the PCMH process (including Care Management and Coordination) and demonstrated quality and outcomes.

Within the 2020 model, 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. MDHHS acknowledges that there have been years of

demonstrations that highlight the advantages of Care Management and Coordination to the Medicaid population in Michigan, however, to date most of these services have not been available to patients outside of the limited pilot populations. In the 2020 model, these services will be available to populations beyond the historic MiPCT and SIM pilots, allowing MDHHS to continue to monitor the application of CMCC across the Medicaid population and design mechanisms to advance Managed Care programs to meet the needs of our collective patients. MDHHS will continue stakeholder engagement by leveraging standing meetings with the MHPs to support continued discussions on provider-delivered care management and coordination as a mechanism to achieve population health goals, APM penetration, workforce development/expansion (via CHW requirements), and address non-clinical determinants of health. The following forums will be used for these purposes:

- Care Management Directors
- Quality Improvement Directors
- MHP/MDHHS Operations Workgroup
- Bi-monthly Administrative Meeting
- MHP/MDHHS Chief Executive Officer (CEO) meetings

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 K.

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.

24. MDHHS. Michigan State Plan. April 1, 2020. http://www.mdch.state.mi.us/dch-medicaid/manuals/MichiganStatePlan/MichiganStatePlan.pdf

To better understand the quality performance of the SNAF program and determine the improvement areas, MDHHS generated 16 quality measures (refer to Appendix K). Some of these measures assess the potential statewide impact of the SNAF program, such as "Children and Adolescents' Access to Primary Care Practitioners." 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 about 50% of the adult population in Michigan Medicaid's program. In addition, Medicaid pays for about 50% 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. 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 L). 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 four Prevention Quality Indicators (PQI) measures; and a pregnancy care measure related to cesarean section procedures (refer to Appendix L).

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. Women make up about 50% of the adult population in Michigan Medicaid's program. In addition, Medicaid pays for about 50% of the births in Michigan. 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. 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

Michigan has long-been a national leader in behavioral health. The MDHHS is eager to build on this history and expertise, in collaboration with stakeholders across the state, to strengthen Michigan's Medicaid-funded behavioral health system. 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 has implemented many interventions that have made a positive impact on the care, services and outcomes for beneficiaries. This section will highlight 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 plans continues to demonstrate success, with contracted plans meeting and exceeding established requirements in the areas of infrastructure, administrative practices, access and availability, coverage and benefits, quality assessment and improvement, and utilization. Plans actively participate statewide assessment methods (e.g., HEDIS® and CAHPS/member surveys, performance improvement projects, performance monitoring, compliance visits) and External Quality Review processes. Plans also actively engage in MDHHS and CMS performance bonus activities which incentivize performance and quality improvement (Refer to Table 4.)

HEDIS® performance levels for Michigan Medicaid plans are consistently high and meet established thresholds based on national percentiles. Similarly, overall CAHPS reports show high performance and member satisfaction with the plan programs. Mandated External Quality Review assessments, which evaluate plan 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, is high. The 2018–2019 External Quality Review Technical Report for Medicaid Health Plans indicates 28 of the 64 statewide HEDIS® rates with available national benchmarks demonstrated improvement from HEDIS® 2018 to HEDIS® 2019. Additionally, 14 measure rates from HEDIS® 2018 to HEDIS® 2019 indicated a statistically significant improvement. Improvement was demonstrated in multiple domains including Child & Adolescent Care, Access to Care, Obesity, and Living With Illness; and multiple domains (Child & Adolescent Care, Women— Adult Care, Access to Care, Obesity, Living With Illness, and Utilization) had one or more statewide rates that performed at or above the 75th National HEDIS® percentile. In addition, MHPs are focusing efforts on improving the timeliness of prenatal care and eliminating disparities related to timely receipt of prenatal care through implementation of the required PIP.

The 2018–2019 External Quality Review Technical Report for Prepaid Inpatient Health Plans Community Mental Health Services Programs (CMHSPs)/Pre-paid Inpatient Health

Plans (PIHPs) also demonstrates areas of high performance in managing and adhering to expectations established for the Medicaid program through State and federal requirements. PIHP performance measure activities also reflect that statewide average scores exceeded all corresponding MDHHS-established performance standards related to providing high-quality, accessible, and timely behavioral health and substance use disorder services. PIHP participation in Performance Improvement Projects (PIPs), further focus efforts on specific quality outcomes to improve the health outcomes of members.

The 2018–2019 External Quality Review Technical Report for the MI Health Link Integrated Care Organizations (ICOs) demonstrates moderate to high performance in managing and adhering to most of the expectations established for the Medicaid program through State and federal requirements. Specifically, the overall statewide average performance score for the 11 program standards reviewed was 81 percent, with two standards scoring 95 percent or above; and all ICOs were able to successfully report data for the identified Core Measures. Further, through their participation in QIPs, the ICOs are focusing efforts on quality outcomes related to following up with a mental health provider after hospitalization, with an end goal to improve the health outcomes of MI Health Link members.

The 2019 External Quality Review Technical Report for the MI Choice Wavier demonstrates moderate to high performance in managing and adhering to most of the expectations established for the Medicaid program through State and federal requirements. The overall statewide average for MI Choice performance standards reviewed was 97% percent. Out of 38 performance measures, 34 performance measures were above 95% and only 4 were below 95%. Through their participation in QIPs, the Waiver agencies are focusing their efforts on quality outcomes with the goal of improving outcomes for MI Choice participants.

Statewide CAHPS Home and Community-Bases Services Survey results for the MI Choice program demonstrated high satisfaction with the program across multiple domains that address issues such as unmet needs, physical safety, helpfulness of the case manager, quality of the patient-caregiver relationship, and the respondent's feelings of self-determination. Ten of the eleven domains scored above 90%. Enrollees indicated high satisfaction with having their needs met, 95.4% knew about their service plan, and ratings for the help they receive from personal assistance staff, homemakers and case managers were at 90% or above. In addition, over 90% indicated they had a way to get to medical appointments and that it was easy to get into and out of the ride.

Health Plan Performance: Opportunities

Key areas of opportunity for the Medicaid Health Plans are related to children's and adolescent access to preventive care and services and pregnancy care, specifically prenatal care. The Prenatal and Postpartum Care—Timeliness of Prenatal Care HEDIS® performance measure rate was below the national Medicaid 50th percentile even with implementation of the State-mandated PIP, Addressing Disparities in Timeliness of Prenatal Care, in SFY 2016–2017. In addition, MHPs did not meet established goals to reduce disparities and/or improve the timeliness of prenatal care for its pregnant members.

Access and availability of services and information, management of the appeal process, and oversight of delegated entities are key areas of opportunity for the BHDDA and the Community Mental Health Services Programs (CMHSPs)/Pre-paid Inpatient Health Plans (PIHPs). Although statewide average performance measure scores exceeded their corresponding MDHHS-established performance standards, with the exception of one, all PIHPs had at least one performance measure rate that fell below the established standard, indicating that network deficiencies or other barriers to receiving timely access to services may exist for some members. The 2017–2018 compliance monitoring review identified opportunities for the PIHPs to improve internal appeal processes to ensure that members can challenge the denial of coverage of prescribed services, receive notice of resolution timely, and have an opportunity to request a State fair hearing when the internal PIHP appeal process has been exhausted.

The MI Health Link program 2018–2019 External Quality Review Technical Report for the Integrated Care Organizations (ICO's) identified opportunities for improvement in these primary areas of focus: coordination and continuity of care, coverage and authorization of services member notification processes, grievance and appeal systems procedures and sub-contractual relationships and delegation. In addition, the EQRO recommended an enhanced focus on the ICOs' Quality Assessment and Performance Improvement Plans (QAPIPs) to improve performance across the program in the areas of quality, timeliness, and access to care.

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 CQS Goal #1: Ensure high quality and high levels of access to care.

Michigan's most recent CAHPS reports indicate members' Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor were key drivers of member experience. The CSHCS CAHPS report also reflects the Rating of Specialist Seen Most Often was an important driver for families receiving CSHCS services. Based on the 2019 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 better coordinate communications among primary and specialty care providers. CSHCS CAHPS survey findings further indicate an opportunity to improve access to therapies, special medical equipment and transportation related to their child's condition. Interventions to address coordination among primary and specialty care providers address CQS Goal #3: Promote effective care coordination and communication of care among managed care programs, providers and stakeholders. In addition, Objective 3.2 supports the integration of services and transitions across the care continuum among providers and systems; and promoting the use of health information technology and health information exchange will improve community and connect providers to optimize patient outcomes (Goal #3, Objective 3.3).

MDHHS/Managed Care Program: Challenges and Opportunities

Establishing Performance Measures

Through the Comprehensive Quality Strategy (CQS) visioning process, the Michigan Medicaid managed care programs have recognized a critical need to conduct analyses for subpopulations and establish population performance thresholds and goals.

As previously indicated, during the development of this first CQS, the MDHHS internal Visioning Team took considerable time to discuss the identifying and establishing a common set of performance measures to address the required Medicaid Managed Care and CHIP Managed Care Final Rule, (CFR) § 438.340. Although the Medicaid managed care programs have established performance metrics and monitoring standards/ thresholds, they are specific to each program and the populations served. After reviewing and deliberating on existing program measures, the Visioning Team identified four common domains for potential CQS performance metrics development:

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

These domains address the required State-defined network adequacy and availability of services standards and take into consideration the health status of all populations served by the MCOs, PIHPs, and PAHPs in Michigan. MDHHS acknowledges that establishing performance goals is a key priority for the Medicaid managed care programs moving forward. The internal work has been initiated for meaningful collaboration across program areas and delivery systems; and the Visioning Team will need to exert continued and persistent efforts moving forward to establish a set of CQS performance measures to drive the quality of care and services for Michigan Medicaid beneficiaries.

The Visioning Team further acknowledged that beneficiaries are at the core of the Medicaid programs and that beneficiaries must be reflected in the performance measures selected to evaluate quality improvement and program outcomes. This is particularly important given the multiple subpopulations included in Michigan's Medicaid managed care programs, and to focus on health equity and decrease health disparities.

Health Equity Data Collection and Reporting

CQS Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes, requires a data-driven approach to identify and address racial and ethnic disparities. MDHHS is aware that the Medicaid managed care programs are at varying degrees of maturity with regard to 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.

Partnership with Public Health

The Medical Services Administration (MSA) and Behavioral Health and Developmental Disabilities Administration (BHDDA) are 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 2.5 – Encourage community engagement and systematic referrals among health care providers and to other needed services.

Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes.
Objective 4.6 – Collaborate and expand partnerships with community-based organizations and public health entities across the state to address racial inequities.

The Children's Special Health Care Services (CSHCS) program is one 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.

In addition, per federal requirements, MDHHS completed a five-year Title V needs assessment in 2020. Based on the assessment, state priority needs were established, and state action plans were created to address the following areas to improve the health of the maternal child health (MCH) population in Michigan in FY 2021-2025:

- Low-risk Cesarean Delivery
- Breastfeeding

- Infant Safe Sleep
- Bullying
- Transition for Youth with Special Health Care Needs to Adult Health Care
- Preventive Dental Visits for Women and Children
- Childhood Lead Poisoning Prevention
- Immunizations for Children and Adolescents
- Medical Care and Treatment for Children with Special Health Care Needs
- Intended Pregnancy
- Developmental, 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. 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 also 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 over the last several years. The Medicaid Health Plan Low Birth Weight (LBW) Project, which promotes health equity and monitors racial and ethnic disparities within the managed care population, promoted web-based reproductive counseling education developed by the Family Planning Program. MDHHS Family Planning Program staff also actively engage with the Michigan Medicaid Adult Medicaid Quality: Improving Maternal and Infant Health Outcomes in Medicaid and CHIP grant project team. The intent of this multiyear project is to increase the use of effective methods of contraception among all women in Medicaid and CHIP as part of growing efforts to improve birth spacing and self-determined pregnancies.

In addition, Medicaid 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.

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 was 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.

Currently, MDHHS is in the process of moving toward a Michigan Preferred Drug List (PDL) that will be used by both the Medicaid Health Plans and the Fee-for-Service (FFS) pharmacy program. The Single PDL will align coverage of PDL drug products under managed care with FFS and simplify pharmacy coverage for program beneficiaries and prescribers. MDHHS and the plans will continue to work toward implementing the required Medicaid policy and procedures to implement the PDL.

Integration of Behavioral Health

MDHHS will continue to work toward integrating physical and specialty behavioral health services to better meet the whole person needs of people with significant mental health, substance use disorder, and intellectual or developmental disabilities.

COVID-19 Policy

In response to the COVID-19 pandemic, Michigan expanded certain Medicaid coverages, access, and licensure policies to expand beneficiary care and services. Following the policy changes, Michigan Medicaid has 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 is focused on three main sub workgroups focused on behavioral health, data, and coding. Ongoing discussion and analysis are expected as more information is collected on beneficiary and provider impacts as a result of the COVID-19 policy changes.

Telemedicine/Telehealth

As a result of the COVID-19 pandemic, 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. 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. In addition, health care insurance providers were required to reimburse for virtual telehealth visits. In June 2020, Governor Gretchen Whitmer signed into a law a package of bills that expand telehealth in the state, Medicaid coverage for telehealth services and allows for the use of remote patient monitoring and asynchronous platforms. The bills codify significant pieces of **Executive Order 2020-86**, which broadly expanded access to telemedicine as part of Michigan's emergency response to the COVID-19 pandemic.

MDHHS will continue to work toward implementing Medicaid policy to provide telehealth services to beneficiaries in a safe and compliant manner and that meets Michigan Mental Health Code.

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. The NQS is organized around 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). 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, and value-based delivery models and identify gaps in areas such as community engagement. Table 2 outlines alignment of the CQS goals and objectives to the NQS aims.

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 first Comprehensive Quality Strategy which outlines the managed care program strengths and opportunities for improvement. Further development and integration of quality improvement program functions will continue in an effort to positively impact the care and services provided to all Medicaid populations and programs consistent with the National Quality Strategy (NQS).

Appendix A

Michigan Medicaid Managed Care Program
Comprehensive Health Care Program: Medicaid Health Plans (MHPs)

Managed Care Program Description: Comprehensive Health Care Program (CHCP) - Medicaid Health Plans (MHPs)

As of January 1, 2020, MDHHS contracts with ten (10) managed care plans in targeted geographical service areas comprised of 83 counties (divided into 10 regions) and provides services to approximately 1.7 million managed care beneficiaries in the state. MDHHS employs a population health management framework and contracts with high-performing health plans in order to build a Medicaid managed care delivery system that maximizes the health status of beneficiaries, improves Beneficiary experience and contains cost. MDHHS supports the MHPs to achieve these goals through evidence- and value-based care delivery models. 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, pursuing Health Equity particularly addressing racial inequities in healthcare services and health outcomes, 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.

Populations Served

In Michigan, multiple Medicaid health care programs are available to children, adults, and families. The goal of these health care programs is to ensure that essential health care services are made available to those who otherwise do not have the financial resources to purchase them. Information on Michigan's health care programs is available at: https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-35199--,00.html

Within the Medicaid eligible population, there are groups mandatorily enrolled in the CHCP, groups who may voluntarily enroll, and groups excluded from enrollment. Medicaid Eligible Groups Mandatorily Enrolled in the CHCP include: Children in foster care; Families with children receiving assistance under the Financial Independence Program (FIP); Persons enrolled in Children's Special Health Care Services (CSHCS); Persons under age 21 who are receiving Medicaid; Persons Enrolled in the MIChild Program; Persons receiving Medicaid for the aged; Persons receiving Medicaid for the blind or disabled; Persons receiving Medicaid for caretaker relatives and families with dependent children who do not receive FIP ; Pregnant women; Medicaid eligible persons enrolled under the Healthy Michigan Plan (HMP); and Supplemental Security Income (SSI) Beneficiaries who do not receive Medicare. Listings of Medicaid Eligible Groups Who May Voluntarily Enroll and who are excluded from enrollment are outlined in the CHCP Sample Contract available at https://www.michigan.gov/documents/contract_7696_7.pdf

Quality Structure/Committees

Oversight and management of the Comprehensive Health Care Program falls under the scope of the Medical Services Administration, Managed Care Plan Division. MHP contractual requirements and reporting are discussed at established MDHHS/MHP committees including the Quality Improvement Directors, Care Management Directors, MDHHS/MHP Operations meetings, Pharmacy and Dental programs meetings, etc.

Assessment Methods

The MHPs are responsible for all of the medical care and treatment of their members and are contractually required to conduct HEDIS®, member surveys/CAHPS, performance improvement projects, and population health initiatives. MHP performance expectations and reporting requirements are outlined in the CHCP MHP contract and appendices.

HEDIS®: MHPs are required to conduct and submit annual HEDIS® data. MDHHS Statewide Aggregate HEDIS® Reports are available at https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-39268--,00.html

Member Surveys/CAHPS: MDHHS contracts with Health Services Advisory Group, Inc. (HSAG) to annually administer and report the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey for the MDHHS Medicaid Program. MDHHS assess member satisfaction of the adult and child members enrolled in an MHP. The goal of the CAHPS Health Plan Survey is to provide performance feedback that is actionable and that will aid in improving members' overall experiences. The standardized survey instruments include the CAHPS 5.0 Adult Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®) supplemental item set; and the CAHPS 5.0 Child Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®) supplemental item set. MDHHS CAHPS Survey Reports are available online at: https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446_78576-130530--,00.html

External Quality Review (EQR): MDHHS has contracted with HSAG to conduct an external independent review of the quality and outcomes, timeliness of, and access to Covered Services provided by the Medicaid Health Plans. The EQR activities are intended to provide valid and reliable data and information about the MHPs' performance in the following areas: compliance monitoring; validation of performance measures; and validation of Performance Improvement Projects (PIPs) to ensure that the projects were designed, conducted, and reported in a methodologically sound manner. Reports describing the manner in which data from EQR-mandated activities were aggregated and analyzed, and the conclusions drawn related to the following: Quality of care , Timeliness of care, and Access to care may be viewed at https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446_78576-28384--,00.html

Performance Improvement Projects (PIPs): MDHHS requires MHPs to conduct PIPs and report the status/results to MDHHS as requested, but not less than annually as part of the compliance review. PIPs focus on clinical and non-clinical areas including any performance improvement projects required by CMS. Each PIP must be designed to achieve significant improvement, sustained over time, in physical and oral health outcomes and enrollee satisfaction. In addition, MHPs may be required to participate in statewide performance improvement projects that cover clinical and non-clinical areas that may include but are not limited to examination of disparate access, utilization, or outcomes. MDHHS may collaborate with the MHPs and stakeholders to determine priority areas for the statewide PIPs that may vary from year to year and will reflect the needs of the population such as care of children, pregnant women, and Persons with Special Health Care Needs, as defined by MDHHS. The FY 2019 – 2020 the identified PIP topic was *Addressing Disparities in Timeliness of Prenatal Care*, and this has been the topic since FY 2016. PIPs are a federally required EQR activity. Additional

information regarding the PIP can be found by reading the EQR at https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446_78576-28384--,00.html.

Performance Bonus: A portion of the approved capitation payment from each MHP is withheld which are used for an annual performance bonus incentive. The incentives are distributed to the MHPs at the end of the year based on plan performance using criteria and standards established by MDHHS in the areas of: Maintenance Measures, Improvement Measures, Plan-Specific Improvement Measures, Health Equity Measures, CAHPS Survey Measures and the Compliance Review. The MHP FY20 Performance Bonus Template is included in APPENDIX 5a of the CHCP contract https://www.michigan.gov/documents/contract_7696_7.pdf

In addition, the CHCP contract includes additional pay for performance initiatives:

- Pay for Performance on Population Health and Health Equity (Appendix 5b)
- Focus Bonus-Emergency Department Utilization (Appendix 5c)
- Pay for Performance-Healthy Michigan Plan Cost-Sharing/Value Based Services (Appendix 5d)
- Performance Bonus-Integration of Behavioral Health and Physical Health Services (Appendix 5e)
- Alternative Payment Model (APM) Pay for Performance Bonus Program (Appendix 5f)

Compliance Visits: The Managed Care Plan Division conducts annual compliance reviews for the ten (10) contracted MHPs. The MHP annual on-site compliance review includes at least one focused study based on identified priorities such as Community Health Workers, the Maternal Infant Health Program (MIHP) home visiting program, and CSHCS. The compliance review includes both a desk audit and an on-site focus component related to specific areas of health plan performance as determined by MDHHS. Standard review protocol is utilized to record and document site-review findings. The review process determines if contracted plans are meeting contractual requirements and assesses health plan compliance with established standards.

A review of dental programs was added to the FY2020 compliance review and there will be separate focus study reviews for the HKD Dental and HMP Dental programs. The dental compliance review will also access Provider Directory Network Adequacy (accuracy, timeliness for submissions, website updates); and Secret Shopper Calls are being conducted.
The on-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 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.

Quality/Population Health Initiatives

MDHHS contractually requires the MHPs to conduct multiple quality and population health initiatives. The 2019 Pay for Performance ***Population Health Management Intervention*** project is intended to improve the health of the Michigan Medicaid population and address Social Determinants of Health. In FY 20, housing stability was identified as a high priority area requiring intervention. The ***Low Birth Weight (LBW)*** project, which was initiated in June 2017, supports and aligns with the Medicaid Health Equity Project to promote health equity and monitor

racial and ethnic disparities within the managed care population. Project requirement and timelines are described in the CHCP contact appendices at https://www.michigan.gov/documents/contract_7696_7.pdf

Payment Model(s)

The CHCP utilizes a per member per month (PMPM) Capitated Rate Contract arrangement with the MHPs. Payments are based on eligible MHP members.

Performance Measures

MDHHS has established performance monitoring standards for the ongoing monitoring of health plan performance in important areas of quality, access, customer services and reporting. The monitoring process is dynamic and reflects state and national issues that may change on a year-to-year basis. Performance measurement is shared with MHPs during the fiscal year and compares performance of each plan over time, to other health plans, and to industry standards, where available. The Performance Monitoring Standards address the following:

- MDHHS Administrative Measures
- Healthy Michigan Plan (HMP) Measures
- MDHHS Dental Measures
- Health Equity HEDIS®
- CMS Core Set Measures / HEDIS® / Managed Care Quality Measures

For each performance area, the following categories are identified: Measure, Goal, Minimum Standard for each measure, Data Source and Monitoring Intervals, (annually, quarterly, monthly). 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 Monitoring Standards are outlined in Appendix 4: https://www.michigan.gov/documents/contract_7696_7.pdf

Appendix B

Michigan Medicaid Managed Care Program
Children's Special Health Care Services (CSHCS)

Managed Care Program Description: Children's Special Health Care Services (CSHCS)

Children's Special Health Care Services (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. CSHCS is charged 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 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 include assisting enrollees and their families in accessing the broadest possible range of appropriate medical care, health education and supports; ensuring delivery of these services and supports within an accessible, family centered, culturally competent, community-based and coordinated manner; promoting and incorporating parent/professional collaboration in all aspects of the program; and identifying and removing barriers preventing enrollees and their families from achieving these goals. CSHCS enrollment is contingent upon having one or more qualifying conditions that necessitates management by a physician specialist/sub-specialist.

Beginning in October 2012, persons who have both CSHCS and Medicaid coverage are enrolled into a Medicaid Health Plan (MHP), however, persons do not need to be in a Medicaid managed care plan to be enrolled in CSHCS. Approximately 65% of the CSHCS population is enrolled in managed care, 15% 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 administrative efficiency and allows both programs to avoid duplication of needed 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. https://www.michigan.gov/documents/contract_7696_7.pdf

Populations Served

Children and youth with special health care needs (CYSHCN) are a diverse group including those with chronic conditions, medically complex health issues, and children with behavioral or emotional conditions. The 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 CSHCS Population is a subset of the CYSHCN population and includes children and some adults who are medically eligible for CSHCS. CSHCS provides coverage for medical/physical conditions, and typically does not cover behavioral or developmental conditions.

Quality Structure/Committees

Michigan's CSHCS Program Division is part of the Medical Services Administration (MSA), MDHHS.

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.

CSHCS Local Advisory Council (CLAC): CLAC receives input from CSHCS staff in the Local Health Departments (LHDs). LHD professional staff members are appointed to work with CSHCS to develop, implement, evaluate and revise components of the CSHCS program. CLAC is comprised of State CSHCS staff and representatives from LHDs who represent various geographic areas of the state, as well as rural, urban, small and large departments. This committee meets every other month via teleconference.

Medical Services Administration, Office of Medical Affairs (OMA): OMA makes medical consultants available to CSHCS program staff, LHDs and hospitals providing CSHCS services.

The Family Center for Children and Youth with Special Health Care Needs (Family Center)

The Family Center is the statewide parent-directed center within CSHCS and the MDHHS. Children do not need to be enrolled in CSHCS to receive services from the Family Center. The Family Center offers emotional support, information, and connections to community-based resources to families of children and youth with special health care needs. This includes all children who have or are at an increased risk for: physical, developmental, behavioral, or emotional conditions. The Family Center provides parental perspectives and input on health care matters while focusing on families' access to coordinated systems of care; utilizes a family-centered care approach; and promotes family/professional partnerships at all levels of care. This ensures that families participate in the decision-making process and are satisfied with the services they receive.

Assessment Methods

The MHPs are responsible for all medical care and treatment of their members while community-based services beyond medical care and treatment are available through the local health department (LHD) CSHCS offices. As a result, the CSHCS population is included in Medicaid Health Plan (MHP) quality assessment, evaluation and monitoring processes.

HEDIS®: CSHCS members are included in annual MHP HEDIS® data reporting. MHPs may also be asked to generate data reports specifically for the CSHCS population.

Member Surveys/CAHPS: MDHHS periodically assesses the perceptions and experiences of members enrolled in the CSHCS Program as part of its process for evaluating the quality of health care services provided to child members. MDHHS contracted with Health Services Advisory Group, Inc. (HSAG) to administer and report the results of the CSHCS Survey. The goal of the CSHCS Survey is to provide performance feedback that is actionable and that will aid in improving overall member satisfaction. CAHPS surveys are conducted for both the CSHCS Fee-for-Service (FFS) and Medicaid Health Plan populations annually. A modified version of the CAHPS® 5.0 Child Medicaid Health Plan Survey with the HEDIS® supplemental item set and the Children with Chronic Conditions (CCC) measurement set are utilized.

External Quality Review Organization (EQR): MDHHS annually conducts an MHP external independent review of the quality and outcomes, timeliness of, and access to Covered Services provided by the plan. CSHCS enrollees would be included in the overall EQR evaluation process.

Performance Improvement Projects (PIPs): MDHHS requires MHPs to conduct PIPs which may include CSHCS enrollees.

Quality Improvement Projects (QIPs): An MHP FY 20 QIP project that impacts the CSHCS population focuses on pediatric sickle cell disease. According to MDHHS data, approximately 75% of sickle cell cases in Michigan are enrolled in CSHCS. The initial stage of this project is to better understand the care, services and activities provided by MHPS to children and youth ages birth through 17 years with pediatric sickle cell disease. Three pediatric sickle cell anemia quality of care measures will be assessed: Proportion of Pediatric Members (ages 2 -15 years) with Sickle Cell Anemia with a Completed Transcranial Doppler (TCD) screening; Proportion of Pediatric Members with Sickle Cell Anemia <5 years old with at least 300 days of Dispensed antibiotics; and Proportion of Pediatric Members (ages 1 through 17 with Sickle Cell anemia with at least 300 days of Dispensed Hydroxyurea.
The MHP Low Birth Weight (LBW) initiative, which supports and aligns with the Medicaid Health Equity Project, also directly impacts the CSHCS population. The LBW initiative aligns with MDHHS efforts to promote health equity in maternity care and infant care and improve infant health outcomes by addressing documented health disparities and health inequities with a focus on reducing the LBW rate.

Performance Bonus: Child and adolescent measures are included in the MDHHS MHP Performance Bonus Model. As such, CSHCS enrollees may be included in the rates (numerators/denominators) included in the Bonus calculation. The FY20 Performance Bonus Measures Template includes the following NCQA Medicaid HEDIS® measures related to both medical and behavioral health care and services: Blood Lead Testing, Children and Adolescents' Access to Primary Care Practitioners and Adolescent Well-Care Visits. Plan-Specific Improvement Measures include Appropriate Testing for Children With Pharyngitis; Follow-Up Care for Children Prescribed ADHD Medication—Initiation; and Asthma Medication Ratio— Total. Health Equity measures included in the MHP Performance Bonus Model include Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life. CSHCS members would also be included in the Non-Emergent Medical Transportation (NEMT) Encounter Submissions requirement.

Compliance Visits: The CSHCS program components are included in the annual MDHHS MHP site review and CSHCS has been a topic of focus. CSHCS program staff and the Medical Services Administration, Office of Medical Affairs (OMA) medical consultants participate in the compliance review process.

Local Public Health Department Accreditation Process: Accreditation is a partnership between the state and Local Health Departments (LHDs) to ensure greater consistency across Michigan regarding the level of local CSHCS services available. CSHCS and the Family Center work collaboratively with LHDs to refine and improve the Minimum Program Requirements (MPR) and accreditation indicators for each new 3-year cycle. The accreditation process ensures that all LHDs are meeting the minimum program expectations. The Accreditation Review Team utilizes a review tool that outlines indicators included in the accreditation process. The Michigan Local Public Health Accreditation Program Tool 2020 – MPR Indicator Guide outlining the MPRs and Indicators can be found at **https://www.michigan.gov/documents/mdch/CSHCS-2015_Final_Tool_476456_7.pdf** The review includes but is not limited to an assessment of policies and procedures, family and community outreach and communication materials, referral processes, enrollment and coverage assistance, and care coordination, case management and care transition services. CSHCS developed a Guidance Manual (GM) for LHDs as a resource document. It contains CSHCS program policy in addition to procedural and guidance information that assists LHDs serving CSHCS clients as well as enhancing communication between state and local offices.

Quality/Population Health Initiatives

CSHCS enrollees may be included in the MHP population health initiatives. For example, CSHCS members may be included the 2019 Pay for Performance Population Health Management

Intervention which is intended to improve the health of the Michigan Medicaid population and to address Social Determinants of Health. In FY 20, housing stability was identified as a high priority area requiring intervention. The MHPs annually report their initiatives to MDHHS.
Payment Model(s)
CSCHS Medicaid managed care enrollees are included in the MHP capitation rates. Medicaid covers a broad range of medical services and conditions for CSHCS enrollees under the MDHHS/MHP contract.
Performance Measures
CSHCS enrollees are included in data gathered for the **MDHHS MHP Performance Monitoring Standards**. The purpose of the performance monitoring standards is to establish an explicit process for the ongoing monitoring of health plan performance in important areas of quality, access, customer services and reporting. The process is dynamic and reflects state and national issues that may change on a year-to-year basis. Performance measurement is shared with Health Plans during the fiscal year and compares performance of each plan over time, to other health plans, and to industry standards, where available. For example, CSHCS enrollees may be included in well child visit, adolescent visit, and developmental screening measures, etc. The Performance Monitoring Standards include HEDIS®, the CMS Adult and Child Core Sets, dental measures, MDHHS Health Equity measures along with MDHHS administrative measures (e.g., claims and encounter reporting).

Appendix C

Michigan Medicaid Managed Care Program
Healthy Michigan Plan (HMP)

Managed Care Program Description: Healthy Michigan Plan (HMP)
The Healthy Michigan Plan (HMP) is a category of eligibility authorized under the Patient Protection and Affordable Care Act and Michigan Public Act 107 of 2013 began April 1, 2014. The benefit design of the Healthy Michigan Plan ensures beneficiary access to quality health care, encourages utilization of high-value services, and promotes adoption of healthy behaviors. 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. The State began accepting applications for the HMP on April 1, 2014. HMP enrollees receive benefits required under the Affordable Care Act and all of the Essential Health Benefits required by federal law and regulation. Enrollees 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 (MHP) (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.
Populations Served
The Healthy Michigan Plan provides health care coverage for individuals who: are age 19-64 years of age; have income at or below 133% of the federal poverty level under the Modified Adjusted Gross Income methodology; do not qualify for or are not enrolled in Medicare; do not qualify for or are not enrolled in other Medicaid programs; are not pregnant at the time of application; and are residents of the State of Michigan.
Quality Structure/Committees
HMP program oversight and management falls under the scope of the Medical Services Administration, Managed Care Plan Division. HMP program contractual requirements and are discussed at established MDHHS/MHP committees including the Quality Improvement Directors, Care Management Directors, MDHHS/MHP Operations meetings, Pharmacy and Dental programs meetings.
Assessment Methods
The MHPs are responsible for all of the medical care and treatment of their HMP members. HMP enrollees may be included in HEDIS®, member surveys/CAHPS, performance improvement project, and population health initiatives. Performance measures specific to the HMP population are outlined in the MHP Performance Monitoring Standards and enrollees may be included in the Performance Bonus Template rates/calculations.
HEDIS®: HMP members are included in annual MHP HEDIS® data reporting. MHPs may also be asked to generate data reports specifically for the HMP population, as requested.

Member Surveys/CAHPS: MDHHS assesses the perceptions and experiences of HMP members as a part of its process for evaluating the quality of health care services provided to eligible adult members in the HMP Program. MDHHS contracts with Health Services Advisory Group, Inc. (HSAG) to administer and report the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey for the HMP Program. The goal of the CAHPS Health Plan Survey is to provide performance feedback that is actionable and that will aid in improving members' overall experiences. The survey instrument is the CAHPS 5.0 Adult Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®) supplemental item set.1-2 MDHHS elected to include six supplemental questions in the survey.

External Quality Review (EQR): MDHHS has contracted with HSAG to conduct an external independent review of the quality and outcomes, timeliness of, and access to Covered Services provided by the Medicaid Health Plan including HMP enrollees.

In addition, MDHHS contracted with the University of Michigan Institute for Healthcare Policy and Innovation to conduct the independent evaluation of HMP required by CMS. This evaluation examined the following six domains, as described in the CMS-approved Special Terms & Conditions for the Healthy Michigan Plan Section 1115 Demonstration Waiver covering the five-year period December 31, 2013-December 31, 2018:

- Domain I: The impact on uncompensated care costs borne by Michigan hospitals;
- Domain II: The effect on the number of uninsured in Michigan;
- Domain III: The impact on increasing healthy behaviors & improving health outcomes;
- Domain IV: The viewpoints of beneficiaries and providers of the impact of HMP;
- Domain V: The impact of contribution requirements on beneficiary utilization;
- Domain VI: The impact of the MI Health Accounts on beneficiary healthcare utilization.

Performance Improvement Projects (PIPs): MDHHS require MHPs to conduct performance improvement projects they may include HMP enrollees.

Performance Bonus: The MHP FY20 Performance Bonus Measures Template includes the following NCQA Medicaid HEDIS® measures related to both medical and behavioral health care and services that may be applicable to HMP members:

- Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years
- Asthma Medication Ratio— Total
- Controlling High Blood Pressure
- Breast Cancer Screening
- Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg
- HMP CAHPS: Health Plan Rating (9+10) & Tobacco Cessation Strategies

HMP members may also be included in adult MHP plan-specific and MHP plan-specific health equity measures.

Healthy Michigan Plan Cost-Sharing and Value-based Services: Public Act (PA) 208 of 2018 requires that cost-sharing be included in the performance bonus. Cost-Sharing and Value-based Services are key components of the Healthy Michigan Plan (HMP); as such, MHPs are required to create and/or maintain systems and processes to appropriately implement cost-sharing requirements and to ensure the provision of value-based services. The FY20 Pay for Performance (P4P) incentivizes MHPs to continue to develop and maintain processes related to collection of cost-sharing, incentives and value-based services. Several domains are to be reviewed: Performance on Healthy Michigan Plan Measures; Tracking and confirmation that incentives are applied as required; Implementing Wellness Programs for HMP members; and Assisting members to meet HMP work requirements.

Compliance Visits: HMP contractually required program components are included in the annual MDHHS MHP site review.

Quality/Population Health Initiatives

HMP enrollees may be included in the MHP population health initiatives. For example, enrollees may be included the 2019 Pay for Performance Population Health Management Intervention project which is intended to improve the health of the Michigan Medicaid population and address Social Determinants of Health. In FY 20, housing stability was identified as a high priority area requiring intervention. HMP enrollees may also be included in the Non-Emergent Medical Transportation (NEMT) Encounter Submissions requirement. The Medicaid Health Plans (MHPs) annually report their initiatives to MDHHS.

Payment Model(s)

Medicaid covers a broad range of medical services and conditions for HMP enrollees under the MDHHS/MHP managed care program contract.

Performance Measures

The Performance Monitoring Standards address: MDHHS Administrative Measures; Healthy Michigan Plan (HMP) Measure; MDHHS Dental Measures; Health Equity HEDIS®; CMS Core Set Measures; HEDIS®; and Managed Care Quality Measures. For each performance area, the following categories are identified: Measure, Goal, Minimum Standard for each measure, Data Source and Monitoring Intervals, (annually, quarterly, monthly).

HMP-specific measures are included in the MHP performance monitoring standards which establish an explicit process for the ongoing monitoring of health plan performance in important areas of quality, access, customer services and reporting. MDHHS HMP measures are all run with custom coded queries. The performance monitoring standards are incorporated into the MDHHS/MHP contract. Performance measurement is shared with the MHPs during the fiscal year and compares performance of each plan over time, to other health plans, and to industry standards, where available. 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.

HMP members may also be included in MHP HEDIS® and MHP Health Equity HEDIS® measures and CMS Core Set measures depending on the age specifications for the measure. HMP dental measures have been established for preventive, diagnostic, and restorative services as well as comprehensive diabetes preventive, diagnostic and restorative dental services.

Appendix D

Medicaid Managed Care Program
Flint Waiver

Managed Care Program Description: Flint, Michigan Section 1115 Demonstration (Flint Waiver)

In 2016, MDHHS received a 1115 waiver from CMS to expand Medicaid coverage and benefits to individuals affected by the Flint Water Crisis which occurred when the city's water source was changed in April 2014. 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 women) and pregnant women (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 women in households with higher incomes levels; eliminating cost sharing and Medicaid premiums for eligible enrollees; and permitting eligible children and pregnant women above the 400% FPL and served by the Flint water system to buy into Medicaid benefits by paying premiums. The demonstration also added a Family Supports Coordination (FSC) (Targeted Case Management) benefit to all low-income children (up to age 21 including children born to eligible pregnant women) and pregnant women (through two months post-delivery) served by the Flint water system as of 4/1/2014. The activities included in the FSC benefit were to: assist enrolled eligible children and pregnant women served by the Flint water system to gain access to needed medical, social, educational, 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.

Populations Served

The Flint Waiver supports access to care and FSC for affected at-risk persons. The eligibility criteria for receiving Medicaid coverage has been established by MDHHS policy to include:

- Any pregnant woman or child up to age 21 with a household income up to and including 400% of the Federal Poverty Level (FPL) who has been served by the Flint water system on or between 4/1/2014 and the date water is deemed safe (Date TBD).
- Any child born to a pregnant woman served by the Flint water system during the specified time period. The child will remain eligible until age 21.
- Water service is defined as:
  - consumed water drawn from the Flint water system during the specified time period and:
    - resides or resided in a dwelling connected to this system;
    - is employed or had employment at a location served by this system; or
    - is receiving or received childcare or education at a location connected to this system.

Pregnant women covered under the waiver will remain eligible through their pregnancy and for a period of two months post-partum. Children will remain eligible until age 21 as long as other eligibility requirements are met. Individuals above the 400% FPL but otherwise meeting the eligibility criteria may enroll into Medicaid by paying the appropriate premiums and participating with cost-sharing as described per current Medicaid policy.

Quality Structure/Committees

The Flint Waiver population is included in Medicaid Health Plan (MHP) quality and committee structure.

Assessment Methods

The MHPs are responsible for all of the medical care and treatment of their members while community-based services beyond medical care and treatment are available through local health departments (LHD). As a result, the Flint Waiver population is included in MHP quality assessment, evaluation and monitoring processes. In addition, an evaluation is conducted on the expansion of Medicaid services in four Domains: 1) access to services; 2) access to targeted case management (TCM); 3) improved health outcomes; and 4) lead hazard investigation. The evaluation plan was approved August 2017.

HEDIS®: Flint Waiver members are included in annual MHP HEDIS® data reporting. MHPs may also be asked to generate data reports specifically for the Flint Waiver population.

Member Surveys/CAHPS: MDHHS periodically assesses the perceptions and experiences of members enrolled in the Flint Waiver. Enrollees are surveyed to ascertain whether the expanded eligibility and FSC supported them in accessing services. Enrollee surveys are being conducted in three waives designed to address: beneficiary attestation to improved access to health care; and beneficiary report of improved satisfaction with ability to access health care.

In addition, qualitative key informant interviews of FSC personnel are being conducted to address the implementation of FSC services. The interviews address four domains, particularly Domain 2. The interviews were guided by five topics that are tied to the hypotheses for Domain 2 including: 1) Provider Characteristics, 2) Assessment, 3) Service Capacity, 4) Service Delivery, and 5) Client Services.

External Quality Review (EQR): MDHHS has contracted with MSU-IHP to conduct an external independent review of the quality and outcomes, timeliness of, and access to Covered Services provided by the Flint Waiver. Flint Waiver enrollees may also be included in annual EQR activities conducted by MDHHS.

Performance Improvement Projects (PIPs): MDHHS require MHPs to conduct performance improvement projects they may include Flint Waiver enrollees.

Performance Bonus: Child and adolescent measures are included in the MDHHS MHP Performance Bonus Model. As such, Flint Waiver enrollees may be included in the rates (numerators/
denominators) included in the Bonus calculation.

The FY20 Performance Bonus Measures Template includes the following NCQA Medicaid HEDIS® measures related to both medical and behavioral health care and services: Blood Lead Testing, Children and Adolescents' Access to Primary Care Practitioners and Adolescent Well-Care Visits. Plan-Specific Improvement Measures include Appropriate Testing for Children With Pharyngitis; Follow-Up Care for Children Prescribed ADHD Medication—Initiation; and Asthma Medication Ratio— Total. Health Equity measures also included in the MHP Performance Bonus Model include Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life. Flint Waiver enrollees may also be included in the Low Birth Weight, population health and Non-Emergent Medical Transportation (NEMT) Encounter Submissions requirement.

Compliance Visits: The Flint Waiver program components are included in the annual MDHHS MHP site review.

Quality/Population Health Initiatives

Flint Waiver enrollees may be included in the MHP population health initiatives. For example, enrollees may be included the 2019 Pay for Performance Population Health Management Intervention which is intended to improve the health of the Michigan Medicaid population and to

address Social Determinants of Health. In FY 20, housing stability was identified as a high priority area requiring intervention. Flint Waiver enrollees may also be included in the Low Birth Weight and Non-Emergent Medical Transportation (NEMT) Encounter Submissions requirement. The Medicaid Health Plans (MHPs) annually report their initiatives to MDHHS.

Payment Model(s)

Medicaid covers a broad range of medical services and conditions for enrollees under the MDHHS/MHP contract. Family Supports Coordination (FSC) services are paid on a FFS basis.

Performance Measures

The Flint Waiver evaluation includes analyses of Medicaid administrative data sources (e.g., enrollment, claims/encounter) available through the MDHHS Data Warehouse at least semi-annually. Some access/quality of care measures are being evaluated (e.g., immunization status) on an annual basis as recommended by the measure stewards (HEDIS®). Claims/encounter data requires a lag period to allow for claim processing; no less than 180 days will be used for this claim run-out period. Medicaid services are assessed in four Domains: 1) access to services; 2) access to targeted case management (TCM); 3) improved health outcomes; and 4) lead hazard investigation.

Appendix E

Michigan Medicaid Managed Care Program
MI Choice: Prepaid Ambulatory Health Plans (PAHPs)

Managed Care Program Description: MI Choice Home and Community Based Services for Elderly and Other Adults with Disability Waiver

Since 1992, the MI Choice Waiver program, (formerly the *Home and Community Based Services for the Elderly and Disabled* program) has enabled beneficiaries who meet Michigan nursing facility level of care criteria to live independently while receiving long term services and supports (LTSS) in their home or community setting. The waiver is approved by the Centers for Medicare & Medicaid Services (CMS) under sections 1915(b) and 1915(c) of the Social Security Act and became available in all Michigan counties October 1, 1998. The goal of the MI Choice Waiver program is to provide services through a person-centered planning process which supports health maintenance and improvement, welfare and optimal quality of life through any one of Michigan's twenty, ***pre-paid ambulatory health plans (PAHPs),*** also known ***waiver agencies.***

Populations Served

MI Choice is limited to serving older adults (age 65 and over) and adults with disabilities (age 18 and older) who meet the nursing facility level of care.

Quality Structure/Committees

Statewide MI Choice Quality Management Collaborative (QMC)*:* The QMC advises and provides insight into the development and review of MI Choice quality management activities and initiatives. Through the QMC, consumers, waiver agencies, Program Directors, advocates and providers review quality outcomes, identify barriers and improvement opportunities, and develop service delivery remediation strategies. Consumers and advocates also contribute their valuable perspectives during the implementation of care options such as person-centered planning and self-determination.

Local Consumer Advisory Teams*:* The Local Advisory Team is comprised of participants and waiver agency representatives who meet monthly or bimonthly to discuss quality initiatives and activities. Team members may attend QMC meetings to report on quality improvement activities at the local level.

MI Choice Steering Committee: The Steering Committee includes a Chair, Vice Chair and members from both the QMC and Local Consumer Advisory Teams. The Steering Committee meets monthly to establish the agenda and work of the QMC.

Assessment Methods

The MI Choice Quality Improvement Strategy (QIS) describes how the program assesses and improves the quality of services and supports managed by the waiver agencies. The QIS outlines the methods used to gather data and measure individual and system performance including: the MDHHS Quality Management Plan (QMP), waiver agency specific QMPs, Clinical Quality Assurance Review, Administrative Quality Assurance Review and Critical Incident Reporting (CIR) System. Waiver agencies are required to develop their own QMP every other year to address CMS and MDHHS quality requirements. MDHHS reviews and analyzes the QMPs and associated yearly reports; and complies and compares individual waiver agency quality indicator data and statewide averages to monitor agency performance, as indicated.

HEDIS®: MI Choice does not utilize HEDIS®.

Member Surveys/CAHPS: The MI Choice program contracts with a third-party vendor to conduct participant satisfaction and quality of life surveys using the CAHPS Home and Community-Based Services Survey. The vendor assures a statistically significant sample from each waiver agency and analyzes the data for trends and system improvements that can be made locally or statewide. The analysis is provided to MDHHS and waiver agencies to use for quality improvement

initiatives. Waiver agencies may also conduct member satisfaction surveys to gather feedback and identify opportunities for improvement.

EQR: MDHHS contracts with an EQRO annually to assess wavier agency performance related to the quality of, timeliness of, and access to care and services they provide, as mandated by 42 Code of Federal Regulations (CFR) §438.364. The EQRO conducts the annual CQAR and evaluates the waiver agency's enrollment, assessment, level of care evaluations, care planning, and reassessment activities seeking evidence of compliance to the Clinical Quality Assurance Review (CQAR) standards.

Performance Improvement Projects (PIPs): Waiver agencies are contractually required to conduct clinical and non-clinical PIPs and report findings to the MDHHS.

Performance Monitoring: MDHHS monitors the waiver agencies using multiple methods including established performance measures in six waiver assurances and requirements in the areas of service adequacy, access, provider network training, care plans, satisfaction and quality of life and incidents.

Program compliance review includes the Administrative Quality Assurance Review (AQAR) and the Clinical Quality Assurance Review (CQAR). The AQAR and CQAR are outlined in the Compliance Visit section below.

Additional MDHHS Monitoring and Data Collection include:

- **Michigan Medicaid Data Warehouse:** Encounter and capitation data are routinely monitored by MDHHS using the State's Medicaid Data Warehouse.
- **Michigan Licensing and Regulatory Affairs (LARA) database:** MDHHS performs professional license verification for WA-employed registered nurses and social workers at least annually.
- **MI Choice Administrative Hearings and Appeals Decisions:** MDHHS routinely reviews, analyzes and compiles all MI Choice administrative hearings and appeals decisions, taking corrective action in cases of non-compliance with subsequent decisions and orders.
- **MI Choice Complaint Investigation and Resolution Activities:** Operations-related complaints are reviewed, monitored and resolved through discussions with pertinent parties including but not limited to the MDHHS, waiver agencies, participants or their representatives.
- **Critical Incident Reporting System:** Critical incidents are routinely reviewed, monitored and evaluated.

Waiver Agency Risk Management and Quality Improvement Activities:

- Risk Management Planning is conducted with enrollees during the person-centered planning process.
- Quality Indicator (QI) Selection, Measurement, Reporting and Improvement activities assess participant health status outcomes in the following domains: nutrition, incontinence, skin ulcers, physical and cognitive function, pain and safety/environment. Quarterly reports are generated and shared with MDHHS for review and analysis. The Quality Management Committee selects five indicators for focused quality improvement efforts over a minimum, two-year period and regularly meets with local consumer advisory teams to collaborate on related activities.

Compliance Visits: MDHHS uses Administrative Quality Assurance Review (AQAR) and Clinical Quality Assurance Review (CQAR) standards and criteria in the review of the MI Choice Program. The AQAR and CQAR annually review participant access and level of care determination; participant-centered service planning; service delivery; provider capacity and capabilities;

participant safeguards related to health and welfare; participant rights and responsibilities; participant outcomes and satisfaction; and system performance.

- MDHHS conducts a periodic on-site ***AQAR*** on each of the 20 waiver agencies on a biennial schedule, assuring that each agency is reviewed at least once every two years to determine if the agency is compliant with State and Federal requirements. MDHHS seeks evidence of compliance through examination of agency policies and procedures, provider contracts, financial systems, encounter accuracy and quality management plans.
- MDHHS contracts with the EQRO to conduct the ***CQAR*** annually to determine waiver agency adherence to the MI Choice Program clinical requirements. The EQRO process includes a review of medical records and home visits with enrollees. The CQAR reviews determine whether the authorized services in the plan of service are sufficient to protect the health and welfare of the participant. Medical records are randomly selected for review; a minimum of five home visits are conducted to verify information in the medical records.

Performance Bonus: MDHHS withholds a portion of the approved capitation payment from each MI Choice waiver agency which are used for the agency's annual performance bonus incentive. The incentives are distributed to agencies after the end of the year according rankings based on criteria and standards established annually by MDHHS. Waiver agency rankings are calculated based on CQAR/AQAR performance indicators, encounter data, SSP, Acuity, Critical Incidents reporting, Agency reports, and Supports Coordinator per participant.

Quality/Population Health Initiatives

Individual waiver agencies may conduct quality/population health initiatives.

Payment Model(s)

MI Choice utilizes a capitated payment model, e.g., payments are based on the number of eligible waiver participants.

Performance Measures

MDHHS uses several methods to assess the performance of waiver agencies and assure assigned operational and administrative functions are completed in accordance with waiver requirements. MDHHS biennially examines administrative elements during the on-site Administrative Quality Assurance Reviews (AQAR). MDHHS contracts with an External Quality Review Organization (EQRO) to examine the case record elements during the Clinical Quality Assurance Reviews (CQARs). MDHHS contracts with a third party vendor to conduct participant satisfaction surveys and provide analysis of the results.

The AQAR process includes an examination of policy and procedure manuals, peer review reports, provider monitoring reports, provider contract templates, financial systems, encounter data accuracy, quality management plans (QMPs) and verification of required provider licensure to assure that each waiver agency meets all requirements. The AQAR also verifies the waiver agency meets administrative, program policy, and procedural requirements by ensuring maintenance of program records for ten years, controlled access to program records according to HIPAA requirements, waiver agency employee access to program policies and procedures, and proper accounting procedures. MDHHS reviews waiver agency agreements with subcontracted providers, performs provider reviews, and may conduct interviews with both supports coordinators and MI Choice participants.

The second element is the CQAR. The EQRO employs qualified reviewers to complete the CQAR for every waiver agency each fiscal year. During the CQAR, reviewers examine case records and other information to gauge the level of compliance with program standards and to assess the quality of waiver agency service to each participant. The CQAR includes a review of whether person-centered service plans and service delivery are in compliance with State and Federal

requirements. Identified discrepancies are reviewed and addressed. Corrective Action Plans are reviewed and approved by MDHHS and implemented by each waiver agency based upon the results of the AQAR and CQAR.

Appendix F

Michigan Medicaid Managed Care Program
MI Health Link: Integrated Care Organizations (ICOs)

Managed Care Program Description: MI Health Link (ICOs)

Michigan launched the MI Health Link demonstration in March 2015 to integrate care for Medicare-Medicaid beneficiaries in four regions in the state. The goal of MHL is to provide seamless access to high quality care through coordination of services currently covered separately by Medicare and Medicaid. MI Health Link offers a broad range of medical and behavioral health services, nursing home care, pharmacy and home and community-based services through managed care entities called Integrated Care Organizations (ICOs) and Medicaid's existing Pre-paid Inpatient Health Plans (PIHPs). 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. 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. Michigan's seven ICOs (Aetna, AmeriHealth, Michigan Complete Health, HAP Empowered, Meridian, Molina, and Upper Peninsula Health Plan), contract with MDHHS and CMS to provide primary, acute, behavioral health, and long-term services and supports (LTSS) to dual-eligible recipients in Michigan.

Populations Served

MI Health Link (MHL) provides a health care option for adults ages 21 and older, enrolled in both Medicare and Medicaid, residing in Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Macomb, St, Joseph, Van Buren, Wayne counties as well as all counties in Michigan' upper peninsula.

Quality Structure/Committees

The MI Health Link program falls under the MDHHS Medical Services Administration and sits within the Bureau of Medicaid Long-Term Care Services & Support, Integrated Care Division (ICD). The ICD staff work collaboratively with other Divisions and Operational Units with MDHHS to achieve program goals and objectives.

- 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.
- A Quality Sub-Workgroup comprised of MSA, ICOs and PIHPs provides opportunity for collaboration and information sharing. This work group discusses promising practices related to quality measures, reporting requirements, improvement activities, stakeholder communications and other topics related to program quality.
- An Internal Data Quality Workgroup comprised of several sections within MSA that 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.

Assessment Methods

MDHHS regularly monitors ICO performance to identify, track, trend, and correct problems related to program efficiency, effectiveness, and responsiveness. This includes the review of ICO compliance with contract requirements and performance monitoring results such as complaint and grievance reports, member assessment timeliness, claims payment timeliness, encounter data submission timeliness, member surveys results, and quality measures. MDHHS regularly solicits input from key stakeholders related to program efficiency, effectiveness, and responsiveness. Further, MDHHS analyzes information at the ICO level and program level to support comprehensive oversight processes.

The MI Health Link Quality Strategy provides a framework for measuring and improving care and services for members in the MI Health Link program. The Quality Strategy uses measures of quality based on health outcomes, care coordination, member and caregiver experience, resource use, and organizational structure and efficiency; and includes members and their families in the program design and implementation, which is critically important in assessing the degree to which individuals can access the full range of services in a person-centered way. The Quality Strategy incorporates CMS core performance measures required of States participating in the Financial Alignment Initiative. In addition, ICOs are required to report state-specific measures which directly supplement the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements.

HEDIS®: The three-way contract between CMS, MDHHS and each ICO requires the ICO to report the full set of HEDIS® data required by Medicare. HEDIS® data is included in the external quality review (EQR).

Member Surveys/CAHPS: MI Health Link conducts the following member surveys:

- CAHPS 5.0 Adult Medicaid Health Plan Survey with HEDIS® supplemental item set (HSAG)
- Medicare Advantage Prescription Drug CAHPS with 10 supplemental questions (added by RTI International)
- Medicare Health Outcomes Survey (HOS)
- CAHPS Home and Community-Based Services (HCBS) Survey

External Quality Review (EQR): An EQR is performed by Health Services Advisory Group (HSAG) to assess ICO performance related to the quality of, timeliness of, and access to care and services. The annual EQR Technical Report summarizes all EQR activities, including:

- A comprehensive review of ICO compliance with all Federally mandated Medicaid managed care standards and their associated State-specific requirements, when applicable.
- Data collection, reporting and performance measure validation processes for selected CMS and MI specific measures.
- ICO-specific and statewide aggregated HEDIS® data provided by MDHHS.
- Quality Improvement Projects (QIPs) validation to ensure ICOs design, conduct and report the QIP using sound methodology and in compliance with pertinent State and Federal requirements.

Performance Improvement Projects (PIPs): MDHHS and CMS may require ICOs to conduct PIPs that focus on specific clinical and non-clinical areas based on identified areas of opportunity. PIPs are assigned to selected plans, as needed, throughout the year.

Quality Improvement Projects (QIPs): QIPs are assigned to all ICOs on a three-year cycle. The QIP is administered by the EQR vendor, HSAG. The 2019-2021 QIP topic of focus is *Follow-Up After Hospitalization for Mental Illness (30 days).* The pror three-year QIP was on *Reducing Avoidable Hospital Readmissions*.

Performance Monitoring Standards: MI Health Link ICO performance is monitored through both CMS Core measures and Michigan specific measures. The measures are published annually to indicate changes and measures that were suspended and retired.

- The CMS Core measures are listed here: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/CoreReportingRegsCY2020.pdf

- The MI specific Measures are listed here: https://www.cms.gov/files/document/mireportingrequirements02282020.pdf

Performance Bonus (Quality Withholds): 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.

- CMS Core Measures: CMS and the state established a set of quality withhold measures for the ICOs. The ICOs are expected to meet established thresholds that address domains of access, assessment, care coordination, enrollee protection, organization structure and staffing, performance and quality improvement, provider network, and systems and service utilization. The CMS Quality withhold measures are listed here: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/QualityWithholdGuidanceDY2-503142018.pdf
- The MI Specific quality withhold measures are listed here: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/MIQualityWithholdGuidanceDY2-510102018.pdf Additional withhold measures are being considered starting in 2021.
- MDHHS also uses a passive enrollment algorithm that includes nine measures. The algorithm assigns each ICO a score based on their performance using a point system and stratified into three tiers. Plans that score lower, are assigned a smaller percentage of passively enrolled enrollees.

Compliance Visits: On a three-year cycle, a comprehensive compliance review is conducted by HSAG on the 7 ICOs to determine their compliance with federal standards set forth in 42 CFR §438—Managed Care Subpart D and the quality assessment and performance improvement requirements described in 42 CFR §438.330. The review includes eleven standards: 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, Subcontractual Relationships and Delegation, Practice Guidelines, Health Information Systems, and Quality Assessment and Performance Improvement Program. MI Health Link also conducts annual audits for the HCBS C-Waiver population (a subset of the entire program). Beginning in 2020, MDHHS contracted with Michigan Public Health Institute (MPHI) to conduct the audit. The audit tool incorporates measures mapped into 9 domains: Care coordination and transitions; quality of care, health and well-being, quality of life; person-centered planning; enrollee/caregiver experience; access/availability; screening, assessment and prevention; organizational structure, administration and staffing; and utilization. This audit process is handled separately from the remaining elements of the MI Health Link quality program. For both activities, ICOs must implement a formal Corrective Action Plan (CAP) to ensure any identified deficiencies are remediated. All CAPs are subject to review, approval and oversight from HSAG for Compliance Review and from MPHI for HCBS C-Waiver audits.

Quality/Population Health Initiatives

Not applicable at this time.

Payment Model(s)

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. Behavioral health services are provided separately through the PIHPs. Financial incentives are included in contracts to promote care coordination between the

two managed care systems (ICOs and PIHPs). Plans are also Incentivized through a withhold of ICO capitation payment which they can earn back if they meet certain quality thresholds. CMS and MDHHS identified specific quality measures that are used as the basis for the quality withhold bonus.
Performance Measures
MI Health Link regularly monitors and assesses ICO performance in collaboration with the plans using a CMS Core and state specific measures, member surveys, the enrollment algorithm, HEDIS®, etc. There are nine CMS Core Measures and eleven Michigan specific measures. ICO's report all Medicare HEDIS® measures.

Appendix G

Michigan Medicaid Managed Care Program
Program of All-Inclusive Care for the Elderly (PACE)

Managed Care Program Description: Program of All-Inclusive Care for the Elderly (PACE)

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 (LOC) 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. PACE organizations enter 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.

In Michigan, services are provided through thirteen PACE organizations who operate twenty-one (21) centers across most of Michigan's Lower Peninsula. PACE is not a statewide service; currently PACE services are not offered in the Upper Peninsula. PACE organizations perform a functional assessment to determine if a person meets Medicaid LOC criteria. The PACE service package includes all Medicare and Medicaid covered services, and other services as determined necessary by the interdisciplinary team. PACE organizations receive referrals from providers and others in the community who believe a person meets Medicaid and LOC eligibility criteria. An interdisciplinary licensed professional team assess the patient's needs, develop personalized care plans and deliver all services, including acute care services, hospital services and if necessary, nursing facility services. PACE organizations provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services, according to the participant's assessed needs.

Populations Served

PACE eligibility criteria require that individuals be 55 years old or older, and medically qualified, meet Medicaid's LOC 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 any other Medicaid or Medicare program.

Quality Structure/Committees

MDHHS PACE Program oversight is conducted by both CMS and MDHHS. MDHHS program staff facilitate quarterly PACE Directors Meetings with the 13 PACE organizations. PACE Contract Managers have regular contact with PACE organizations. In addition, CMS Region 5 Account Managers meet monthly or bi-monthly with Michigan PACE organizations which include MDHHS PACE program staff.

PACE organizations must have a:

- Current organizational chart showing officials in the PACE organization and relationships to any other organizational entities. The organization must have a program director responsible for oversight and administration of the entity. The organization must also have a medical director who is responsible for the delivery of participant care, clinical outcomes, and implementation, as well as oversight, of the quality improvement program (QIP).
- Written quality improvement plan (QIP) that is collaborative and interdisciplinary in nature. The plan must be reviewed by a governing body annually and revised as indicated.
- Establish one or more 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 implementation of the Patient Self-Determination Act. The Participant Advisory Committee provides advice to the governing body on matters of concern to participants. Participants and representatives of participants must constitute a majority of the membership of this committee.

Assessment Methods

PACE quality monitoring and reporting requirements are outlined in Title 42 of The Code of Federal Regulations. PACE organizations must provide quarterly reports to CMS containing both aggregate and individual PACE quality data. CMS further requires ongoing quality data and any root cause analysis conducted to be reported to their CMS Account Manager. PACE organizations submit annual reports to MDHHS that include an Annual QIP Effectiveness Review and Work Plan and results of enrollee satisfaction surveys.

HEDIS®: Not Applicable

Member Surveys/CAHPS: PACE centers must conduct an annual participant satisfaction survey. Although a specific survey is not required, multiple PACE organizations utilize the Integrated Satisfaction Measurement for PACE (I-SAT™) survey. In addition, CMS administers the Medicare Health Outcomes Survey-Modified (HOS-M) to PACE enrollees. The HOS-M is a modified version of the Medicare HOS. The HOS-M design is based on a randomly selected sample of individuals from each participating PACE organization. The HOS–M is a cross–sectional survey, measuring the physical and mental health functioning of beneficiaries at a single point in time. This differs from the HOS, which has a follow-up component. https://www.hosonline.org/en/hos-modified-overview/

External Quality Review (EQR): An external quality review is conducted quarterly by CMS and MDHHS.

Performance Improvement Projects (PIPs): PACE organizations are required to conduct two PIPs that are described in their QIP. Examples of PIP topics include reducing falls, increased satisfaction with transportation, meals and homecare services. Organizations must: (1) Use a set of outcome measures to identify areas of good or problematic performance. (2) Take actions targeted at maintaining or improving care based on outcome measures. (3) Incorporate actions resulting in performance improvement into standards of practice for the delivery of care and periodically track performance to ensure that any performance improvements are sustained over time. (4) Set priorities for performance improvement, considering prevalence and severity of identified problems, and give priority to improvement activities that affect clinical outcomes. (5) Immediately correct any identified problem that directly or potentially threatens the health and safety of a PACE participant. The organization must designate an individual to coordinate and oversee implementation of quality assessment and performance improvement activities; and ensure that all interdisciplinary team members, PACE staff, and contract providers are involved in the development and implementation of quality improvement activities and are aware of the results of these activities. The QI coordinator must encourage a PACE participant and his or her caregivers to be involved in quality improvement activities, including providing information about their satisfaction with services.

Performance Monitoring Standards: All PACE quality data is reported in the *PACE Quality Monitoring Module in the Health Plan Management System (HPMS)*. At a minimum, the organization's QIP must specify how the PACE organization proposes to meet the following requirements:

- Identify areas to improve or maintain the delivery of services and patient care.
- Develop and implement plans of action to improve or maintain quality of care.

- Document and disseminate to PACE staff and contractors the results from the quality improvement activities.

The PACE QI program must include, but is not limited to, the use of objective measures to demonstrate improved performance for the following: (1) Utilization of PACE services (e.g., decreased inpatient hospitalizations and emergency room visits). (2) Caregiver and participant satisfaction. (3) Outcome measures derived from data collected during assessments, including data on physiological well-being, functional status, cognitive ability, social/behavioral functioning, and quality of life of participants. (4) Effectiveness and safety of staff-provided and contracted services, including competency of clinical staff, promptness of service delivery, achievement of treatment goals and measurable outcomes, and nonclinical areas, such as grievances and appeals, transportation services, meals, life safety, and environmental issues. Outcome measures must be based on current clinical practice guidelines and professional practice standards applicable to the care of PACE participants. Organizations must meet or exceed minimum levels of performance, established by CMS and MDHHS, on standardized quality measures which are specified in the PACE program agreement. PACE organizations may utilize National PACE Association (NPA) data reporting benchmarks when analyzing data and comparing performance.
https://www.npaonline.org/member-resources/analytics-data-and-benchmarking

Performance Bonus: PACE organizations will receive an incentive bonus or penalty that will be administered after the end of the rate year once the PACE organization's monthly enrollment reaches 150 participants by the first month of the proposed year. This adjustment is designed to minimize the number of voluntary disenrollments the PACE organization experiences. The adjustment will be based on the difference in cost of the region's fee-for-service average amount for an eligible beneficiary not enrolled in PACE compared to the capitation rate paid to the PACE organization. This difference will then be multiplied by the number of individuals above or below the "normal" disenrollment rate (which is currently 5% as established by the national PACE association). Voluntary disenrollment rates of less than 5% will entitle the PACE organization to receive this amount as a bonus while rates higher than 5% will result in this amount being charged as a monetary penalty.

Compliance Visits: CMS and MDHHS conduct comprehensive compliance reviews for contracted PACE organizations. CMS conducts an oversight visit every year for the first three years the organization is in operation. After this trial period, CMS audits based on a risk assessment. MDHHS PACE program staff conduct a review annually. If it is a CMS year, MDHHS staff coordinate with the scheduled CMS visit.

Quality/Population Health Initiatives

Not Applicable at this time.

Payment Model(s)

PACE is a capitated program with a per member per month payment. PACE organizations receive two separate payments if the enrollee is a dual Medicaid and Medicare participant. If an enrollee is a Medicaid only participant, the organization receives a higher reimbursement rate. The PACE program allows participants to provide private payment for the program services.

Performance Measures

PACE quality data reporting requirements and thresholds are outlined in ***Appendix A of the April 2018, CMS PACE Quality Monitoring & Reporting Guidance***. Organization must collect data, maintain records, and submit reports as required. Categories of data include, but are not limited to, quality data incidents related to abuse, adverse outcomes, elopements, adverse drug reactions, Emergency Department (ED) visits, enrollment data, equipment failures, grievances and appeals, immunizations, use of restraints, etc. Organizations must establish and maintain a health information system that collects, analyzes, integrates, and reports data necessary to

measure the organization's performance, including outcomes of care furnished to participants. The data items collected are specified in the PACE program agreement.

Appendix H

Michigan Medicaid Managed Care Program
Dental Programs

Managed Care Program Description: Dental Programs

MDHHS operates and oversees the Healthy Kids Dental (HKD) managed care dental program for children and Adults Dental Benefits including the Healthy Michigan Plan (HMP) Dental and Pregnant Women Dental Benefits. Multiple barriers to oral health have been identified including limited awareness of the importance of oral health; inequity in access in vulnerable populations such as women, children, physically disabled, tribal populations and elderly; cultural, gender and social barriers; and escalating cost of dental care. There is also a documented correlation between physical and oral health. MDHHS believes that access to effective oral health is necessary to improve overall physical health and to reduce health disparity and to achieve better health equity. We believe that better oral health leads to better quality of life and is an integral part of people's pursuit of happiness, hope and self-worth.

Healthy Kids/Healthy Kids Dental

The Healthy Kids program provides a wide range of health care coverage and support services for qualifying pregnant women, babies and children under age 19 (Healthy Kids Dental coverage is through age 20). 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 under the age of 21. 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.

Healthy Michigan Plan Dental

The Healthy Michigan Plan (HMP) provides dental benefits including preventive services, x-rays, fillings, tooth extractions, dentures and partial dentures to beneficiaries aged 19-64 yrs. HMP dental services are provided through Medicaid Fee-for-Service dental providers and after enrollment in a Medicaid Health Plan (MHP), dental services are provided by dental providers in the MHP network.

Pregnant Women Dental

Effective July 1, 2018, MDHHS expanded access to managed care dental services for pregnant women who are eligible for the Medicaid Dental Fee-for-Service benefit and enrolled in a Medicaid Health Plan (MHP). Beneficiaries are eligible to receive managed care dental services when beneficiaries: become pregnant, are enrolled in Medicaid Dental FFS; and are enrolled in a Medicaid Health Plan (MHP). Pregnant beneficiaries enrolled in the Healthy Kids Dental program continue to receive services through the Healthy Kids Dental program. Beneficiaries are eligible for the managed care dental benefit for the duration of their pregnancy and postpartum. The managed care dental benefit is administered through a contracted MHP dental vendor in the beneficiary's service area.

Populations with Dental Benefits

MDHHS dental programs and benefits serve a range of Medicaid populations including qualifying pregnant women, babies and children and adults through age 64 in Managed Care.

Quality Structure/Committees

MDHHS facilitates multiple committees where the contractual and performance requirements for the dental programs are discussed including the HKD Dental Quality Improvement Directors and HKD Operations meetings. In addition, HMP Dental and Pregnant Women Dental benefits are

discussed during MDHHS/MHP Bimonthly, Operations, and Quality Improvement Directors meetings.

Assessment Methods

HEDIS®: MDHHS currently utilizes one HEDIS® measure (Annual Dental visit) to assess plan performance. (This measure is currently under consideration for retirement by AHRQ.)

Member Surveys/CAHPS: MDHHS contracted with Health Services Advisory Group, Inc. (HSAG) to administer and report the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) for HKD and HMP Dental in FY 20. The goal of the CAHPS Health Plan Survey is to provide performance feedback that is actionable and that will aid in improving members' overall experiences with dental services. This is the first year Member satisfaction surveys were administered for HKD and HMP Dental.

External Quality Review (EQR): MDHHS has contracted with HSAG to conduct an external independent review of the quality and outcomes, timeliness of, and access to Covered Services provided by the Medicaid Health Plans. The EQR activities are intended to provide valid and reliable data and information about the MHPs' performance in the following areas: compliance monitoring; validation of performance measures; and validation of Performance Improvement Projects (PIPs) to ensure that the projects were designed, conducted, and reported in a methodologically sound manner. In FY 20, the HMP Dental CAHPS survey and compliance review for HMP and Pregnant Women Dental will be added to the MHP EQR technical report. MDHHS has also requested that HSAG create a separate EQR Report for the HKD program in FY 20.

Performance Improvement Projects (PIPs): A PIP is a required component for the HKD program and in FY 20 the topic of interest is increasing the number of dental visits before six years of age. The PIP should identify and be designed to achieve significant improvement, sustained over time, in oral health outcomes and enrollee satisfaction. In addition, the PIP must be data driven and include assessment of race/ethnicity, geography (region, county), etc. to identify target populations within the HKD program. The PIP will be included in the EQR Report and HSAG is providing technical assistance to the HKD program providers.

Performance Bonus: MDHHS has established a Value Based Performance (VBP) bonus for the HKD program. Focus areas in FY20 include: 1. Tracking of Non-utilizers and creating a roster; 2. Reporting telehealth visits for dental emergencies and any follow-up visits to telehealth visits; and 3. Outreach to Non-utilizers and facilitation of a Dental Home. In FY21, MDHHS will additionally require that plans submit a FY20 evaluation, create a proposal for VBP and provider scorecard, and enrollment of providers in VBP.

There is also cost sharing strategy for HMP Dental. In FY2020, the HMP Dental Measures include:

1. Diagnostic Dental Services: Members who received at least one diagnostic dental service within the measurement period.
2. Preventive Dental Services: Members who received at least one preventive dental service within the measurement period.

In FY 2020, MHPs will be compared to the State's overall percentiles at 50th, 75th and 90th and awarded points based on performance against the percentiles.

Compliance Visits: MDHHS conducts a compliance review for each of the 10 Medicaid Health Plans and the HKD program and HMP dental benefit. The review of Dental programs was added to the MDHHS FY2020 compliance review process. In addition, there will be separate focus study reviews for the HKD Dental and HMP Dental programs including submission of Quality strategies for Pregnant Women Dental Benefits. The review process includes but is not limited to an

assessment of dental policy, procedures and documentation, complaints processing, and data validation, etc.
The compliance review also accesses Provider Directory Network Adequacy (Accuracy, Timeliness for submissions). Future compliance review activities may include Secret Shopper Calls.

Third Party Evaluations: A program evaluation on the HKD program is conducted by the Child Health Evaluation and Research (CHEAR) Center at the University of Michigan (UM) (through a Public Health grant initiated by MDHHS) every few years. MDHHS annually submits the HKD evaluation results to the legislature every year, as required. In addition, MDHHS is required to submit EQR technical reports to the legislature for all Medicaid Health plans and a detailed report on the Pregnant Women Dental Benefits.

Quality/Population Health Initiatives

Social Determinants of Health (SDOH) are addressed as part of the Dental Quality Strategy in the area of Program outreach.

Payment Model(s)

MDHHS utilize a per member per month (PMPM) Capitated Rate Contract arrangement based on eligible members.

Performance Measures

Performance measures have been established for the HMP Dental program. Performance measures have also been established for Pregnant women dental on an "informational only" basis in FY20 to establish baseline data. Michigan specific benchmarks/performance goals will be established for FY21. Currently, CMS 416 measures are being collected and submitted for the HKD Dental program but not all measures have established national benchmarks. MDHHS is considering some dental quality assurance measures in the future.

MDHHS dental performance measures are included in the MHP Performance Monitoring Standards. The purpose of the performance monitoring standards is to establish an explicit process for the ongoing monitoring of health plan performance in important areas of quality, access, customer services and reporting. The performance monitoring standards are incorporated into the Contract between the State of Michigan and Contracting Health Plans. The MDHHS HMP and Pregnant Women Dental Measures are all run with custom coded queries.

Appendix I

Michigan Medicaid Managed Care Program
Behavioral Health Managed Care: Prepaid Inpatient Health Plans (PIHPs)/
Community Mental Health Service Programs (CMHSPs)

Managed Care Program Description: Pre-Paid Inpatient Health Plans (PIHPs) /Community Mental Health Service Programs (CMHSPs)

The Behavioral Health and Developmental Disabilities Administration (BHDDA) 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). It also administers Medicaid Waivers for people with developmental disabilities, mental illness, serious emotional disturbance, and it administers prevention and treatment services for substance use disorders.

BHDDA 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 CMHP networks. Through a combination of different PIHP/CMHSP management and service delivery models, CMHSPs are normally contracted to directly provide or contract for the majority of direct service including evaluation, service plan development/authorization, and certain quality improvement activities related to clinical service delivery.

Populations Served

The PIHPs serve Medicaid beneficiaries who require the Medicaid services included under: the 1115 Demonstration Waiver, 1915(i); who are eligible for the 1115 Healthy Michigan Plan, the Flint 1115 Waiver or Community Block Grant, who are enrolled in the 1915(c) Habilitation Supports Waiver; 1915(c) Children Waivers (SEDW and CWP) who are enrolled in program; or for whom the PIHP has assumed or been assigned County of Financial Responsibility (COFR) status under Chapter 3 of the Mental Health Code. The PIHPs also serve individuals covered under the SUD Community Grant. The Demonstration does not cover hospital, nursing facility for Long Term Supports Services.

Quality Structure/Committees

MDHHS requires that each specialty PIHP have a quality assessment and performance improvement program (QAPIP). In addition, the MDHHS, Quality Management and Planning (QMP) site review team completes on site reviews of PIHPs and their provider networks on a biennial basis assuring the service needs, including the health and welfare are met for the section 1115 population. Committees are as follows:

BHDDA Quality Improvement Council (QIC): The QIC meets quarterly; membership includes BHDDA, PIHP, and CMHSP representatives from quality and contract administration, provider organizations and advocacy members.

Behavior Treatment Review Committee: The committee meets monthly to review behavioral treatment processes at the CMHSP level.

Recovery-Oriented Systems of Care Recovery: In order to move toward a recovery-based system of services, MDHHS worked with the Recovery-Oriented System of Care (ROSC) Transformation Steering Committee (TSC) to develop expectations for systems change. These expectations are included in a formal document called Transformation Steering Committee, Recovery- Oriented System of Care Recovery Policy and Practice Advisory. The recovery-oriented system of care supports an individual's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports. The ROSC TSC created guiding principles of recovery and established expectations to guide organizations, including the PIHPs, in creating an environment and system of behavioral health services and supports that foster recovery and create a recovery-oriented system of care.

Assessment Methods

Each PIHP is required to have a quality assessment and performance improvement program (QAPIP) that includes the following components: performance measurement using standardized indicators in the areas of access, efficiency, and outcomes; Performance Improvement Projects (PIPs) that address clinical and non-clinical services; a process for the review and follow-up of sentinel events and other critical incidents and events that put members at risk of harm; periodic quantitative and qualitative assessments of member experiences with services; process for the adoption, development, implementation, and continuous monitoring and evaluation of practice guidelines, clinical standards and evidence-based practices; processes for credentialing and recredentialing providers; a process for verifying if reimbursed Medicaid services were performed; a written utilization management program description; and annual monitoring of provider network(s), affiliates, and subcontractors.

HEDIS®: A subset of HEDIS® measures are utilized to assess PIHP performance. PIHPs are evaluated on a small number of HEDIS®/NCQA measures, some jointly with the Medicaid Health Plans (MHPs).

Member Surveys/CAHPS: PIHPs must conduct periodic quantitative (e.g., surveys) and qualitative (e.g., focus groups) assessments of member experiences with its services. These assessments must be representative of the persons served and the services and supports offered; and must address the quality, availability, and accessibility of care.

Michigan participates in the annual **National Core Indicators (NCI) Survey**, a nationally recognized set of performance and outcome indicators to measure and track performance of public services for people with intellectual or developmental disabilities. Implementation of the NCI survey is done in collaboration with the PIHPs who provide the information/demographics needed to schedule and conduct the face to face surveys for the identified participants. The NCI survey indicators provide comprehensive and statistically reliable information based on a random sample of adult service recipients. BHDDA uses 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 BHDDA managed care performance dashboard. The indicators summarize the survey results from personal interviews with individuals with intellectual/developmental disabilities (I/DD) and the background information provided by the community mental health system. Performance indicators assess individual outcomes, health, welfare and rights (e.g., safety and personal security; health and wellness; and protection of and respect for individual rights.); and system performance (e.g., service coordination; family and individual participation in provider-level decisions; the utilization of and outlays for various types of services and supports; (d) cultural competency; and access to services).

External Quality Review (EQR): MDHHS contracts with Health Services Advisory Group (HSAG) to conduct an annual External Quality Review of the 10 PIHPs to gather valid and reliable data and information about the PIHPs' performance. HSAG uses the findings to derive conclusions and make

recommendations about the quality of, timeliness of, and access to care and services provided by each PIHP. Aggregate state and individual PIHP recommendations are provided.

Compliance monitoring: In the 2017–2018 reporting period, which was the first year of the three-year compliance review cycle, HSAG reviewed 50 percent of federally-mandated standards (4 of 8 standards) and their associated State-specific requirements, when applicable.

Validation of performance measures: HSAG validated the performance measures identified by MDHHS to evaluate the accuracy of the rates reported by or on behalf of each PIHP. The validation also determined the extent to which Medicaid-specific performance measures calculated by a PIHP followed the specifications established by MDHHS.

Validation of performance improvement projects (PIPs): For each PIHP, HSAG reviewed one PIP to ensure that the PIHP designed, conducted, and reported about the project in a methodologically sound manner to allow for improvements in care.

Performance Improvement Projects (PIPs): PIHPs must conduct two PIPs project during the waiver renewal period. PIPs may address clinical or non-clinical services that can be expected to have a beneficial effect on health outcomes and customer satisfaction. Clinical areas may include high-volume or high-risk services, and continuity and coordination of care. Non-clinical areas may be related to appeals, grievances and trends and patterns of complaints, and access to and availability of services. PIP topics address CMS' requirement for outcomes related to quality and access to care and services. EQR PIP topics for the 3-year cycle starting FY 2017/2018 are below. PIHPs were required to select one of the HEDIS® measures relating to integrated physical/mental health.

1. Follow-Up After Hospitalization for Mental Illness Within Seven Days of Discharge for Members Ages 6 Years and Older
2. Follow-Up Care for Children Prescribed ADHD Medication
3. Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)
4. Improving Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication
5. Patients with Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test
6. Patients with Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test
7. Improving Diabetes Screening Rates for People with Schizophrenia or Bipolar Who Are Using Antipsychotic Medications
8. Improving Diabetes Screening Rates for People with Schizophrenia or Bipolar Disorders Who Are Using Antipsychotic Medication
9. Reducing Acute Inpatient Recidivism for Adults with Serious Mental Illness (SMI)

Performance Monitoring Standards: Each fiscal year PIHPs and CMHSPs are measured on a specified set of performance indicators; the **Michigan Mission Based Performance Indicator System**. The performance indicator domains include access to care, adequacy and appropriateness of services provided, efficiency (administrative cost vs service costs), outcomes (employment, housing, inpatient readmission). Validation of the performance measures is included in the EQR.

Performance Bonus: MDHHS withholds a percent of payments to the specialty prepaid health plans for the purpose of establishing a performance bonus incentive pool (PBIP). Distribution of funds from the PBIP is contingent on the PIHP's results on the joint metrics, narrative reports and PIHP-only metrics.

Compliance Visits: MDHHS certifies Community Mental Health Programs every three years, and directly completes site reviews of PIHPs/CMHSP's and contract providers every two years. The MDHHS Quality Management and Planning (QMP) Site Review team conducts comprehensive

biennial reviews of the 10 PIHPs. A standard site review protocol is used at the time of each site visit. This site visit strategy includes rigorous standards for assuring the needs, including health and welfare of the current and proposed 1915 (c) waiver populations. The comprehensive reviews include consistent, uniform, person-centered and medical necessity/needs assessments from clinical record reviews, administrative reviews, consumer/stakeholder meetings and consumer interviews.

Quality/Population Health Initiatives

MDHHS emphasizes continuous evaluation of each PIHP's oversight of vulnerable members to determine opportunities for improving oversight of their care and outcomes. MDHHS works with the PIHPs to develop uniform methods for targeted monitoring of vulnerable members; and requires the PIHPs to annually analyze whether improvements have occurred in quality of healthcare and services for members as a result of quality assessment and improvement activities and implemented interventions. The PIHPs must evaluate its oversight of "vulnerable" people in order to determine opportunities for improving oversight of their care and their outcomes.

Payment Model(s)

MDHHS uses a managed care delivery structure using the 10 PIHPs who contract for service delivery with 46 CMHSP's and other non-for-profit providers. Through a combination of different PIHP and CMHSP management and service delivery models, CMHSP are contracted to directly provide or contract for the majority of direct service including evaluation, service plan development/authorization, and certain quality improvement activities related to clinical service delivery. MDHHS develops the rate methodologies for the 10 PIHPs who distribute funds and manage or provide oversight of the provider network including any MDHHS delegated functions. Substance Abuse services are purchased through the PIHPs and delivered through local Recovery Oriented Systems of Care.

Performance Measures

MDHHS measures PIHP performance using standard indicators based upon the systematic, ongoing collection and analysis of valid and reliable data. PIHPs must utilize performance measures established by MDHHS in the areas of access, adequacy/appropriateness, efficiency and outcomes and report data to MDHHS. The indicators are reported into Michigan's Mission-based Performance Indicator System (MMBPIS). The PIHPs may establish and monitor other performance indicators specific to its own program for the purpose of identifying process improvement projects. MDHHS establishes minimum performance levels for performance indicators. The MMBPIS establishes performance benchmarks/thresholds for the specified indicators (e.g., indicators 1, 2, 4, 4a and 4b have a 95% standard; indicator 10 is 15% (reverse measure)). For FY20, of the Performance Bonus Incentive Program measures only Follow Up after Hospitalization for Mental Illness within 30 Days (FUH) has a standard (Adult = 58%, Child = 70%). The URL for the MMBPIS is: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html Click on – 'PIHP and CMHSP Performance Indicator System.'

PIHPs must also follow-up on sentinel events and other critical incidents and events that put enrollees at risk for physical harm. The Critical Incent Reporting System captures information on five specific reportable events: suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospital due to injury or medication error, and arrest of consumer. The events are analyzed quarterly and are included in the site visit process.

Below are the performance measures that the site review team focuses on for the approved waiver populations:

1. Number and percent of reviewed participants where the IPOS includes services and supports that align with the individual's assessed needs.

2. Number and percent of reviewed participants where the IPOS had adequate strategies to address their assessed health and safety risks.
3. Number and percent of reviewed participants where the IPOS reflect their goals and preferences.
4. Number and percent of IPOS for reviewed participants in which services and supports are provided as specified in the plan, including type, amount, scope, duration and frequency.
5. Number and percent of participants requiring hospitalization due to injury related to the use of physical management.
6. How the number of beneficiaries within the PIHP boundaries are identified and tracked including how interventions are addressed in the IPOS including the prevention of modifiable risk factors and access to physical healthcare for individuals considered "High Utilizers".
7. Number and percent of participants requiring hospitalization due to medication error.
8. Number and percent of participants being reviewed where the BTPRC policy was followed.
9. MDHHS is in the process of developing performance measures to assess the settings' status in getting into compliance with the HCBS final rule, person-centered planning process and requirements around conflict free case management.

Appendix J

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:
(2.7) PROVIDER STIE 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: 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 an in-network provider or arranges for the member to obtain a second opinion outside the 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)
NCQA: MED 1, Element E: Out-of-Network Cost to Member

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:

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)

NCQA: MED 5, Element A: Coordinating Health Care Services for Members;
MED 6, Element A: Initial Screening of Member Needs

Submit policies and procedures for care coordination process including provisions for all members, including:

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)

NCQA: MED 6, Element A: Initial Screening of Member Needs

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)

NCQA: MED 6, Element A: Sharing Identification and Assessment Results

Submit policies and procedures that show MHP shares the results of its identification and assessment of members with:

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)

NCQA: MED 5, Element B: Maintaining and Sharing Member Health Records

Submit policies and procedures that show MHP requires:

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)

NCQA: MED 4, Element A: Adopting Written Policies for Privacy and Confidentiality

Submit written policies and procedures that address:

1. Information included in notification of privacy practices.
2. Access to PHI.
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.

NCQA: MED 4, Element B: Authorization

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.

(3.22) DELEGATION AGREEMENTS

Authority: 438.230(c)(1)(i-iii)

NCQA: MED 15: Element A: Delegation Agreement

Submit written delegation agreement which must meet the following:

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.

NCQA QUALITY MANAGEMENT AND IMPROVEMENT STANDARDS:

(4.1) ADOPTION OF CLINICAL PRACTICE GUIDELINES

Authority: 1.1XI(A); CMS 438.236(b)(1-4)

NCQA: MED 2: Element A: Adoption of Practice Guidelines

Submit policies and procedures that demonstrate MHP adopts at least four evidence-based clinical practice guidelines, approved by its QI committee, that:

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.

(4.2) POLICY/PROCEDURE FOR CLINICAL PRACTICE GUIDELINES

Authority: 1.1XI(A); CMS 438.236(c)

NCQA: MED 2: Element B: Distribution of Practice Guidelines

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.

(4.21) COMPENSATION FOR UTILIZATION MANAGEMENT ACTIVITIES

Authority: XI. I. 6.; 438.210(e)

NCQA: MED 9: Element D: Affirmative Statement About Incentives

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:

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.

(4.22) BASIC ELEMENTS OF QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAMS

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.
3. Mechanisms to assess the quality and appropriateness of care provided to members using LTSS.
4. Participation in efforts to prevent, detect and remediate critical incidents for members with LTSS needs.

Appendix K

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 (6):

- *Children and Adolescents' Access to Primary Care Practitioners*— assesses the percentage of members who had a visit with a PCP during the measurement year or the year prior to the measurement year.
- *Ages 12 to 24 Months*,
- *Ages 25 Months to 6 Years*,
- *Ages 7 to 11 Years*, and
- *Ages 12 to 19 Years*
- Adults' Access to Preventive/Ambulatory Health Services—Total (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.

Chronic Care Set of three (3) HEDIS® and four (4) AHRQ – Prevention Quality Indicators (PQIs) Measures.

Diabetes HEDIS® Measures:

- *Comprehensive Diabetes Care—HbA1c Testing* assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had HbA1c testing.
- *Comprehensive Diabetes Care— Eye Exam (Retinal) Performed* assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had screening or monitoring for diabetic retinal disease.
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy* assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who received medical attention for nephropathy.
- Prevention Quality Indicators for Asthma & COPD

AHRQ Prevention Quality Indicator (PQI) Measures:

- *PQI 01: Diabetes short-term complications admission rate* 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.
- *PQI 05: Chronic obstructive pulmonary disease or Asthma in older adults admission rate* 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.
- *PQI 08: Congestive heart failure admission rate* 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

Three (3) Women—Adult Care Measures and one (1) Pregnancy Care Measure.

Women-Adult Care Measures:

- *Breast Cancer Screening* assesses the percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer on or after October 1 two years

prior to the measurement year. Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2019 and prior years.

- *Cervical Cancer Screening* assesses the percentage of women 21 to 64 years of age who were screened for cervical cancer using either of the following criteria:
    - Women 21 to 64 years of age who had cervical cytology performed every three years.
    - Women 30 to 64 years of age who had cervical cytology/human papillomavirus co-testing performed every five years.
- *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.

Appendix L

Hospital Reimbursement Adjustment (HRA) Program
Quality Performance Measures

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. 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):

- *Ambulatory Care—Total* (Per 1,000 Member Months) measure summarizes use of ambulatory care for ED Visits—Total and Outpatient Visits—Total
- *Inpatient Utilization—General Hospital/Acute Care—Total* measure summarizes use of acute inpatient care and services in four categories:
  - Total Inpatient,
  - Medicine,
  - Surgery, and
  - Maternity.
- *Children and Adolescents' Access to Primary Care Practitioners* assesses the percentage of members who had a visit with a PCP during the measurement year or the year prior to the measurement year for the following age categories:
  - Ages 12 to 24 Months,
  - Ages 25 Months to 6 Years,
  - Ages 7 to 11 Years, and
  - Ages 12 to 19 Years.
- *Adults' Access to Preventive/Ambulatory Health Services—Total* (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.
- *Plan All-Cause Readmissions* 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 (4):

- *PQI 01: Diabetes short-term complications admission rate* 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.
- *PQI 05: Chronic obstructive pulmonary disease or Asthma in older adults admission rate* 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.
- *PQI 08: Congestive heart failure admission rate* 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
- *PQI 15: Asthma in younger adults' admission rate* 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):

- ***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.