SFY 2018–2019 External Quality Review Technical Report *for* Integrated Care Organizations

March 2020

HSAG HEALTH SERVICES ADVISORY GROUP

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HSAG HEALTH SERVICES ADVISORY GROUP

1. Executive Summary

Purpose and Overview of Report

States with Medicaid managed care delivery systems are required to annually provide an assessment of managed care entities' 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. To meet this requirement, the Michigan Department of Health and Human Services (MDHHS) has contracted with Health Services Advisory Group, Inc. (HSAG) to perform the assessment and produce this annual report.

MDHHS administers and oversees the MI Health Link program, which provides integrated services to individuals eligible for both Medicare and Medicaid benefits. The MI Health Link program's managed care entities include seven integrated care organizations (ICOs) contracted with MDHHS to provide primary, acute, behavioral health, and long-term services and supports (LTSS) to dual-eligible recipients in Michigan. The ICOs include:

- Aetna Better Health of Michigan
- AmeriHealth Michigan, Inc.
- HAP Empowered
- Meridian Health Plan
- Michigan Complete Health
- Molina Healthcare of Michigan
- Upper Peninsula Health Plan

Scope of External Quality Review Activities

To conduct this assessment, HSAG used the results of mandatory external quality review (EQR) activities, as described in 42 CFR §438.358. The purpose of these activities, in general, is to provide valid and reliable data and information about the ICOs' performance. For the state fiscal year (SFY) 2018–2019 assessment, HSAG used 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 provided by each ICO. More detailed information about each activity is provided in ***Section 4*** of this report.

- **Compliance Review:** HSAG conducted a comprehensive review of the ICOs' compliance with all federally-mandated Medicaid managed care standards and their associated State-specific requirements, when applicable.
- **Validation of Performance Measures:** Centers for Medicare & Medicaid Services (CMS) contracted with the National Opinion Research Center at the University of Chicago (NORC), who

subcontracted with HSAG to validate the data collection and reporting processes used by the ICOs to report data for two CMS-selected performance measures. For this annual EQR, HSAG also reviewed and reported on ICO-specific and statewide aggregated Healthcare Effectiveness Data and Information Set (HEDIS®)[1-1] 2018 data collected by MDHHS.

- **Validation of Quality Improvement Projects (QIPs):** HSAG reviewed one QIP for each ICO 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.

High-Level Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from the preceding 12 months to comprehensively assess the ICOs' performance in providing quality, timely, and accessible healthcare services to Michigan dual-eligible members. For each ICO reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the ICO's performance. For a more detailed and comprehensive discussion of the strengths, weaknesses, conclusions, and recommendations for each ICO, please refer to ***Section 5*** of this report.

The overall findings and conclusions for all ICOs were also compared and analyzed to develop overarching conclusions and recommendations for the Medicaid managed care program specific to the MI Health Link program. For a more detailed discussion of the strengths, weaknesses, conclusions, and recommendations for the MI Health Link program, please refer to ***Section 6*** of this report.

Michigan Department of Health and Human Services

Program Strengths

Through completion of this annual comprehensive EQR technical report, HSAG aggregated and analyzed the performance results for the MDHHS managed care program, identifying areas of strength across the program. Through the compliance review activity, the program demonstrated 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.

Additionally, as demonstrated through the performance measure activities, The MI Health Link program performed better than the Medicare-Medicaid Plan (MMP) National Average in 17 of the 43 reported HEDIS measures. Domains demonstrating strong performance included Respiratory Conditions, Medication Management and Care Coordination, Overuse/Appropriateness, Access/Availability of Care, and Risk Adjusted Utilization.

[1-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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.

Program Opportunities for Improvement

This annual comprehensive assessment also revealed that predominant areas of the program had opportunities for improvement when overall program performance was evaluated through the compliance review, performance measure validation (PMV) and HEDIS performance rates, and QIP activities. These primary areas of focus include:

Coordination and continuity of care

Results from the compliance review activity indicated a significant need to enhance care management records and processes, as indicated by a statewide performance score of 76 percent, which was the lowest performing program area.

Additionally, statewide performance in all six HEDIS measures within the Behavioral Health domain rated below the MMP National Average when compared to other MMPs. Although MDHHS has implemented a QIP related to follow-up after hospitalization for mental illness, the program still has opportunities to improve coordination of care related to behavioral health services.

Coverage and authorization of services

The Coverage and Authorization of Services standard through the compliance review was the third lowest performing area. The compliance review indicated the ICOs were not consistently adhering to State and federal rules related to member notices.

Grievance and appeal systems

The compliance review activity revealed there were significant opportunities for improvement in the ICOs' grievance and appeal procedures as indicated by a statewide performance score of 77 percent, which was the second lowest performing program area.

Subcontractual relationships and delegation

Although the ICOs received an aggregate score of 80 percent in the Subcontractual Relationships and Delegation standard during the compliance review activity, there was a significant deficiency at most ICOs related to formal reviews being conducted on member-facing delegates.

Quality assessment and performance improvement program

While there were mixed performance results across the MI Health Link program related to quality assessment and performance improvement, HSAG determined that, overall, there is need for enhanced focus on the ICOs' Quality Assessment and Performance Improvement Plans (QAPIPs) in order to improve performance across the program in the areas of quality, timeliness, and access to care.

Significant opportunities for improvement for the MI Health Link program were identified specifically when statewide HEDIS performance was compared to the MMP National Average.

Program Recommendations

To improve statewide performance in the quality and timeliness of, and access to care, HSAG makes the following recommendations to MDHHS in the performance areas of Coordination and Continuity of Care, Coverage and Authorization of Services, Grievance and Appeal Systems, Subcontractual Relationships and Delegation, and Quality Assessment and Performance Improvement Program.

- Coordination and continuity of care
  - Improve statewide performance related to individualized service planning by targeting specific areas of the Individual Integrated Care and Supports Plan (IICSP) periodically to monitor compliance with the person-centered planning process.
- Coverage and authorization of services
  - Improve statewide performance related to utilization management—specifically, authorization denials—by requiring ICOs to submit a quarterly authorization denial file with specific data sets to allow MDHHS to monitor compliance with coverage denial decision requirements.
- Grievance and appeal systems
  - Conduct a review of the number and types of grievances tracked by each ICO to identify systemic trends and statewide improvement strategies.
- Subcontractual relationships and delegation
  - Require ICOs to conduct a formal review of each member-facing delegate, including the prepaid inpatient health plans (PIHPs), annually or another time frame specified by the State.
- Quality assessment and performance improvement program
  - Complete a comprehensive assessment of each ICO's QAPIP annually.

Aetna Better Health of Michigan

Based on the aggregated results of the SFY 2018–2019 EQR activities, **Aetna Better Health of Michigan** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **Aetna Better Health of Michigan** received a total compliance score of 90 percent across all 11 standards reviewed in 2019, which was the highest score across all ICOs.
- **Aetna Better Health of Michigan** scored at or above 90 percent in the Assurance of Adequate Capacity and Services, Coverage and Authorization of Services, Provider Selection, Subcontractual Relationships and Delegation, Practice Guidelines, Health Information Systems, and Quality Assessment and Performance Improvement Program standards, indicating strong performance in these areas.
- **Aetna Better Health of Michigan** scored 82 percent, 82 percent, 86 percent, and 88 percent, respectively, in the Availability of Services, Coordination and Continuity of Care, Confidentiality,

and Grievance and Appeal Systems standards, reflecting that additional focus is needed in these areas.

- **Aetna Better Health of Michigan**'s Core Measure 2.1 and Core Measure 3.2 PMV resulted in the validation designation of REPORT for both measures, indicating measure data were compliant with CMS' specifications and the data were valid.
- **Aetna Better Health of Michigan** performed better than the statewide average in 23 of the 43 HEDIS performance measures (53 percent).
- **Aetna Better Health of Michigan** demonstrated opportunities for improvement in the Medication Management and Care Coordination, and Access/Availability of Care domains in comparison to the statewide average.
- **Aetna Better Health of Michigan** received a *Met* score in 91 percent of the applicable Design and Implementation stages reviewed during the SFY 2018–2019 QIP *Follow-Up After Hospitalization for Mental Illness*.

As a result of the findings related to the quality and timeliness of, and access to care and services provided by **Aetna Better Health of Michigan** to members, HSAG recommends that **Aetna Better Health of Michigan** develop a quality improvement strategy to address the performance measures requiring improvement, listed in ***Section 5***. **Aetna Better Health of Michigan** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Aetna Better Health of Michigan** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the SFY 2018–2019 compliance review. Further, **Aetna Better Health of Michigan** should take proactive steps to ensure a successful QIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner.

AmeriHealth Michigan, Inc.

Based on the aggregated results of the SFY 2018–2019 EQR activities, **AmeriHealth Michigan, Inc.** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **AmeriHealth Michigan, Inc.** received a total compliance score of 76 percent across all 11 standards reviewed in 2019, which was one of the lowest scores across all ICOs.
- **AmeriHealth Michigan, Inc.** scored 100 percent in the Confidentiality standard, indicating strong performance in this area.
- **AmeriHealth Michigan, Inc.** scored 82 percent, 67 percent, 71 percent, 68 percent, 80 percent, 73 percent, 80 percent, 75 percent, 88 percent, and 82 percent, respectively, in the Availability of Services, Assurance of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Grievance and Appeal Systems, Subcontractual Relationships and Delegation, Practice Guidelines, Health Information Systems, and

Quality Assessment and Performance Improvement Program standards, reflecting that additional focus is needed in these areas.

- **AmeriHealth Michigan, Inc.**'s Core Measure 2.1 and Core Measure 3.2 PMV resulted in the validation designation of REPORT for both measures, indicating measure data were compliant with CMS' specifications and the data were valid.
- **AmeriHealth Michigan, Inc.** performed better than the statewide average in 10 of the 43 HEDIS performance measures (23 percent).
- **AmeriHealth Michigan, Inc.** demonstrated opportunities for improvement in the Prevention and Screening, Diabetes, Musculoskeletal Conditions, Behavioral Health, Medication Management and Care Coordination, Access/Availability of Care, and Risk Adjusted Utilization domains in comparison to the statewide average.
- **AmeriHealth Michigan, Inc.** received a *Met* score in 100 percent of the applicable Design and Implementation stages reviewed during the SFY 2018–2019 QIP *Follow-Up After Hospitalization for Mental Illness*.

As a result of the findings related to the quality and timeliness of, and access to care and services provided by **AmeriHealth Michigan, Inc.** to members, HSAG recommends that **AmeriHealth Michigan, Inc.** develop a quality improvement strategy to address the performance measures requiring improvement, listed in ***Section 5***. **AmeriHealth Michigan, Inc.** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **AmeriHealth Michigan, Inc.** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the SFY 2018–2019 compliance review. Further, **AmeriHealth Michigan, Inc.** should take proactive steps to ensure a successful QIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner.

HAP Empowered

Based on the aggregated results of the SFY 2018–2019 EQR activities, **HAP Empowered** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **HAP Empowered** received a total compliance score of 76 percent across all 11 standards reviewed in 2019, which was one of the lowest scores across all ICOs.
- **HAP Empowered** scored 100 percent in the Health Information Systems standard, indicating strong performance in this area.
- **HAP Empowered** scored 73 percent, 83 percent, 82 percent, 79 percent, 80 percent, 86 percent, 67 percent, 60 percent, 75 percent, and 73 percent, respectively, in the 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, and Quality Assessment and Performance Improvement Program standards, reflecting that additional focus is needed in these areas.

- **HAP Empowered**'s Core Measure 2.1 and Core Measure 3.2 PMV resulted in the validation designation of REPORT for both measures, indicating measure data were compliant with CMS' specifications and the data were valid.
- **HAP Empowered** performed better than the statewide average in 13 of the 43 HEDIS performance measures (30 percent).
- **HAP Empowered** demonstrated opportunities for improvement in the Prevention and Screening, Respiratory Conditions, Diabetes, Medication Management and Care Coordination, and Access/Availability of Care domains in comparison to the statewide average.
- **HAP Empowered** received a *Met* score in 100 percent of the applicable Design and Implementation stages reviewed during the SFY 2018–2019 QIP *Follow-Up After Hospitalization for Mental Illness*.

As a result of the findings related to the quality and timeliness of, and access to care and services provided by **HAP Empowered** to members, HSAG recommends that **HAP Empowered** develop a quality improvement strategy to address the performance measures requiring improvement, listed in ***Section 5***. **HAP Empowered** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **HAP Empowered** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the SFY 2018–2019 compliance review. Further, **HAP Empowered** should take proactive steps to ensure a successful QIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner.

Meridian Health Plan

Based on the aggregated results of the SFY 2018–2019 EQR activities, **Meridian Health Plan** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **Meridian Health Plan** received a total compliance score of 76 percent across all 11 standards reviewed in 2019, which was one of the lowest scores across all ICOs.
- **Meridian Health Plan** scored 100 percent in the Confidentiality standard, indicating strong performance in this area.
- **Meridian Health Plan** scored 73 percent, 67 percent, 65 percent, 68 percent, 80 percent, 85 percent, 80 percent, 50 percent, 88 percent, and 64 percent, respectively, in the Availability of Services, Assurance of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Grievance and Appeal Systems, Subcontractual Relationships and Delegation, Practice Guidelines, Health Information Systems, and Quality

Assessment and Performance Improvement Program standards, reflecting that additional focus is needed in these areas.

- **Meridian Health Plan**'s Core Measure 2.1 and Core Measure 3.2 PMV resulted in the validation designation of REPORT for both measures, indicating measure data were compliant with CMS' specifications and the data were valid.
- **Meridian Health Plan** performed better than the statewide average in 26 of the 43 HEDIS performance measures (60 percent).
- **Meridian Health Plan** demonstrated opportunities for improvement in the Overuse/Appropriateness and Access/Availability of Care domains in comparison to the statewide average.
- **Meridian Health Plan** received a *Met* score in 100 percent of the applicable Design and Implementation stages reviewed during the SFY 2018–2019 QIP *Follow-Up After Hospitalization for Mental Illness.*

As a result of the findings related to the quality and timeliness of, and access to care and services provided by **Meridian Health Plan** to members, HSAG recommends that **Meridian Health Plan** develop a quality improvement strategy to address the performance measures requiring improvement, listed in ***Section 5***. **Meridian Health Plan** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Meridian Health Plan** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the SFY 2018–2019 compliance review. Further, **Meridian Health Plan** should take proactive steps to ensure a successful QIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner.

Michigan Complete Health

Based on the aggregated results of the SFY 2018–2019 EQR activities, **Michigan Complete Health** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **Michigan Complete Health** received a total compliance score of 86 percent across all 11 standards reviewed in 2019, which was the second highest score across all ICOs.
- **Michigan Complete Health** scored above 90 percent in the Availability of Services, Assurance of Adequate Capacity and Services, Provider Selection, Confidentiality, Practice Guidelines, Health Information Systems, and Quality Assessment and Performance Improvement Program standards, indicating strong performance in these areas.
- **Michigan Complete Health** scored 82 percent, 68 percent, 79 percent, and 80 percent, respectively, in the Coordination and Continuity of Care, Coverage and Authorization of Services, Grievance and Appeal Systems, and Subcontractual Relationships and Delegation standards, reflecting that additional focus is needed in these areas.

- **Michigan Complete Health**'s Core Measure 2.1 and Core Measure 3.2 PMV resulted in the validation designation of REPORT for both measures, indicating measure data were compliant with CMS' specifications and the data were valid.
- **Michigan Complete Health** performed better than the statewide average in 20 of the 43 HEDIS performance measures (47 percent).
- **Michigan Complete Health** demonstrated opportunities for improvement in the Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Musculoskeletal Conditions, Medication Management and Care Coordination, and Access/Availability of Care domains in comparison to the statewide average.
- **Michigan Complete Health** received a *Met* score in 100 percent of the applicable Design and Implementation stages reviewed during the SFY 2018–2019 QIP *Follow-Up After Hospitalization for Mental Illness.*

As a result of the findings related to the quality and timeliness of, and access to care and services provided by **Michigan Complete Health** to members, HSAG recommends that **Michigan Complete Health** develop a quality improvement strategy to address the performance measures requiring improvement, listed in ***Section 5***. **Michigan Complete Health** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Michigan Complete Health** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the SFY 2018–2019 compliance review. Further, **Michigan Complete Health** should take proactive steps to ensure a successful QIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner.

Molina Healthcare of Michigan

Based on the aggregated results of the SFY 2018–2019 EQR activities, **Molina Healthcare of Michigan** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **Molina Healthcare of Michigan** received a total compliance score of 80 percent across all 11 standards reviewed in 2019, which was similar to the aggregated performance score across all ICOs.
- **Molina Healthcare of Michigan** scored above 90 percent in the Availability of Services, Provider Selection, Confidentiality, Practice Guidelines, and Health Information Systems standards, indicating strong performance in these areas.
- **Molina Healthcare of Michigan** scored 83 percent, 82 percent, 84 percent, 58 percent, 80 percent, and 73 percent, respectively, in the Assurance of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Grievance and Appeal Systems,

Subcontractual Relationships and Delegation, and Quality Assessment and Performance Improvement Program standards, reflecting that additional focus is needed in these areas.

- **Molina Healthcare of Michigan**'s Core Measure 2.1 and Core Measure 3.2 PMV resulted in the validation designation of REPORT for both measures, indicating measure data were compliant with CMS' specifications and the data were valid.
- **Molina Healthcare of Michigan** performed better than the statewide average in 27 of the 43 HEDIS performance measures (63 percent).
- **Molina Healthcare of Michigan** demonstrated opportunities for improvement in the Respiratory Conditions, Cardiovascular Conditions, Medication Management and Care Coordination, Overuse/Appropriateness, and Risk Adjusted Utilization domains in comparison to the statewide average.
- **Molina Healthcare of Michigan** received a *Met* score in 100 percent of the applicable Design and Implementation stages reviewed during the SFY 2018–2019 QIP *Follow-Up After Hospitalization for Mental Illness.*

As a result of the findings related to the quality and timeliness of, and access to care and services provided by **Molina Healthcare of Michigan** to members, HSAG recommends that **Molina Healthcare of Michigan** develop a quality improvement strategy to address the performance measures requiring improvement, listed in ***Section 5***. **Molina Healthcare of Michigan** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Molina Healthcare of Michigan** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the SFY 2018–2019 compliance review. Further, **Molina Healthcare of Michigan** should take proactive steps to ensure a successful QIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner.

Upper Peninsula Health Plan

Based on the aggregated results of the SFY 2018–2019 EQR activities, **Upper Peninsula Health Plan** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **Upper Peninsula Health Plan** received a total compliance score of 85 percent across all 11 standards reviewed in 2019, which was the third highest score across all ICOs.
- **Upper Peninsula Health Plan** scored at or above 90 percent in the Assurance of Adequate Capacity and Services, Provider Selection, Confidentiality, and Practice Guidelines standards, indicating strong performance in these areas.
- **Upper Peninsula Health Plan** scored 82 percent, 71 percent, 84 percent, 88 percent, 80 percent, 88 percent, and 82 percent, respectively, in the Availability of Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Grievance and Appeal Systems, Subcontractual

Relationships and Delegation, Health Information Systems, and Quality Assessment and Performance Improvement Program standards, reflecting that additional focus is needed in these areas.

- **Upper Peninsula Health Plan**'s Core Measure 2.1 and Core Measure 3.2 PMV resulted in the validation designation of REPORT for both measures, indicating measure data were compliant with CMS' specifications and the data were valid.
- **Upper Peninsula Health Plan** performed better than the statewide average in 31 of the 43 HEDIS performance measures (72 percent).
- **Upper Peninsula Health Plan** demonstrated opportunities for improvement in the Respiratory Conditions and Overuse/Appropriateness domains in comparison to the statewide average.
- **Upper Peninsula Health Plan** received a *Met* score in 100 percent of the applicable Design and Implementation stages reviewed during the SFY 2018–2019 QIP *Follow-Up After Hospitalization for Mental Illness*.

As a result of the findings related to the quality and timeliness of, and access to care and services provided by **Upper Peninsula Health Plan** to members, HSAG recommends that **Upper Peninsula Health Plan** develop a quality improvement strategy to address the performance measures requiring improvement, listed in ***Section 5***. **Upper Peninsula Health Plan** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Upper Peninsula Health Plan** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the SFY 2018–2019 compliance review. Further, **Upper Peninsula Health Plan** should take proactive steps to ensure a successful QIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner.

2. Introduction to the Annual Technical Report

Purpose of Report

States that provide Medicaid services through contracts with ICOs are required to conduct EQR activities of the ICOs and to ensure that the results of those activities are used to perform an external, independent assessment and to produce an annual report. The annual assessment evaluates each ICO's performance related to the quality of, timeliness of, and access to the care and services it provides. To meet the requirement to conduct this annual evaluation and produce this report of results, MDHHS contracted with HSAG as its external quality review organization (EQRO).

Organizational Structure of Report

As mandated by CFR §438.364 and in compliance with CMS' EQR protocols and the External Quality Review Toolkit for States, this technical report:

- Describes how data from EQR activities conducted in accordance with §438.358 were aggregated and analyzed by HSAG.
- Describes the scope of the EQR activities.
- Assesses each ICO's strengths and weaknesses and presents conclusions drawn about the quality of, timeliness of, and access to care furnished by the ICOs.
- Includes recommendations for improving the quality of, timeliness of, and access to care and services furnished by the ICOs, including recommendations for each individual ICO and recommendations for MDHHS to target the MI Health Link Quality Strategy and MDHHS strategic priorities to improve the quality of care provided by the MI Health Link program.
- Contains methodological and comparative information for all ICOs.
- Assesses the degree to which each ICO has effectively addressed recommendations for quality improvement made by the EQRO during the previous year's EQR.

This report is composed of six sections: Executive Summary, Introduction to the Annual Technical Report, Overview of MI Health Link Program, External Quality Review Activities, Assessment of ICO Performance, and ICO Comparative Information With Recommendations for MDHHS.

Section 1—Executive Summary

The Executive Summary section presents a high-level overview of the EQR activities, conclusions, and recommendations for the MDHHS MI Health Link program and the ICOs.

Section 2—Introduction to the Annual Technical Report

The Introduction to the Annual Technical Report section provides information about the purpose, contents, and organization of the annual technical report.

Section 3—Overview of MI Health Link Program

The Overview of MI Health Link Program section gives a description of the Medicaid managed care MI Health Link program, brief descriptions of each of the ICOs that contract with MDHHS to provide services to members, and a brief overview of the MI Health Link Quality Strategy and goals for the health of Michigan's dual-eligible population.

Section 4—External Quality Review Activities

The External Quality Review Activities section presents information about each of the EQR activities conducted, including the activity's objectives, technical methods of data collection and analysis, a description of the data obtained, and the time period under review.

Section 5—Assessment of ICO Performance

The Assessment of ICO Performance section presents the ICO-specific results for each of the EQR activities conducted during the SFY 2018–2019 review period.

Section 6—ICO Comparative Information With Recommendations for MDHHS

The ICO Comparative Information With Recommendations for MDHHS section presents summarized data and comparative information about the ICOs' performance. This section also identifies areas in which MDHHS could leverage or modify the MI Health Link Quality Strategy to promote improvement based on ICO performance.

3. Overview of MI Health Link Program

Managed Care in Michigan and Overview of ICOs

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

Overview of ICOs

During the SFY 2018–2019 review period, MDHHS contracted with seven qualified ICOs. These ICOs are responsible for the provision of services to MI Health Link members. Table 3-1 provides a profile for each ICO.

Table 3-1—ICO Profiles

ICO	Covered Services	Regions Served by ICO[3-1]
Aetna Better Health of Michigan	All ICOs cover medically necessary services such as the following: • Medical services, including preventive care and screening, physician visits, lab tests and x-rays, therapy, and hospital stays • Dental, vision, and hearing services • In-home services • Community-based long-term care services • Community mental health services • Nursing facility care • Medications • Equipment and supplies • Transportation	Regions 4, 7, and 9
AmeriHealth Michigan, Inc.		Regions 7 and 9
HAP Empowered		Regions 7 and 9
Meridian Health Plan		Region 4
Michigan Complete Health		Regions 7 and 9
Molina Healthcare of Michigan		Regions 7 and 9
Upper Peninsula Health Plan		Region 1

[3-1] Michigan Department of Health and Human Services Integrated Care Division. *Enrollment Dashboard*. February 2018. Available at: https://www.michigan.gov/documents/mdhhs/MI_Health_Link_Public_Dashboard_502731_7.pdf. Accessed on: December 30, 2019.

Quality Strategy

To carry out its mission to provide opportunities, services, and programs that promote a healthy, safe, and stable environment for Michigan residents to be self-sufficient, MDHHS has established six strategic priority areas. Table 3-2 outlines the MDHHS strategic priorities.

Table 3-2—MDHHS Strategic Priorities

Priorities	
Children*	Ensure that Michigan youth are healthy, protected, and supported on their path to adulthood.
Adults	Safeguard, respect, and encourage the wellbeing of Michigan adults in our communities and our care.
Family Support	Support families and individuals on their road to self-sufficiency through responsive, innovative, and accessible service delivery.
Health Services	Transform the healthcare system and behavioral health coordination to improve outcomes for residents.
Population Health	Promote and protect the health, wellness, and safety of all Michigan residents.
Workforce	Strengthen opportunities, promote diversity, and empower our workforce to contribute to Michigan's economic development.

*The MI Health Link program includes members ages 21 years and older; therefore, this priority would not be applicable to the program.

MDHHS has employed a population health management framework and contracted with high-performing health plans in order to build a Medicaid managed care delivery system that maximizes the health status of members, improves member experience, and lowers cost. Through evidence- and value-based care delivery models, supported by health information technology/health information exchange and a robust quality strategy with focused initiatives, MDHHS supports ICOs in achieving the goals of the Medicaid program and Michigan's strategic priorities. In addition to the overarching Michigan Medicaid priority areas, MDHHS developed goals and objectives within its MI Health Link Quality Strategy that align with the six priorities of the National Strategy for Quality Improvement in Health Care established by the Secretary of Health and Human Services: making care safer; ensuring that each person and his or her family is engaged as partners in their care; promoting effective communication and coordination of care; promoting the most effective prevention and treatment practices for the leading causes of mortality; working with communities to promote wide use of best practices to enable healthy living; and making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models. These goals and objectives include:

Goal 1: ***Provide seamless access to supports and services***

Objective: ***Ensure ICO timeliness of screening, Level I and Level II assessments, and documentation of member's desired care plan goals***

All members receive an initial screening and Level I assessment performed by the ICO. A Level II assessment is performed for members who require additional community-based LTSS and/or behavioral health supports and services. Based on the results of the comprehensive assessment, an IICSP is developed that identifies and prioritizes the member's desired clinical, behavioral, functional, and social support needs. Through timely performance of assessments, regular interaction of the member with his or her care coordinator and the integrated care team (ICT), and adherence to the IICSP, members will have seamless access to care.

Goal 2: ***Maximize program efficiency, effectiveness, and responsiveness***

Objective: ***Develop and maintain an MI Health Link performance indicator dashboard***

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.

Goal 3: ***Emphasize use of in home and community-based services***

Objective: ***Integrate 1915(c) waiver requirements into ICO contracts and performance monitoring processes***

Michigan provides home and community-based services (HCBS) to MI Health Link members through a 1915(c) waiver authorized by CMS specifically for FAI. The ICOs have responsibility for determining the appropriateness of HCBS for members, which includes conducting the Michigan nursing facility level of care determination (NFLOCD) tool. The ICO uses the results of the NFLOCD and comprehensive assessment to identify the supports and services for which a member qualifies, including self-directed community benefits. The ICO works with the member and the member's ICT in the person-centered planning process to develop an IICSP that ensures, among other things, the member's health, safety, and welfare that may delay or prevent the need for institutional placement.

Goal 4: ***Monitor and improve quality of care and the health and welfare of members***

Objective: ***Incorporate clinical improvement initiatives based on the Quality Withhold Measures into the ICO contracts and each ICO's QAPIP***

The MI Health Link program quality measures are aligned with CMS FAI requirements, regulatory requirements, and stakeholder input. MDHHS reviews, analyzes trends, and reports quality measures established for the MI Health Link program. Additionally, MDHHS monitors and evaluates ICO compliance with established standards for access, structure and operations, and measurement and improvement standards. ICO performance is compared to the overall ICO average, other State demonstration program results, and national benchmarks where available. Based on performance

monitoring and measurement results, improvement opportunities are identified and incorporated into the MI Health Link Quality Strategy framework. To incentivize quality improvement, CMS and MDHHS withhold a portion of the ICO capitation payment that ICOs can earn back if they meet certain quality thresholds. CMS and MDHHS have identified specific quality measures that are the basis for the quality withhold bonus.

In summary, the MI Health Link Quality Strategy is intended to provide a framework for measuring and improving care and services for members in the MI Health Link program. The MI Health Link Quality Strategy uses measures of quality based on health outcomes, care coordination, member and caregiver experience, resource use, and organizational structure and efficiency. The MI Health Link Quality Strategy 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. Successful implementation of the MI Health Link program will mean that members get the right care and supportive services from the right providers at the right time, every time.

Compliance Review

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the ICOs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D and the quality assessment and performance improvement requirements described in 42 CFR §438.330. To complete this requirement, HSAG, through its EQRO contract with MDHHS, performed compliance reviews of the seven ICOs with which the State contracts.

During SFY 2018–2019, which was year one in the three-year compliance review cycle, MDHHS contracted with HSAG to conduct a comprehensive review of the 11 federally-required standards, as displayed in Table 4-1.

Table 4-1—Standards Reviewed

SFY 2018–2019	
Standard I—Availability of Services	Standard VII—Grievance and Appeal Systems
Standard II—Assurance of Adequate Capacity and Services	Standard VIII—Subcontractual Relationships and Delegation
Standard III—Coordination and Continuity of Care	Standard IX—Practice Guidelines
Standard IV—Coverage and Authorization of Services	Standard X—Health Information Systems
Standard V—Provider Selection	Standard XI—Quality Assessment and Performance Improvement Program
Standard VI—Confidentiality	

This report presents the results of the SFY 2018–2019 review. MDHHS and the individual ICOs use the information and findings from the compliance reviews to:

- Evaluate the quality and timeliness of and access to healthcare services furnished by the ICOs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

Technical Methods of Data Collection and Analysis

Prior to beginning compliance reviews of the ICOs, HSAG developed standardized tools for use during the reviews. The content of the tools was based on applicable federal regulations and the requirements set forth in the three-way contract agreement among CMS, the State of Michigan, and the ICOs. The review processes and scoring methodology used by HSAG in evaluating the ICOs' compliance were consistent with CMS' publication, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[4-1]

For each of the ICO reviews, HSAG followed the same basic steps:

Pre-on-site review activities included:

- Scheduling the Webex session and on-site review.
- Developing the compliance review and case file review tools.
- Preparing and forwarding the compliance review tools and instructions for submitting the requested documentation to each ICO.
- Hosting a training webinar for all ICOs in preparation for the review.
- Generating the sample selection for the care management case file review.
- Conducting a Webex with each ICO to walk through the selected case files.
- Conducting a desk review of all completed review tools and supporting documentation submitted by the ICO. The desk review, along with the case file review, enabled HSAG reviewers to increase their knowledge and understanding of the ICO's operations, identify areas needing clarification, and begin compiling information before the on-site review.
- Preparing and forwarding the on-site review agenda to the ICO.

On-site review activities included:

- An opening session, with introductions and a review of the agenda and logistics for HSAG's one-day review activities.
- Interview sessions with the ICO's key administrative and program staff members.
- A closing session during which HSAG reviewed summarized preliminary findings.

Reviewers used the compliance review tools to document findings regarding ICO compliance with the standards. Based on the evaluation of findings, reviewers noted compliance with each element. The *Compliance Review Tool* listed the score for each element evaluated.

[4-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-1.pdf. Accessed on: December 30, 2019.

HSAG evaluated and scored each element addressed in the compliance review as *Met*, *Not Met*, or *Not Applicable*. The overall score for each of the 11 standards was determined by totaling the number of *Met* (1 point), *Not Met* (0 points), and *Not Applicable* (no value) elements, then dividing the summed score by the total number of applicable elements for that standard. The scoring methodology is displayed in Table 4-2.

Table 4-2—Scoring Methodology*

Compliance Designation	Point Value	Definition
Met	Value = 1 point	***Met*** indicates "full compliance" defined as all of the following: • All documentation and data sources reviewed, including ICO data and documentation, case file review, and systems demonstrations for a regulatory provision or component thereof are present and provide supportive evidence of congruence. • Staff members are able to provide responses to reviewers that are consistent with one another, with the data and documentation reviewed, and with the regulatory provision.
Not Met	Value = 0 points	***Not Met*** indicates "noncompliance" defined as one or more of the following: • Documentation and data sources are not present and/or do not provide supportive evidence of congruence with the regulatory provision. • Staff members have little or no knowledge of processes or issues addressed by the regulatory provisions. • For those provisions with multiple components, key components of the provision could not be identified and/or do not provide sufficient evidence of congruence with the regulatory provision. Any findings of ***Not Met*** for these components would result in an overall finding of "noncompliance" for the provision, regardless of the findings noted for the remaining components.
Not Applicable	No value	• The provision is required by federal or State rule, but MDHHS has indicated that the rule is still in process of being implemented. • The requirement does not apply to the MI Health Link line of business during the review period.

* This scoring methodology is consistent with CMS' final protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

Description of Data Obtained and Related Time Period

To assess the ICO's compliance with federal regulations and contract requirements, HSAG obtained information from a wide range of written documents produced by the ICO, including, but not limited to, the following:

- Committee meeting agendas, minutes, and handouts
- Written policies and procedures
- Management/monitoring reports
- Member and provider materials
- Care management records
- Letter templates
- Narrative and/or data reports across a broad range of performance and content areas
- System demonstrations

Interviews with ICO staff (e.g., ICO leadership, staff members) provided additional information.

Table 4-3 lists the major data sources that HSAG used in determining the ICO's performance in complying with requirements and states the time period to which the data applied.

Table 4-3—Data Sources and Applicable Time Periods

Data Obtained	Time Period to Which the Data Applied
Desk review documentation	July 1, 2018, through February 1, 2019
Information obtained through interviews	July 1, 2018, through the end of each ICO's on-site review
Individual Integrated Care and Support Plans (for those applicable during the time period under review)	July 1, 2018, through September 30, 2018

Validation of Performance Measures

Activity Objectives

In accordance with 42 CFR §438.330(c), states must require that managed care organizations (MCOs), PIHPs, prepaid ambulatory health plans (PAHPs), and primary care case management (PCCM) entities submit performance measurement data as part of their QAPIPs. Validating performance measures is one of the mandatory EQR activities described in §438.358(b)(2). For the MCO, PIHP, PAHP, and PCCM entity, the EQR technical report must include information regarding the validation of performance measures (as required by the State) and/or performance measures calculated by the State during the preceding 12 months.

The primary objectives of the PMV process are to:

- Evaluate the accuracy of the performance measure data collected by the ICO.
- Determine the extent to which the specific performance measures calculated by the ICO (or on behalf of the ICO) followed the specifications established for each performance measure.
- Identify overall strengths and areas for improvement in the performance measure calculation process.

To meet the primary objectives of the validation activity, HSAG validated two Core Measures selected by CMS as indicated below, and completed a review of each ICO's audited HEDIS measure performance data as provided by MDHHS.

Technical Methods of Data Collection and Analysis

Performance Measure Validation

CMS subcontracted through NORC with HSAG to conduct validation of select performance measures for MMPs participating in capitated model demonstrations under the Medicare-Medicaid FAI. In Michigan, these MMP plans are the ICOs. CMS selected Core Measure 2.1, *Members with an assessment completed within 90 days of enrollment*, and Core Measure 3.2, *Members with a care plan completed within 90 days of enrollment*, for validation in 2019. Core Measure 2.1 captures the number of members who had a completed assessment within 90 days of their enrollment in the ICO. This measure also captures the count of members who either refused to complete the assessment or could not be reached by the ICO to complete the assessment. Core Measure 3.2 captures the number of members who had a completed care plan within 90 days of their enrollment in the ICO. This measure also captures the count of members who either refused to complete the care plan or could not be reached by the ICO to complete the care plan. Quarterly, Core Measure 2.1 and Core Measure 3.2 data were validated during the review period. For this annual technical report, MDHHS provided HSAG with the final *Medicare-Medicaid Capitated Financial Alignment Initiative 2019 Performance Measure Validation* report for each ICO that was submitted to CMS from NORC on January 8, 2020.

During the 2019 PMV activity, HSAG validated the processes used by the ICOs to collect and report data for Core Measure 2.1 and Core Measure 3.2 during the 2018 reporting periods. Quarterly Core Measure 2.1 and Core Measure 3.2 data were validated during this review.

HSAG developed the PMV protocol for ICOs in accordance with the CMS publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012. The CMS Core Reporting Requirements document (issued October 25, 2017, and effective as of January 1, 2018) provides the reporting specifications that ICOs were required to follow.

The CMS EQR protocol identifies key types of data that should be reviewed as part of the validation process. The following list describes the types of data collected and how HSAG conducted analysis of these data.

- **Information Systems Capabilities Assessment Tool (ISCAT)**—ICOs were required to submit a completed ISCAT. An ISCAT is a systems and process assessment tool that allows the ICO to provide step-by-step details on its information systems, processes and/or vendors used for collecting and processing data, and processes used for performance measure reporting. The ISCAT was customized to include questions related to systems and processes for measure data calculation. Upon receipt by HSAG, the ISCAT was reviewed to ensure each section was completed and all applicable attachments were present. HSAG contacted the ICOs for any missing ISCAT-related information. HSAG then thoroughly reviewed all documentation, noting any potential issues, concerns, or items that needed additional clarification.
- **Source Code (programming language) for the Performance Measures**—ICOs were required to submit computer programming language/source code that they used to generate Core Measure 2.1 and Core Measure 3.2. HSAG completed line-by-line review of the supplied source code to ensure compliance with the CMS performance measure specifications. HSAG identified areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any). If an ICO did not use computer programming language to calculate the performance measure, it was required to submit documentation describing the steps taken for measure calculation.
- **Supporting Documentation**—ICOs submitted documentation to HSAG that provided additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, data collection process descriptions, and member-level detail files. HSAG reviewed all supporting documentation, with issues or items that needed additional clarification identified for follow-up.

Webex Review Activities

HSAG conducted a three and a half hour Webex review with each ICO between August 19, 2019, and October 18, 2019. HSAG collected information using several methods including interviews, system demonstrations, review of data output files, primary source verification (PSV), observation of data processing, and review of data reports. The Webex review activities are described in sequential order below.

- **Opening Session**—The opening session included introductions of the HSAG validation team and key ICO staff members involved in the PMV activities. Discussion during the session covered the purpose of the Webex review and the data validation, the required documentation, and basic meeting logistics.
- **Evaluation of Enrollment and Eligibility Process—**The evaluation included a review of the ICO's system for processing enrollment and disenrollment data. HSAG requested a demonstration of the eligibility system to review the processes by which eligibility data were stored and transferred for the purposes of conducting and completing assessments and care plans. Based on the desk review of the ISCAT, HSAG conducted interviews with key ICO enrollment and eligibility staff members to develop an understanding of the process and procedures used by the ICO in obtaining, processing, and sharing member enrollment information with key assessment and care plan staff members.
- **Review of Assessment and Care Plan Process and Procedures**—HSAG conducted review of the systems used for conducting, collecting, receiving, and processing assessment and care plan-related information and outreach efforts. If vendors were used by the ICO, vendor process and system demonstrations were reviewed to understand the role of the vendor in conducting and completing assessments and/or care plans. Based on the desk review of the ISCAT, HSAG conducted interviews with key ICO staff members such as executive leadership, business analysts, customer operations staff members, data analytics staff members, and other frontline staff members familiar with the processing, monitoring, and calculation of the performance measures. HSAG used interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that written policies and procedures were used and followed in daily practice.
- **Overview of Data Integration and Control Procedures**—The overview included discussion and observation of source code logic, a review of how all data sources were combined, and how the analytic file used for reporting the performance measures was generated. HSAG performed PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Using this technique, HSAG assessed the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across data elements and quarters for each performance measure from the member-level detail to verify that the ICO had system documentation which supported that the ICO appropriately counted the member in the correct data element. The technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors are detected, the outcome is determined based on the type of error. For example, the review of one case may be sufficient in detecting a programming language error and, as a result, no additional cases related to that issue may be reviewed. In other scenarios, one case error detected may result in the selection of additional cases to better examine the extent of the issue and its impact on reporting. HSAG also reviewed any supporting documentation provided for data integration and reporting. In addition, this session addressed how data were integrated from various sources, systems, or vendors, and how these data were validated to ensure accuracy and confirm that no data were missing.
- **Closing Conference**—The closing conference summarized preliminary findings based on the review of the ISCAT and the Webex review and listed any follow-up documentation requirements for any post-Webex review activities.

Post-Webex Review Activities

- **Follow-up Documentation—**The follow-up documentation included, but was not limited to, process documents, auto dialer decision tree, and quality metrics or State-specific guidance that may have been referenced in programming measure specifications. The ICOs had three business days after the Webex review to submit all follow-up items to HSAG. Follow-up documentation submitted by each ICO was reviewed by HSAG. This follow-up review was conducted to confirm information provided during the Webex review by the ICO. In instances when the follow-up documentation did not meet requirements to complete the validation process, additional documentation and questions were requested by HSAG, or an additional Webex review was recommended. In certain instances, ICOs had to provide multiple rounds of follow-up documentation when the prior submission failed to provide HSAG with the necessary information or data.
- **Additional Webex Reviews—**During the original Webex review, if it was identified that the ICO would need to correct and re-report the data for Core Measure 2.1 and/or Core Measure 3.2, a re-review Webex session was conducted. During the additional Webex review session, the ICO provided a detailed account of the programmatic changes, process modifications, etc. made to generate updated data element values. HSAG performed PSV to validate the updated reporting methodology and data element values. Once PSV was completed, the ICO was provided instructions for resubmitting Core Measure 2.1 and/or Core Measure 3.2 data to the CMS Health Plan Management System (HPMS). In certain instances, multiple Webex re-reviews were needed for ICOs that failed to demonstrate to HSAG the necessary processes in place to report correct data for Core Measure 2.1 and/or Core Measure 3.2.

Final Validation Results

Based on the validation activities described above, HSAG provided each ICO a validation designation for Core Measure 2.1 and Core Measure 3.2. The ICO received a validation designation of either REPORT (R) or NOT REPORTED (NR) for each performance measure. Table 4-4 includes a definition of each validation designation.

Table 4-4—Measure-Specific Validation Designations

Validation Designation	Definition
REPORT (R)	Measure data were compliant with CMS' specifications and the data, as reported, were valid.
NOT REPORTED (NR)	Measure data were materially biased.

HEDIS Data

MDHHS and CMS required each ICO to contract with an NCQA-certified HEDIS vendor and undergo a full audit of its HEDIS reporting process. For this EQR technical report, HSAG reviewed HEDIS 2018 performance data for each ICO, as well as statewide comparison data, to assess performance in the areas of prevention and screening, respiratory conditions, cardiovascular conditions, diabetes, musculoskeletal

conditions, behavioral health, medication management and care coordination, overuse/appropriateness, access/availability of care, and utilization. These data were compiled by a CMS vendor and provided to MDHHS, and subsequently to HSAG, for inclusion into this EQR.

Description of Data Obtained and Related Time Period

Performance Measure Validation

HSAG validated data submitted for the appropriate quarterly reporting periods to ensure that (1) the member met eligibility criteria; (2) the ICO only included the assessment refusals, outreach efforts, and completed assessments that occurred within 90 days of member enrollment; and (3) the ICO only included the care plan refusals, outreach efforts, and completed care plans that occurred within 90 days of member enrollment. The reporting periods and the associated member enrollment dates represented in each reporting period are specified in Table 4-5.

Table 4-5—Reporting Periods

Reporting Period	Member Enrollment Dates Represented in Reporting Period
Quarter 1: January 1, 2018–March 31, 2018	November 1, 2017–January 31, 2018
Quarter 2: April 1, 2018–June 30, 2018	February 1, 2018–April 30, 2018
Quarter 3: July 1, 2018–September 30, 2018	May 1, 2018–July 31, 2018
Quarter 4: October 1, 2018–December 31, 2018	August 1, 2018–October 31, 2018

HEDIS Data

In accordance with the three-way contract between CMS, MDHHS, and each ICO, HEDIS data must be reported consistent with Medicare requirements plus the additional Medicaid measures required by MDHHS. The ICOs are required to report a combined set of core measures annually. For this EQR, HSAG reviewed HEDIS 2018 reported data.

Validation of Quality Improvement Projects

Activity Objectives

Validating QIPs is one of the mandatory EQR activities described at 42 CFR §438.330(b)(1). In accordance with 42 CFR §438.330(d), ICOs are required to have a comprehensive quality assessment and quality improvement program which includes QIPs that focus on both clinical and non-clinical areas. Each QIP must be designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and must include the following:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

The EQR technical report must include information on the validation of QIPs required by the State and underway during the preceding 12 months.

The primary objective of QIP validation is to determine the ICO's compliance with the requirements of 42 CFR §438.330(d). HSAG's evaluation of the QIP includes two key components of the quality improvement process:

1. HSAG evaluates the technical structure of the QIP to ensure that the ICO designs, conducts, and reports the QIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the QIP design (e.g., study question, population, indicator[s], sampling techniques, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported QIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the QIP. Once designed, a QIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, identification of causes and barriers, and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the ICO improves its rates through implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results).

The goal of HSAG's QIP validation is to ensure that MDHHS and key stakeholders can have confidence that any reported improvement is related to and can be directly linked to the quality improvement strategies and activities conducted by the ICO during the QIP.

MDHHS requires that each ICO conduct one QIP that is validated by HSAG. For this year's 2018–2019 validation, ICOs submitted baseline data for the State-mandated QIP topic, *Follow-Up After Hospitalization for Mental Illness*. The selected QIP topic utilizes the NCQA HEDIS *Follow-Up After Hospitalization for Mental Illness (FUH)* methodology. The State-mandated QIP topic addresses follow-up visits with a mental health practitioner following a hospitalization for mental illness. The goal of this

QIP is to improve the percentage of discharges for which the member received a follow-up visit within 30 days after discharge. This QIP topic has the potential to improve the health of members with mental illness and reduce readmissions through increasing appropriate follow-up care. HSAG performed validation activities on the QIP study design of the newly selected QIP topic for each ICO. The QIP topics submitted by the ICOs addressed CMS' requirements related to quality outcomes—specifically, timeliness and access to care and services.

Technical Methods of Data Collection and Analysis

The methodology used to validate QIPs was based on CMS guidelines as outlined in the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[4-2] Using this protocol, HSAG, in collaboration with MDHHS, developed the QIP Submission Form, which each ICO completed and submitted to HSAG for review and evaluation. The QIP Submission Form standardized the process for submitting information regarding QIPs and ensured all CMS protocol requirements were addressed.

HSAG, with MDHHS' input and approval, developed a QIP Validation Tool to ensure uniform validation of QIPs. Using this tool, HSAG evaluated each of the QIPs according to the CMS protocols. The HSAG QIP Review Team consisted of, at a minimum, an analyst with expertise in statistics and study design and a clinician with expertise in quality improvement processes. The CMS protocols identify 10 steps that should be validated for each QIP. For the SFY 2018–2019 submissions, the ICOs submitted the study design, reported baseline data, and were validated for Steps I through Step VII in the QIP Validation Tool.

The 10 steps included in the QIP Validation Tool are listed below:

Step I. Appropriate Study Topic
Step II. Clearly Defined, Answerable Study Question(s)
Step III. Correctly Identified Study Population
Step IV. Clearly Defined Study Indicator(s)
Step V. Valid Sampling Techniques (if sampling was used)
Step VI. Accurate/Complete Data Collection
Step VII. Sufficient Data Analysis and Interpretation
Step VIII. Appropriate Improvement Strategies
Step IX. Real Improvement Achieved
Step X. Sustained Improvement Achieved

[4-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/externalquality-review/index.html. Accessed on: December 30, 2019.

HSAG used the following methodology to evaluate QIPs conducted by the ICOs to determine if a QIP is valid and to rate the percentage of compliance with CMS' protocol for conducting QIPs.

Each required step is evaluated on one or more elements that form a valid QIP. The HSAG QIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable,* or *Not Assessed*. HSAG designates evaluation elements pivotal to the QIP process as "critical elements." For a QIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating for the QIP of *Not Met*. The ICO is assigned a *Partially Met* score if 60 percent to 79 percent of all evaluation elements are *Met* or one or more critical elements are *Partially Met*. HSAG provides a *General Comment* when enhanced documentation would have demonstrated a stronger understanding and application of the QIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*) HSAG assigns the QIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

HSAG assessed the implications of the QIP's findings on the likely validity and reliability of the results as follows:

- *Met*: High confidence/confidence in reported QIP results. All critical elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all activities.
- *Partially Met*: Low confidence in reported QIP results. All critical elements were *Met*, and 60 to 79 percent of all evaluation elements were *Met* across all activities; or one or more critical elements were *Partially Met*.
- *Not Met*: All critical elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all activities; or one or more critical elements were *Not Met*.

The ICOs had an opportunity to resubmit a revised QIP Submission Form and provide additional information or documentation in response to HSAG's initial validation scores of *Partially Met* or *Not Met*, regardless of whether the evaluation element was critical or non-critical. At the request of the ICO or MDHHS, HSAG is available for technical assistance at any time during the QIP process. Three of the seven ICOs requested and received technical assistance from HSAG, either prior to or following, the initial submission.

HSAG conducted a final validation for any resubmitted QIPs and documented the findings and recommendations for each QIP. Upon completion of the final validation, HSAG prepared a report of its findings and recommendations for each ICO. These reports, which complied with 42 CFR §438.364, were provided to MDHHS and the ICOs.

Description of Data Obtained and Related Time Period

For SFY 2018–2019, the ICOs submitted the QIP study design and baseline data. The study indicator measurement period dates for the QIP are listed in Table 4-6.

Table 4-6—Description of Data Obtained and Measurement Periods

Data Obtained	Period to Which the Data Applied
Baseline	HEDIS Year 2019/Calendar Year 2018
Remeasurement 1	HEDIS Year 2020/Calendar Year 2019
Remeasurement 2	HEDIS Year 2021/Calendar Year 2020

5. Assessment of ICO Performance

Methodology

HSAG used findings across mandatory EQR activities conducted during the previous 12 months to evaluate the performance of ICOs on providing quality, timely, and accessible healthcare services to MI Health Link members.

To identify strengths and weaknesses and draw conclusions for each ICO, HSAG analyzed and evaluated each EQR activity and its resulting findings related to the provision of healthcare services across the MI Health Link program. The composite findings for each ICO were analyzed and aggregated to identify overarching conclusions and focus areas for the ICO in alignment with the priorities of MDHHS.

Compliance Review

The compliance review comprised an evaluation of each ICO's performance in 11 program areas, called standards, identified in Table 5-1.

Table 5-1—Compliance Review Standards

Standard
Standard I—Availability of Services
Standard II—Assurance of Adequate Capacity and Services
Standard III—Coordination and Continuity of Care
Standard IV—Coverage and Authorization of Services
Standard V—Provider Selection
Standard VI—Confidentiality
Standard VII—Grievance and Appeal Systems
Standard VIII—Subcontractual Relationships and Delegation
Standard IX—Practice Guidelines
Standard X—Health Information Systems
Standard XI—Quality Assessment and Performance Improvement Program

Validation of Performance Measures

The PMV activity included a comprehensive evaluation of the processes used by the ICOs to collect and report data for two performance measures selected by CMS for validation. Table 5-2 lists these performance measures.

Table 5-2—Performance Measures for Validation

Performance Measures
Core Measure 2.1: *Members with an assessment completed within 90 days of enrollment*
Core Measure 3.2: *Members with a care plan completed within 90 days of enrollment*

Additionally, MDHHS required the ICOs to contract with an NCQA-certified HEDIS vendor and undergo a full audit of its HEDIS reporting process. The reported measures are divided into performance measure domains of care as demonstrated in Table 5-3.

Table 5-3—HEDIS Measures

HEDIS Measure
Prevention and Screening
ABA—Adult BMI Assessment
BCS—Breast Cancer Screening
COL—Colorectal Cancer Screening
COA—Care for Older Adults—Advance Care Planning
COA—Care for Older Adults—Medication Review
COA—Care for Older Adults—Functional Status Assessment
COA—Care for Older Adults—Pain Assessment
Respiratory Conditions
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
Cardiovascular Conditions
CBP—Controlling High Blood Pressure
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack
SPC—Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy
SPC—Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%

HEDIS Measure
Diabetes
CDC—Comprehensive Diabetes Care—HbA1c Testing
CDC—Comprehensive Diabetes Care—Poor HbA1c Control
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)
CDC—Comprehensive Diabetes Care—Eye Exams
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy
CDC—Comprehensive Diabetes Care—Blood Pressure Cont. <140/90
SPD—Statin Therapy for Patients with Diabetes—Received Statin Therapy
SPD—Statin Therapy for Patients with Diabetes—Statin Adherence 80%
Musculoskeletal Conditions
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
OMW—Osteoporosis Management in Women Who Had a Fracture
Behavioral Health
AMM—Antidepressant Medication Management—Effect Acute Phase Treatment
AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days
Medication Management and Care Coordination
MRP—Medication Reconciliation Post-Discharge
Overuse/Appropriateness
PSA—Non-Recommended PSA-Based Screening of Older Men
DDE—Potentially Harmful Drug-Disease Interactions in the Elderly
DAE—Use of High-Risk Medications in the Elderly—One Prescription
DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions
Access/Availability of Care
AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years
AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years
AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older
AAP—Adults' Access to Preventative/Ambulatory Health Services—Total
IET—Initiation of Alcohol and Other Drug Dependence Treatment
IET—Engagement of Alcohol and Other Drug Dependence Treatment
Risk Adjusted Utilization
PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)
PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)

Validation of Quality Improvement Projects

The MDHHS-mandated QIP topic addresses follow-up visits with a mental health practitioner within 30 days of discharge for a hospitalization for mental illness. This topic has the potential to improve the health of members with mental illness and reduce readmissions through increasing appropriate follow-up care.

Table 5-4 outlines the selected study indicator for the QIP for all ICOs.

Table 5-4—QIP Topic and Study Indicator

QIP Topic	Study Indicator
Follow-Up After Hospitalization for Mental Illness	Improve the percentage of follow-up visits within 30 days with a mental health practitioner after discharge from an acute hospitalization with mental illness diagnosis.

Aetna Better Health of Michigan

EQR Activity Results

Compliance Review

Table 5-5 presents for each standard the total number of elements as well as the number of elements that received scores of *Met*, *Not Met*, or *Not Applicable (NA)*. Table 5-5 also presents **Aetna Better Health of Michigan**'s overall compliance score for each standard, the totals across the 11 standards reviewed, and the total compliance score across all standards for the 2019 compliance review.

Table 5-5—Summary of 2019 Compliance Review Results for Aetna Better Health of Michigan (AET)

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—Availability of Services	11	9	2	0	82%
Standard II—Assurance of Adequate Capacity and Services	6	6	0	0	100%
Standard III—Coordination and Continuity of Care	17	14	3	1	82%
Standard IV—Coverage and Authorization of Services	19	18	1	1	95%
Standard V—Provider Selection	10	9	1	0	90%
Standard VI—Confidentiality	7	6	1	0	86%
Standard VII—Grievance and Appeal Systems	33	29	4	0	88%
Standard VIII—Subcontractual Relationships and Delegation	5	5	0	0	100%
Standard IX—Practice Guidelines	4	4	0	0	100%
Standard X—Health Information Systems	8	8	0	0	100%
Standard XI—Quality Assessment and Performance Improvement Program	11	10	1	0	91%
Total	**131**	**118**	**13**	**2**	**90%**

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements *Met* were given full value (1 point each). The point values were then totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each standard.

Aetna Better Health of Michigan demonstrated compliance for 118 of 131 elements, with an overall compliance score of 90 percent. **Aetna Better Health of Michigan** demonstrated strong performance, scoring 90 percent or above in seven standards, with four of those standards achieving full compliance. These areas of strength include Assurance of Adequate Capacity and Services, Coverage and Authorization of Services, Provider Selection, Subcontractual Relationships and Delegation, Practice Guidelines, Health Information Systems, and Quality Assessment and Performance Improvement Program.

Opportunities for improvement were identified in seven of the 11 standards, including deficiencies related to the following requirements:

- All urgent and symptomatic office visits must be available to members within 24 hours.
- A work plan must be established, executed, and annually updated to achieve and maintain Americans with Disabilities Act (ADA) compliance.
- The IICSP must include the member's prioritized list of concerns, goals, objectives, and strengths and reflect the risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed. Every member must have an IICSP unless the member refuses and such refusal is documented.
- The provision of all covered services must be authorized, arranged, integrated, and coordinated for the ICO's members.
- The IICSP must be reviewed with the member according to required time frames identified in contract language related to low-, moderate-, and high-risk members.
- For service authorization decisions not reached within the applicable time frame for standard or expedited requests (which constitutes a denial and is thus an adverse benefit determination), the ICO must provide notice on the date that the time frames expire.
- Consideration of performance indicators obtained through the quality improvement plan, utilization management program, grievance and appeal system, member satisfaction surveys, and medical record reviews must be considered in the ICO's recredentialing process.
- Each breach notification letter contains all required content, including the date of the breach and the date of the discovery of the breach.
- Written consent of the member for a provider to request an appeal or file a grievance, or request a State fair hearing, on behalf of a member must be obtained.
- Appeal details must be confirmed to the member in writing when the member requests an appeal orally.
- Punitive action must not be taken against a provider who requests an expedited resolution or supports a member's appeal.
- The QAPIP for the MI Health Link program must be separate from the programs for Medicaid, Medicare, or commercial lines of business.

Aetna Better Health of Michigan was required to develop and implement a corrective action plan (CAP) for each requirement in all standards scored *Not Met*.

Validation of Performance Measures

The PMV review of **Aetna Better Health of Michigan**'s reported data focused on enrollment and eligibility data processes, assessment and care plan processes, performance measure production, and PSV findings. Specifically, the validation processes ensured that **Aetna Better Health of Michigan** appropriately classified members in the four data elements collected for both Core Measure 2.1 and Core Measure 3.2.

Based on its review, HSAG found that the Core Measure 2.1 and Core Measure 3.2 PMV for **Aetna Better Health of Michigan** resulted in the following validation designation:

Table 5-6—Measure-Specific Validation Designation for AET

Performance Measure	Validation Designation
Core Measure 2.1: *Members with an assessment completed within 90 days of enrollment*	**REPORT (R)** Measure data were compliant with CMS' specifications and the data, as reported, were valid.
Core Measure 3.2: *Members with a care plan completed within 90 days of enrollment*	**REPORT (R)** Measure data were compliant with CMS' specifications and the data, as reported, were valid.

HEDIS Data

Table 5-7 shows each of **Aetna Better Health of Michigan**'s audited HEDIS measures, **Aetna Better Health of Michigan**'s rates for HEDIS 2018, and the MI Health Link statewide average performance rates.

Table 5-7—Measure-Specific Percentage Rates for AET

HEDIS Measures	HEDIS 2018	Statewide Average
Prevention and Screening		
ABA—Adult BMI Assessment	95.86	91.51
BCS—Breast Cancer Screening	53.09	57.80
COL—Colorectal Cancer Screening	43.07	53.14
COA—Care for Older Adults—Advance Care Planning	49.64	36.18
COA—Care for Older Adults—Medication Review	76.64	72.10
COA—Care for Older Adults—Functional Status Assessment	61.80	53.95
COA—Care for Older Adults—Pain Assessment	72.99	68.09
Respiratory Conditions		
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	26.92	26.62
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	76.47	72.48
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	85.81	88.47
Cardiovascular Conditions		
CBP—Controlling High Blood Pressure	59.37	58.89
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	88.89	90.69
SPC—Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy	76.79	76.68

HEDIS Measures	HEDIS 2018	Statewide Average
SPC—Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%	69.30	71.33
Diabetes		
CDC—Comprehensive Diabetes Care—HbA1c Testing	88.32	88.82
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control**	28.47	37.39
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)	60.34	53.34
CDC—Comprehensive Diabetes Care—Eye Exams	48.91	63.18
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	94.89	94.14
CDC—Comprehensive Diabetes Care—Blood Pressure Cont. <140/90	62.29	56.81
SPD—Statin Therapy for Patients with Diabetes—Received Statin Therapy	68.68	70.97
SPD—Statin Therapy for Patients with Diabetes—Statin Adherence 80%	69.43	72.38
Musculoskeletal Conditions		
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	78.13	64.21
OMW—Osteoporosis Management in Women Who Had a Fracture	8.00	9.56
Behavioral Health		
AMM—Antidepressant Medication Management—Effect Acute Phase Treatment	59.18	57.08
AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment	41.33	43.57
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days	24.22	23.63
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days	56.52	52.49
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days	35.58	30.48
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days	48.08	48.67
Medication Management and Care Coordination		
MRP—Medication Reconciliation Post-Discharge	36.25	39.18
Overuse/Appropriateness		
*PSA—Non-Recommended PSA-Based Screening of Older Men**	19.95	19.27
*DDE—Potentially Harmful Drug-Disease Interactions in the Elderly**	42.93	44.19
*DAE—Use of High-Risk Medications in the Elderly—One Prescription**	21.21	18.89
*DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions**	11.63	12.40

HEDIS Measures	HEDIS 2018	Statewide Average
Access/Availability of Care		
AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years	85.03	85.31
AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years	93.34	94.10
AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older	89.63	90.49
AAP—Adults' Access to Preventative/Ambulatory Health Services—Total	90.06	90.73
IET—Initiation of Alcohol and Other Drug Dependence Treatment	36.09	30.35
IET—Engagement of Alcohol and Other Drug Dependence Treatment	4.26	3.76
Risk Adjusted Utilization		
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**	0.76	0.74
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**	0.75	0.78

(*) = Measures where lower rates indicate better performance.

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

Aetna Better Health of Michigan performed better than the statewide average in 23 of the 43 reported HEDIS measures (53 percent). Overall, **Aetna Better Health of Michigan** also demonstrated stronger performance in the Prevention and Screening, Respiratory Conditions, and Behavioral Health domains, but showed greater opportunities for improvement in the Medication Management and Care Coordination, and Access/Availability of Care domains in comparison to the statewide average. Mixed results were displayed in the Cardiovascular Conditions, Diabetes, Musculoskeletal Conditions, Overuse/Appropriateness, and Risk Adjusted Utilization domains.

Validation of Performance Improvement Projects

Table 5-8 displays the validation results for **Aetna Better Health of Michigan**'s QIP. This table illustrates the ICO's overall application of the QIP process and success in implementing the QIP. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 5-8 show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all steps.

Table 5-8—QIP Validation Results for AET

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	67% (2/3)	0% (0/3)	33% (1/3)
	VIII.	Appropriate Improvement Strategies	*Not Assessed*		
Implementation Total			**67% (2/3)**	**0% (0/3)**	**33% (1/3)**
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			*Not Assessed*		
Percentage Score of Applicable Evaluation Elements *Met*			**91% (10/11)**		

Overall, 91 percent of all applicable evaluation elements received a score of *Met* for the Design and Implementation stages of the QIP process. The ICO has opportunities for improvement related to documentation and addressing HSAG's validation feedback in both stages.

For the baseline measurement period, **Aetna Better Health of Michigan** reported that 47.8 percent of members received a follow-up visit with a mental health practitioner within 30 days of discharge. The

goal for the QIP is that the ICO will demonstrate a statistically significant improvement over the baseline for the remeasurement periods. The ICO selected a Remeasurement 1 goal of 56 percent.

Strengths, Weaknesses, and Overall Conclusions

Aetna Better Health of Michigan demonstrated both strengths and weaknesses based on the results of the SFY 2018–2019 EQR activities. **Aetna Better Health of Michigan** received a total compliance score of 90 percent across all 11 standards reviewed in 2019, which was the highest score across all ICOs. **Aetna Better Health of Michigan** scored at or above 90 percent in the Assurance of Adequate Capacity and Services, Coverage and Authorization of Services, Provider Selection, Subcontractual Relationships and Delegation, Practice Guidelines, Health Information Systems, and Quality Assessment and Performance Improvement Program standards, indicating strong performance in these areas; however, the ICO did not perform as well in the Availability of Services, Coordination and Continuity of Care, Confidentiality, and Grievance and Appeal Systems standards, as demonstrated by moderate performance scores (82 percent, 82 percent, 86 percent, and 88 percent, respectively), reflecting that additional focus is needed in these areas.

While **Aetna Better Health of Michigan** performed better than the statewide average in 23 of the 43 reported HEDIS measures, indicating strength in these areas, all performance measure domains included at least one measure that performed below the statewide average, indicating opportunities to improve in all domains.

Aetna Better Health of Michigan also designed a scientifically sound QIP supported by using key research principals, meeting 100 percent of the requirements in the Design stage; however, **Aetna Better Health of Michigan** met only 67 percent of the requirements for data analysis and implementation of improvement strategies, indicating opportunities for improvement in this area of the QIP.

Aetna Better Health of Michigan's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-9—Quality, Timeliness, and Access Performance Impact for AET

Performance Area*	Overall Performance Impact
Quality	• Strength: The Subcontractual Relationships and Delegation standard achieved full compliance, suggesting the ICO has adequate and effective processes in place to ensure its delegates comply with all contract obligations. • Strength: The Practice Guidelines standard achieved full compliance, indicating the ICO adopts and disseminates practice guidelines for use in making utilization management decisions and providing member education. • Strength: The Health Information Systems standard achieved full compliance, indicating the ICO maintains a health information system that collects, analyzes,

Performance Area*	Overall Performance Impact
	integrates, and reports data, and ensures that claims data received from providers are accurate and complete. • Strength: The *Care for Older Adults* measures within the Prevention and Screening domain performed better than the statewide average, indicating older adults are receiving the care they need to optimize their quality of life. • Strength: Two of three HEDIS measures within the Respiratory Conditions domain rated above the statewide average, indicating the ICO's providers are assessing for and providing appropriate treatment to members diagnosed with chronic obstructive pulmonary disease (COPD). • Strength: Four of the six *Comprehensive Diabetes Care* measures within the Diabetes domain performed better than the statewide average, indicating members diagnosed with type 1 and type 2 diabetes have appropriate diabetes management necessary to control blood glucose and reduce risks for complications. The ICO should, however, focus on members getting retinal eye exams, as the *Comprehensive Diabetes Care—Eye Exams* measure fell 14 percentage points below the statewide average. • Weakness: Two out of seven HEDIS measures in the Prevention and Screening domain performed worse than the statewide average, indicating members are not always receiving preventive screenings, such as breast cancer and colorectal cancer screenings, in order to prevent and detect diseases early. • Weakness: Two of the four measures within the Cardiovascular Conditions domain, *Persistence of Beta-Blocker Treatment After a Heart Attack* and *Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%,* and two related measures within the Diabetes domain, *Statin Therapy for Patients with Diabetes—Received Statin Therapy* and *Statin Therapy for Patients with Diabetes—Statin Adherence 80%* performed worse than the statewide average, indicating members may not be receiving persistent beta-blocker treatment after discharge for a heart attack, and members with diabetes and cardiovascular disease may not be receiving or adhering to statin therapy to lower blood cholesterol and prevent further complications of their disease.
Timeliness	• Strength: Four of six measures within the Behavioral Health domain rated above the statewide average, implying the ICO has focused its efforts on members diagnosed with mental health conditions, specifically related to follow-up after hospitalization and seven-day follow-up after an emergency department visit for mental illness. The *Follow-Up After Emergency Department Visit for Mental Illness—30 Days* measure fell below the statewide and the MMP National Average, so heightened attention should be placed on ensuring members can access a mental health provider within 30 days of an emergency department visit. • Weakness: The *Medication Reconciliation Post-Discharge* measure rated below the statewide average, indicating members discharged from an inpatient facility do not always have medications reconciled within 30 days.

Performance Area*	Overall Performance Impact
Access	• Strength: The Assurance of Adequate Capacity and Services standard achieved full compliance, suggesting the ICO has the network capacity to serve the members in its service area. • Strength: The *Initiation of Alcohol and Other Drug Dependence Treatment* and *Engagement of Alcohol and Other Drug Dependence Treatment* performed above the statewide average, indicating a higher number of the ICO's members diagnosed with alcohol or drug abuse dependence are getting treatment. • Strength: The *Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)* measure performed better than the statewide average, indicating a lower percentage of members are being readmitted within 30 days after being discharged from an inpatient hospital stay. Conversely, the *Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)* measure performed slightly worse than the statewide average but better than the MMP National Average. • Strength: The ICO designed a QIP that has the potential to improve the health of members with mental illness and reduce readmissions through increasing appropriate follow-up care. • Weakness: The four *Adults' Access to Preventative/Ambulatory Health Services* measures within the Access/Availability of Care domain performed below the statewide average, indicating some members 20 years of age and older do not schedule an appointment with their providers for preventive health services. Preventive care is an important step for members to take to address serious health issues and manage chronic conditions. • Weakness: Two measures within the Access/Availability of Care domain, *Initiation of Alcohol and Other Drug Dependence Treatment* and *Engagement of Alcohol and Other Drug Dependence Treatment,* performed below the MMP National Average, implying that members diagnosed with a new episode of alcohol or drug dependence are not able to access treatment timely after diagnosis.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

SFY 2018–2019 is the first year that an annual detailed technical report was completed for the MI Health Link program and the contracted ICOs. Therefore, there were no previous quality improvement recommendations made to MDHHS or to **Aetna Better Health of Michigan** by HSAG or another EQRO prior to SFY 2018–2019. Future technical reports will include an assessment of the degree to which each ICO addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.

Recommendations for Program Improvement

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Aetna Better Health of Michigan** to members, HSAG recommends that **Aetna Better Health of Michigan** incorporate efforts for improvement for performance measures that fell below the statewide average. To prioritize its efforts, **Aetna Better Health of Michigan** should identify a specific subset of the below measures and develop initiatives to improve the performance of those selected measures. The selected measures, and any subsequent initiatives and interventions, should be included as part of **Aetna Better Health of Michigan**'s quality improvement strategy within its QAPIP:

Domains With Measure Ratings Below the Statewide Average

- **Prevention and Screening**
  - *BCS—Breast Cancer Screening*
  - *COL—Colorectal Cancer Screening*
- **Respiratory Conditions**
  - *PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator*
- **Cardiovascular Conditions**
  - *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack*
  - *SPC—Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%*
- **Diabetes**
  - *CDC—Comprehensive Diabetes Care—HbA1c Testing*
  - *CDC—Comprehensive Diabetes Care—Eye Exams*
  - *SPD—Statin Therapy for Patients with Diabetes—Received Statin Therapy*
  - *SPD—Statin Therapy for Patients with Diabetes—Statin Adherence 80%*
- **Musculoskeletal Conditions**
  - *OMW—Osteoporosis Management in Women Who Had a Fracture*
- **Behavioral Health**
  - *AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment*
  - *FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days*
- **Medication Management and Care Coordination**
  - *MRP—Medication Reconciliation Post-Discharge*
- **Overuse/Appropriateness**
  - *PSA—Non-Recommended PSA-Based Screening of Older Men*
  - *DAE—Use of High-Risk Medications in the Elderly—One Prescription*
- **Access/Availability of Care**
  - *AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years*
  - *AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years*

- *AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older*
- *AAP—Adults' Access to Preventative/Ambulatory Health Services—Total*

- **Risk Adjusted Utilization**
  - PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)

Aetna Better Health of Michigan should include within its next annual QAPIP review the results of analyses for the performance measures selected from those listed above that answer the following questions:

1. What were the root causes associated with low-performing areas?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **Aetna Better Health of Michigan** considering or has already implemented to improve rates and performance for each identified performance measure?

Based on the information presented above, **Aetna Better Health of Michigan** should include the following within its quality improvement work plan:

- Measurable goals and benchmarks for each performance measure
- Mechanisms to measure performance
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates
- Identified opportunities for improvement
- Ongoing analysis to identify factors that impact adequacy of rates
- Quality improvement interventions that address the root cause of the deficiency
- A plan to monitor the quality improvement interventions to detect whether they effect improvement

HSAG also recommends that **Aetna Better Health of Michigan** implement the plans of action approved by MDHHS to bring into compliance each of the following deficient standards:

- Standard I—Availability of Services
- Standard III—Coordination and Continuity of Care
- Standard IV—Coverage and Authorization of Services
- Standard V—Provider Selection
- Standard VI—Confidentiality
- Standard VII—Grievance and Appeal Systems
- Standard XI—Quality Assessment and Performance Improvement Program

Aetna Better Health of Michigan was required to complete plans of action to address each deficiency and submit to MDHHS within 30 days of receipt of the final compliance report. HSAG recommends that **Aetna Better Health of Michigan** implement internal processes to periodically review the status of each plan of action; for example, completing a progress update every 45 business days. This periodic review should include:

- Progress on implementation of each plan of action.
- Successes or barriers in remediating each deficiency.
- Revised actions steps, if necessary.

Once all plans of action are fully implemented, HSAG recommends that **Aetna Better Health of Michigan** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency. HSAG will also be conducting a review of those plans of action in 2020 to ensure deficiencies were mitigated.

Finally, **Aetna Better Health of Michigan** should take proactive steps to ensure a successful QIP. **Aetna Better Health of Michigan** should address all recommendation*s* in the *2018–2019 QIP Validation Report Follow-Up After Hospitalization for Mental Illness for Aetna Better Health of Michigan*, which includes ensuring that all validation feedback is addressed, and necessary corrections are made prior to the next annual submission. HSAG also recommends the following:

- To impact the Remeasurement 1 study indicator rate, **Aetna Better Health of Michigan** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period may not have the time to impact the study indicator rate.
- **Aetna Better Health of Michigan** should document the process/steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- **Aetna Better Health of Michigan** should implement active, innovative improvement strategies that have the potential to directly impact study indicator outcomes.
- **Aetna Better Health of Michigan** should have an evaluation process to determine the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data-driven.

AmeriHealth Michigan, Inc.

EQR Activity Results

Compliance Review

Table 5-10 presents for each standard the total number of elements as well as the number of elements that received scores of *Met*, *Not Met*, or *Not Applicable (NA)*. Table 5-10 also presents **AmeriHealth Michigan, Inc.**'s overall compliance score for each standard, the totals across the 11 standards reviewed, and the total compliance score across all standards for the 2019 compliance review.

Table 5-10—Summary of 2019 Compliance Review Results for AmeriHealth Michigan, Inc. (AMI)

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—Availability of Services	**11**	**9**	**2**	**0**	**82%**
Standard II—Assurance of Adequate Capacity and Services	**6**	**4**	**2**	**0**	**67%**
Standard III—Coordination and Continuity of Care	**17**	**12**	**5**	**1**	**71%**
Standard IV—Coverage and Authorization of Services	**19**	**13**	**6**	**1**	**68%**
Standard V—Provider Selection	**10**	**8**	**2**	**0**	**80%**
Standard VI—Confidentiality	**7**	**7**	**0**	**0**	**100%**
Standard VII—Grievance and Appeal Systems	**33**	**24**	**9**	**0**	**73%**
Standard VIII—Subcontractual Relationships and Delegation	**5**	**4**	**1**	**0**	**80%**
Standard IX—Practice Guidelines	**4**	**3**	**1**	**0**	**75%**
Standard X—Health Information Systems	**8**	**7**	**1**	**0**	**88%**
Standard XI—Quality Assessment and Performance Improvement Program	**11**	**9**	**2**	**0**	**82%**
Total	**131**	**100**	**31**	**2**	**76%**

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements *Met* were given full value (1 point each). The point values were then totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each standard.

AmeriHealth Michigan, Inc. demonstrated compliance for 100 of 131 elements, with an overall compliance score of 76 percent. **AmeriHealth Michigan, Inc.** demonstrated strong performance, scoring 100 percent, in the Confidentiality standard.

Opportunities for improvement were identified in 10 of the 11 standards, including deficiencies related to the following requirements:

- All urgent and symptomatic office visits must be available to members within 24 hours.
- A work plan must be established, executed, and annually updated to achieve and maintain ADA compliance.
- Network adequacy reports must be provided to MDHHS at any time there is a significant change in the ICO's operations.
- Timely notification must be provided to the contract management team when there are significant provider network changes.
- A strategy must be developed and implemented that uses a combination of initial screenings, assessments, referrals, administrative claims data, etc. to help prioritize and determine the care coordination needs of each member. The ICO must review program-level data and utilization data within 15 days of member enrollment.
- The initial screening of each member's needs should be attempted within 15 calendar days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful.
- The IICSP must include the member's prioritized list of concerns, goals, objectives, and strengths and reflect the services and supports, both paid and unpaid, that will assist the member achieve identified goals; the frequency of services; and the providers of those services, including natural supports.
- Implementation of the IICSP must be monitored, including facilitation of the evaluation of the process, progress, and outcomes, as well as identifying barriers and facilitation problem resolution and follow-up.
- The IICSP must be reviewed with the member according to required time frames identified in contract language related to low-, moderate-, and high-risk members.
- For termination, suspension, or reduction of previously authorized Medicaid-covered services, the notice must be mailed at least 10 days before the date of action, except under the circumstances described in rule.
- For the denial of payment, notice must be mailed at the time of any action affecting the claim.
- For standard authorization decisions, notice must be provided as expeditiously as the member's condition requires and within MDHHS-established time frames that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days as required by rule.
- For cases in which a provider indicates or the ICO determines that the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, an expedited authorization decision must be made and notice provided as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. The ICO may extend the 72-hour time period by up to 14 calendar days as required by rule.

- Consideration of performance indicators obtained through the quality improvement plan, utilization management program, grievance and appeal system, member satisfaction surveys, and medical record reviews must be considered in the ICO's recredentialing process.
- Disclosures from all network providers and applicants must be obtained in accordance with 42 CFR 455 Subpart B and 42 CFR §1002.3, including but not limited to obtaining such information through provider enrollment forms and credentialing and recredentialing packages, and such disclosed information must be maintained in a manner that can be periodically searched by the ICO for exclusions and provided to MDHHS in accordance with the contract as well as with relevant State and federal laws and regulations.
- Written consent of the member for a provider or an authorized representative to request an appeal or file a grievance, or request a State fair hearing, on behalf of a member must be obtained.
- Mechanisms must be in place to ensure that any grievances filed with a provider are forwarded to the ICO as required by contract.
- Appeal details must be confirmed to the member in writing when the member requests an appeal orally.
- Parties to the appeal and State fair hearing include the member and his or her representative or the legal representative of a deceased member's estate; and, in State fair hearings, the ICO.
- The process to extend the grievance and appeal resolution time frames by up to 14 calendar days when not at the member's request must include all requirements, including making reasonable efforts to give the member prompt oral notice of the reason for the decision to extend the time frame, providing written notice within two calendar days of the oral notification, and informing the member of the right to file a grievance if he or she disagrees with the decision to extend the time frame for resolution.
- Denied requests for expedited appeal resolution must include transferring the appeal to the time frame for standard resolution; making reasonable efforts to give the member prompt oral notice of the denial; within two calendar days, giving the member written notice of the reason for the decision to extend the time frame, and informing the member of the right to file a grievance if he or she disagrees with that decision; and resolving the appeal as expeditiously as the member's health condition requires, and no later than the date that the extension expires.
- Accurate and complete information about the grievance and appeal system must be provided to all providers and subcontractors at the time they enter into contracts with the ICO.
- Member's benefits must continue while the appeal and/or the State fair hearing is/are pending, when all requirements under rule are met, including that the member must be aware of the requirement and file for continuation of benefits within 10 calendar days of receiving the notice of adverse benefit determination (NABD).
- Subcontractors' performance must be monitored ongoing and subcontractors must have a formal review according to an established periodic schedule.
- Clinical practice guidelines (CPGs) must be adopted in consultation with contracting healthcare professionals. Prior to adoption, CPGs must be reviewed by the ICO's medical director as well as other ICO practitioners and network providers, as appropriate. For guidelines that have been in effect

two years or longer, the ICO must document that the guidelines were reviewed with appropriate practitioner involvement and updated accordingly.

- A health information system must be maintained that collects, analyzes, integrates, and reports data; and which enables the ICO to meet all MDHHS contract requirements and standards as well as any future information technology (IT) architecture or program changes. The system must provide information on areas including membership disenrollment for other than loss of Medicaid eligibility.
- The ICO must demonstrate efforts to prevent, detect, and remediate critical incidents—consistent with assuring member health and welfare per §441.302 and §441.730(a)—that are based, at a minimum, on the requirements of the State for home- and community-based waiver programs per §441.302(h).
- Information on the effectiveness of the ICO's QAPIP program must be disseminated to network providers annually.

AmeriHealth Michigan, Inc. was required to develop and implement a CAP for each requirement in all standards scored *Not Met*.

Validation of Performance Measures

The PMV review of **AmeriHealth Michigan, Inc.**'s reported data focused on enrollment and eligibility data processes, assessment and care plan processes, performance measure production, and PSV findings. Specifically, the validation processes ensured that **AmeriHealth Michigan, Inc.** appropriately classified members in the four data elements collected for both Core Measure 2.1 and Core Measure 3.2.

Based on its review, HSAG found that the Core Measure 2.1 and Core Measure 3.2 PMV for **AmeriHealth Michigan, Inc.** resulted in the following validation designation:

Table 5-11—Measure-Specific Validation Designation for AMI

Performance Measure	Validation Designation
Core Measure 2.1: *Members with an assessment completed within 90 days of enrollment*	**REPORT (R)** Measure data were compliant with CMS' specifications and the data, as reported, were valid.
Core Measure 3.2: *Members with a care plan completed within 90 days of enrollment*	**REPORT (R)** Measure data were compliant with CMS' specifications and the data, as reported, were valid.

HEDIS Data

Table 5-12 shows each of **AmeriHealth Michigan, Inc.**'s audited HEDIS measures, **AmeriHealth Michigan, Inc.**'s rates for HEDIS 2018, and the MI Health Link statewide average performance rates.

Table 5-12—Measure-Specific Percentage Rates for AMI

HEDIS Measure	HEDIS 2018	Statewide Average
Prevention and Screening		
ABA—Adult BMI Assessment	87.35	91.51
BCS—Breast Cancer Screening	47.13	57.80
COL—Colorectal Cancer Screening	31.87	53.14
COA—Care for Older Adults—Advance Care Planning	14.11	36.18
COA—Care for Older Adults—Medication Review	44.04	72.10
COA—Care for Older Adults—Functional Status Assessment	34.06	53.95
COA—Care for Older Adults—Pain Assessment	47.93	68.09
Respiratory Conditions		
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	50.00	26.62
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	79.17	72.48
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	80.21	88.47
Cardiovascular Conditions		
CBP—Controlling High Blood Pressure	49.39	58.89
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	83.33	90.69
SPC—Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy	77.22	76.68
SPC—Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%	80.33	71.33
Diabetes		
CDC—Comprehensive Diabetes Care—HbA1c Testing	85.40	88.82
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control**	42.09	37.39
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)	48.42	53.34
CDC—Comprehensive Diabetes Care—Eye Exams	58.15	63.18
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	90.51	94.14
CDC—Comprehensive Diabetes Care—Blood Pressure Cont. <140/90	53.28	56.81
SPD—Statin Therapy for Patients with Diabetes—Received Statin Therapy	66.84	70.97
SPD—Statin Therapy for Patients with Diabetes—Statin Adherence 80%	82.44	72.38

HEDIS Measure	HEDIS 2018	Statewide Average
Musculoskeletal Conditions		
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	54.17	64.21
OMW—Osteoporosis Management in Women Who Had a Fracture	0.00	9.56
Behavioral Health		
AMM—Antidepressant Medication Management—Effect Acute Phase Treatment	48.15	57.08
AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment	35.19	43.57
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days	3.45	23.63
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days	27.59	52.49
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days	23.28	30.48
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days	37.93	48.67
Medication Management and Care Coordination		
MRP—Medication Reconciliation Post-Discharge	12.41	39.18
Overuse/Appropriateness		
*PSA—Non-Recommended PSA-Based Screening of Older Men**	18.91	19.27
*DDE—Potentially Harmful Drug-Disease Interactions in the Elderly**	44.83	44.19
*DAE—Use of High-Risk Medications in the Elderly—One Prescription**	12.95	18.89
*DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions**	9.08	12.40
Access/Availability of Care		
AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years	76.76	85.31
AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years	89.47	94.10
AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older	83.42	90.49
AAP—Adults' Access to Preventative/Ambulatory Health Services—Total	84.09	90.73
IET—Initiation of Alcohol and Other Drug Dependence Treatment	41.98	30.35
IET—Engagement of Alcohol and Other Drug Dependence Treatment	5.56	3.76
Risk Adjusted Utilization		
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**	0.86	0.74
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**	0.98	0.78

(*) = Measures where lower rates indicate better performance.
Note: Green indicates performance is better than the statewide average.

AmeriHealth Michigan, Inc. performed better than the statewide average in 10 of the 43 reported HEDIS measures (23 percent). Overall, **AmeriHealth Michigan, Inc.** also demonstrated stronger performance in the Respiratory Conditions and Overuse/Appropriateness domains, but showed greater opportunities for improvement in the Prevention and Screening, Diabetes, Musculoskeletal Conditions, Behavioral Health, Medication Management and Care Coordination, Access/Availability of Care, and Risk Adjusted Utilization domains in comparison to the statewide average. Mixed results were displayed in the Cardiovascular Conditions domain.

Validation of Performance Improvement Projects

Table 5-13 displays the validation results for **AmeriHealth Michigan, Inc.**'s QIP. This table illustrates the ICO's overall application of the QIP process and success in implementing the QIP. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 5-13 show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all steps.

Table 5-13—QIP Validation Results for AMI

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
		Design Total	**100% (8/8)**	**0% (0/8)**	**0% (0/8)**

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	*Not Assessed*		
Implementation Total			**100% (3/3)**	**0% (0/3)**	**0% (0/3)**
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**100% (11/11)**		

Overall, 100 percent of all applicable evaluation elements received a score of *Met* for the Design and Implementation stages of the QIP.

For the baseline measurement period, **AmeriHealth Michigan, Inc.** reported that 35.1 percent of members received a follow-up visit with a mental health practitioner within 30 days of discharge. The goal for the QIP is that the ICO will demonstrate a statistically significant improvement over the baseline for the remeasurement periods.

Strengths, Weaknesses, and Overall Conclusions

AmeriHealth Michigan, Inc. demonstrated both strengths and weaknesses based on the results of the SFY 2018–2019 EQR activities. **AmeriHealth Michigan, Inc.** received a total compliance score of 76 percent across all 11 standards reviewed in 2019, which was one of the lowest scores across all ICOs. **AmeriHealth Michigan, Inc.** scored 100 percent in the Confidentiality standard, but did not perform as well in the Availability of Services, Assurance of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Grievance and Appeal Systems, Subcontractual Relationships and Delegation, Practice Guidelines, Health Information Systems, and Quality Assessment and Performance Improvement Program standards, as demonstrated by low to moderate performance scores (82 percent, 67 percent, 71 percent, 68 percent, 80 percent, 73 percent, 80 percent, 75 percent, 88 percent, and 82 percent, respectively), reflecting that additional focus is needed in these areas.

While **AmeriHealth Michigan, Inc.** performed better than the statewide average in 10 of the 43 reported HEDIS measures, indicating strength in these areas, all performance measure domains included at least one measure that performed below the statewide average, indicating opportunities to improve in all domains.

AmeriHealth Michigan, Inc. also designed a scientifically sound QIP supported by using key research principles, meeting 100 percent of the requirements in the Design stage. **AmeriHealth Michigan, Inc.** also met 100 percent of the requirements for data analysis and implementation of improvement strategies.

AmeriHealth Michigan, Inc.'s overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-14—Quality, Timeliness, and Access Performance Impact for AMI

Performance Area*	Overall Performance Impact
Quality	• Strength: The Confidentiality standard achieved full compliance, suggesting the ICO uses and discloses member protected health information in accordance with federal privacy requirements. • Strength: Two of three HEDIS measures within the Respiratory Conditions domain rated above the statewide average, indicating the ICO's providers are assessing for and providing appropriate treatment to members diagnosed with COPD. • Strength: Two measures in the Cardiovascular Conditions domain, *Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy* and *Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%*, and a related measure under the Diabetes domain, *Statin Therapy for Patients with Diabetes—Statin Adherence 80%*, performed better than the statewide average, suggesting members diagnosed with cardiovascular disease and diabetes are being effectively treated to lower blood cholesterol to mitigate the risk of further complications. • Weakness: The Grievance and Appeal Systems standard received a performance score of 73 percent, indicating opportunities exist for the ICO to ensure that it has an effective grievance and appeal system in place for its members. • Weakness: The Practice Guidelines standard received a performance score of 75 percent, suggesting the ICO has opportunities to adopt and disseminate practice guidelines for use in making utilization management and coverage of service decisions and providing member education consistent with the guidelines. • Weakness: All seven measures within the Prevention and Screening domain performed worse than the statewide average, indicating members are not always receiving preventive screenings, such as breast cancer and colorectal cancer screenings, in order to prevent and detect diseases early, and older adults may not be receiving the care they need to optimize their quality of life. • Weakness: Two of the four measures within the Cardiovascular Conditions domain, *Controlling High Blood Pressure* and *Persistence of Beta-Blocker Treatment After a Heart Attack* performed worse than the statewide average, indicating members

Performance Area*	Overall Performance Impact
	diagnosed with hypertension are not adequately controlling their blood pressure, and members may not be receiving persistent beta-blocker treatment after discharge for a heart attack. • Weakness: All six *Comprehensive Diabetes Care* measures within the Diabetes domain performed worse than the statewide average, indicating members diagnosed with type 1 and type 2 diabetes are not receiving appropriate diabetes management necessary to control blood glucose and reduce risks for complications. • Weakness: Both measures in the Musculoskeletal Conditions domain performed below the statewide average, indicating members may not be receiving the appropriate treatment to help preserve function and prevent further damage.
Timeliness	• Weakness: All six measures within the Behavioral Health domain rated below the statewide average, implying the ICO has significant opportunities to ensure members have timely access to a mental health provider, especially after hospitalization and emergency department visits for a mental health illness. • Weakness: The *Medication Reconciliation Post-Discharge* measure rated below the statewide average, indicating members discharged from an inpatient facility do not always have medications reconciled within 30 days.
Access	• Strength: Two measures within the Access/Availability of Care domain, *Initiation of Alcohol and Other Drug Dependence Treatment* and *Engagement of Alcohol and Other Drug Dependence Treatment*, performed above the statewide average, implying that members diagnosed with a new episode of alcohol or drug dependence are able to access treatment timely after diagnosis. • Strength: The ICO designed a QIP that has the potential to improve the health of members with mental illness and reduce readmissions through increasing appropriate follow-up care. • Weakness: The Assurance of Adequate Capacity and Services standard received a performance score of 67 percent, suggesting opportunities exist in the ICO's processes and documentation to demonstrate it has the capacity to serve the expected enrollment in its service area in accordance with the MDHHS standards for access to care. • Weakness: The Coordination and Continuity of Care standard received a performance score of 71 percent, suggesting the ICO has gaps in its procedures to effectively deliver care to and coordinate services for all ICO members. • Weakness: The Coverage and Authorization of Services standard received a performance score of 68 percent, indicating the ICO may not always make authorization determinations and/or provide notice to members in accordance with State and federal rules. • Weakness: The four *Adults' Access to Preventative/Ambulatory Health Services* measures within the Access/Availability of Care domain performed below the statewide average, indicating some members 20 years of age and older do not schedule an appointment with their providers for preventive health services. Preventive care is

Performance Area*	Overall Performance Impact
	an important step for members to take to address serious health issues and manage chronic conditions. • Weakness: The *Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)* and *(65+)* measures performed worse than the statewide average, indicating a higher percentage of members are being readmitted within 30 days after being discharged from an inpatient hospital stay.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

SFY 2018–2019 is the first year that an annual detailed technical report was completed for the MI Health Link program and the contracted ICOs. Therefore, there were no previous quality improvement recommendations made to MDHHS or to **AmeriHealth Michigan, Inc.** by HSAG or another EQRO prior to SFY 2018–2019. Future technical reports will include an assessment of the degree to which each ICO addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.

Recommendations for Program Improvement

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **AmeriHealth Michigan, Inc.** to members, HSAG recommends that **AmeriHealth Michigan, Inc.** incorporate efforts for improvement for performance measures that fell below the statewide average. To prioritize its efforts, **AmeriHealth Michigan, Inc.** should identify a specific subset of the below measures and develop initiatives to improve the performance of those selected measures. The selected measures, and any subsequent initiatives and interventions, should be included as part of **AmeriHealth Michigan, Inc.**'s quality improvement strategy within its QAPIP:

Domains With Measure Ratings Below the Statewide Average

- **Prevention and Screening**
  - *ABA—Adult BMI Assessment*
  - *BCS—Breast Cancer Screening*
  - *COL—Colorectal Cancer Screening*
  - *COA—Care for Older Adults—Advance Care Planning*
  - *COA—Care for Older Adults—Medication Review*
  - *COA—Care for Older Adults—Functional Status Assessment*
  - *COA—Care for Older Adults—Pain Assessment*

- **Respiratory Conditions**
  - *PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator*
- **Cardiovascular Conditions**
  - *CBP—Controlling High Blood Pressure*
  - *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack*
- **Diabetes**
  - *CDC—Comprehensive Diabetes Care—HbA1c Testing*
  - *CDC—Comprehensive Diabetes Care—Poor HbA1c Control*
  - *CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
  - *CDC—Comprehensive Diabetes Care—Eye Exams*
  - *CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy*
  - *CDC - Comprehensive Diabetes Care - Blood Pressure Cont. <140/90*
  - *SPD—Statin Therapy for Patients with Diabetes—Received Statin Therapy*
- **Musculoskeletal Conditions**
  - *ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis*
  - *OMW—Osteoporosis Management in Women Who Had a Fracture*
- **Behavioral Health**
  - *AMM—Antidepressant Medication Management—Effect Acute Phase Treatment*
  - *AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment*
  - *FUH—Follow-Up After Hospitalization for Mental Illness—7 Days*
  - *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days*
  - *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days*
  - *FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days*
- **Medication Management and Care Coordination**
  - *MRP—Medication Reconciliation Post-Discharge*
- **Overuse/Appropriateness**
  - *DDE—Potentially Harmful Drug-Disease Interactions in the Elderly*
- **Access/Availability of Care**
  - *AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years*
  - *AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years*
  - *AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older*
  - *AAP—Adults' Access to Preventative/Ambulatory Health Services—Total*
- **Risk Adjusted Utilization**
  - *PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)*
  - *PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)*

AmeriHealth Michigan, Inc. should include within its next annual QAPIP review the results of analyses for the performance measures selected from those listed above that answer the following questions:

1. What were the root causes associated with low-performing areas?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **AmeriHealth Michigan, Inc.** considering or has already implemented to improve rates and performance for each identified performance measure?

Based on the information presented above, **AmeriHealth Michigan, Inc.** should include the following within its quality improvement work plan:

- Measurable goals and benchmarks for each performance measure
- Mechanisms to measure performance
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates
- Identified opportunities for improvement
- Ongoing analysis to identify factors that impact adequacy of rates
- Quality improvement interventions that address the root cause of the deficiency
- A plan to monitor the quality improvement interventions to detect whether they effect improvement

HSAG also recommends that **AmeriHealth Michigan, Inc.** implement the plans of action approved by MDHHS to bring into compliance each of the following deficient standards:

- Standard I—Availability of Services
- Standard II—Assurance of Adequate Capacity and Services
- Standard III—Coordination and Continuity of Care
- Standard IV—Coverage and Authorization of Services
- Standard V—Provider Selection
- Standard VII—Grievance and Appeal Systems
- Standard VIII—Subcontractual Relationships and Delegation
- Standard IX—Practice Guidelines
- Standard X—Health Information Systems
- Standard XI—Quality Assessment and Performance Improvement Program

AmeriHealth Michigan, Inc. was required to complete plans of action to address each deficiency and submit to MDHHS within 30 days of receipt of the final compliance report. HSAG recommends that **AmeriHealth Michigan, Inc.** implement internal processes to periodically review the status of each

plan of action; for example, completing a progress update every 45 business days. This periodic review should include:

- Progress on implementation of each plan of action.
- Successes or barriers in remediating each deficiency.
- Revised actions steps, if necessary.

Once all plans of action are fully implemented, HSAG recommends that **AmeriHealth Michigan, Inc.** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency. HSAG will also be conducting a review of those plans of action in 2020 to ensure deficiencies were mitigated.

Finally, **AmeriHealth Michigan, Inc.** should take proactive steps to ensure a successful QIP. **AmeriHealth Michigan, Inc.** should address any recommendation*s* in the *2018–2019 QIP Validation Report Follow-Up After Hospitalization for Mental Illness for AmeriHealth Michigan*, *Inc.* HSAG also recommends the following:

- To impact the Remeasurement 1 study indicator rate, **AmeriHealth Michigan, Inc.** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period may not have the time to impact the study indicator rate.
- **AmeriHealth Michigan, Inc.** should document the process/steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- **AmeriHealth Michigan, Inc.** should implement active, innovative improvement strategies that have the potential to directly impact study indicator outcomes.
- **AmeriHealth Michigan, Inc.** should have an evaluation process to determine the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data-driven.

HAP Empowered

EQR Activity Results

Compliance Review

Table 5-15 presents for each standard the total number of elements as well as the number of elements that received scores of *Met*, *Not Met*, or *Not Applicable (NA)*. Table 5-15 also presents **HAP Empowered**'s overall compliance score for each standard, the totals across the 11 standards reviewed, and the total compliance score across all standards for the 2019 compliance review.

Table 5-15—Summary of 2019 Compliance Review Results for HAP Empowered (HAP)

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—Availability of Services	11	8	3	0	73%
Standard II—Assurance of Adequate Capacity and Services	6	5	1	0	83%
Standard III—Coordination and Continuity of Care	17	14	3	1	82%
Standard IV—Coverage and Authorization of Services	19	15	4	1	79%
Standard V—Provider Selection	10	8	2	0	80%
Standard VI—Confidentiality	7	6	1	0	86%
Standard VII—Grievance and Appeal Systems	33	22	11	0	67%
Standard VIII—Subcontractual Relationships and Delegation	5	3	2	0	60%
Standard IX—Practice Guidelines	4	3	1	0	75%
Standard X—Health Information Systems	8	8	0	0	100%
Standard XI—Quality Assessment and Performance Improvement Program	11	8	3	0	73%
Total Compliance Score	**131**	**100**	**31**	**2**	**76%**

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements *Met* were given full value (1 point each). The point values were then totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each standard.

HAP Empowered demonstrated compliance for 100 of 131 elements, with an overall compliance score of 76 percent. **HAP Empowered** demonstrated strong performance, scoring 100 percent, in the Health Information Systems standard.

Opportunities for improvement were identified in 10 of the 11 standards, including deficiencies related to the following requirements:

- All urgent and symptomatic office visits must be available to members within 24 hours.
- Mechanisms must be established to ensure compliance by network providers, monitor network providers regularly to determine compliance, and take corrective action if network providers fail to comply.
- Policies and procedures must document mechanisms to ensure that no physical, communication, or programmatic barriers inhibit individuals with disabilities from obtaining all covered services as required by contract.
- Timely notification must be provided to the contract management team when there are significant provider network changes.
- Legally authorized representatives must be included in the person-centered planning process when indicated. If a member does not have a legally authorized representative or if the legally authorized representative declines to participate, it must be documented.
- Implementation of the IICSP must be monitored, including facilitation of the evaluation of the process, progress, and outcomes, as well as identifying barriers and facilitation problem resolution and follow-up.
- The IICSP must be reviewed with the member according to required time frames identified in contract language related to low-, moderate-, and high-risk members.
- The NABD must include all required content.
- For termination, suspension, or reduction of previously authorized Medicaid-covered services, the notice must be mailed at least 10 days before the date of action, except under the circumstances described in rule.
- For the denial of payment, notice must be mailed at the time of any action affecting the claim.
- Consideration of performance indicators obtained through the quality improvement plan, utilization management program, grievance and appeal system, member satisfaction surveys, and medical record reviews must be considered in the ICO's recredentialing process.
- Disclosures from all network providers and applicants must be obtained in accordance with 42 CFR §455 Subpart B and 42 CFR §1002.3, including but not limited to obtaining such information through provider enrollment forms and credentialing and recredentialing packages, and such disclosed information must be maintained in a manner that can be periodically searched by the ICO for exclusions and provided to MDHHS in accordance with the contract as well as with relevant State and federal laws and regulations.
- The breach notification procedures must ensure that breach notifications are sent by first class mail in accordance with 45 CFR §164.404(d)(1)(i-ii).
- Written consent of the member for a provider or an authorized representative to request an appeal or file a grievance, or request a State fair hearing, on behalf of a member must be obtained.
- Mechanisms must be in place to ensure that any grievances filed with a provider are forwarded to the ICO as required by contract.

- Appeal details must be confirmed to the member in writing when the member requests an appeal orally.
- Appeal processes must ensure that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and are confirmed in writing, unless the member or the provider requests expedited resolution.
- Parties to the appeal and State fair hearing include the member and his or her representative or the legal representative of a deceased member's estate; and, in State fair hearings, the ICO.
- The process to extend the grievance and appeal resolution time frames by up to 14 calendar days when not at the member's request must include all requirements, including making reasonable efforts to give the member prompt oral notice of the reason for the decision to extend the time frame, providing written notice within two calendar days of the oral notification, and informing the member of the right to file a grievance if he or she disagrees with the decision to extend the time frame for resolution.
- The written notice of appeal resolution must contain all required content, including information about the member's right to request a State fair hearing and how to do so within 120 days of the notice of appeal resolution.
- Members must be aware that they have 120 calendar days from the date of the ICO's notice of appeal resolution to request a State fair hearing.
- Denied requests for expedited appeal resolution must include transferring the appeal to the time frame for standard resolution; making reasonable efforts to give the member prompt oral notice of the denial; within two calendar days, giving the member written notice of the reason for the decision to extend the time frame, and informing the member of the right to file a grievance if he or she disagrees with that decision; and resolving the appeal as expeditiously as the member's health condition requires, and no later than the date that the extension expires.
- Accurate and complete information about the grievance and appeal system must be provided to all providers and subcontractors at the time they enter into contracts with the ICO.
- Member's benefits must continue while the appeal and/or the State fair hearing is/are pending, when all requirements under rule are met, including that the member must be aware of the requirement and file for continuation of benefits within 10 calendar days of receiving the NABD.
- Each contract or written agreement must specify that if MDHHS, CMS, or the Health and Human Services Inspector General determines that reasonable possibility of fraud or similar risk exists, any of those entities may inspect, evaluate, or audit the subcontractor at any time.
- Subcontractors' performance must be monitored ongoing and subcontractors must have a formal review according to an established periodic schedule.
- CPGs must be adopted, reviewed, and updated as required by federal rule and contract.
- The QAPIP must include mechanisms to detect both underutilization and overutilization of services, including provider profiles.
- The ICO must demonstrate efforts to prevent, detect, and remediate critical incidents—consistent with assuring member health and welfare per §441.302 and §441.730(a)—that are based, at a

minimum, on the requirements of the State for home- and community-based waiver programs per §441.302(h).

- Information on the effectiveness of the ICO's QAPIP program must be disseminated to network providers annually.

HAP Empowered was required to develop and implement a CAP for each requirement in all standards scored *Not Met*.

Validation of Performance Measures

The PMV review of **HAP Empowered**'s reported data focused on enrollment and eligibility data processes, assessment and care plan processes, performance measure production, and PSV findings. Specifically, the validation processes ensured that **HAP Empowered** appropriately classified members in the four data elements collected for both Core Measure 2.1 and Core Measure 3.2.

Based on its review, HSAG found that the Core Measure 2.1 and Core Measure 3.2 PMV for **HAP Empowered** resulted in the following validation designation:

Table 5-16—Measure-Specific Validation Designation for HAP

Performance Measure	Validation Designation
Core Measure 2.1: *Members with an assessment completed within 90 days of enrollment*	**REPORT (R)** Measure data were compliant with CMS' specifications and the data, as reported, were valid.
Core Measure 3.2: *Members with a care plan completed within 90 days of enrollment*	**REPORT (R)** Measure data were compliant with CMS' specifications and the data, as reported, were valid.

HEDIS Data

Table 5-17 shows each of **HAP Empowered**'s audited HEDIS measures, **HAP Empowered**'s rates for HEDIS 2018, and the MI Health Link statewide average performance rates.

Table 5-17—Measure-Specific Percentage Rates for HAP

HEDIS Measure	HEDIS 2018	Statewide Average
Prevention and Screening		
ABA—Adult BMI Assessment	65.19	91.51
BCS—Breast Cancer Screening	55.53	57.80
COL—Colorectal Cancer Screening	48.40	53.14
COA—Care for Older Adults—Advance Care Planning	10.95	36.18
COA—Care for Older Adults—Medication Review	52.07	72.10

HEDIS Measure	HEDIS 2018	Statewide Average
COA—Care for Older Adults—Functional Status Assessment	17.03	53.95
COA—Care for Older Adults—Pain Assessment	27.25	68.09
Respiratory Conditions		
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	40.00	26.62
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	59.48	72.48
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	87.93	88.47
Cardiovascular Conditions		
CBP—Controlling High Blood Pressure	48.39	58.89
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	91.30	90.69
SPC—Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy	78.48	76.68
SPC—Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%	68.82	71.33
Diabetes		
CDC—Comprehensive Diabetes Care—HbA1c Testing	79.83	88.82
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control**	79.16	37.39
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)	16.18	53.34
CDC—Comprehensive Diabetes Care—Eye Exams	52.14	63.18
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	91.72	94.14
CDC—Comprehensive Diabetes Care—Blood Pressure Cont. <140/90	17.51	56.81
SPD—Statin Therapy for Patients with Diabetes—Received Statin Therapy	76.78	70.97
SPD—Statin Therapy for Patients with Diabetes—Statin Adherence 80%	66.76	72.38
Musculoskeletal Conditions		
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	64.44	64.21
OMW—Osteoporosis Management in Women Who Had a Fracture	0.00	9.56
Behavioral Health		
AMM—Antidepressant Medication Management—Effect Acute Phase Treatment	51.43	57.08
AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment	32.38	43.57
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days	20.22	23.63
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days	57.30	52.49
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days	35.00	30.48

HEDIS Measure	HEDIS 2018	Statewide Average
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days	51.67	48.67
Medication Management and Care Coordination		
MRP—Medication Reconciliation Post-Discharge	30.90	39.18
Overuse/Appropriateness		
*PSA—Non-Recommended PSA-Based Screening of Older Men**	20.15	19.27
*DDE—Potentially Harmful Drug-Disease Interactions in the Elderly**	37.68	44.19
*DAE—Use of High-Risk Medications in the Elderly—One Prescription**	15.33	18.89
*DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions**	9.92	12.40
Access/Availability of Care		
AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years	82.00	85.31
AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years	93.24	94.10
AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older	87.73	90.49
AAP—Adults' Access to Preventative/Ambulatory Health Services—Total	88.44	90.73
IET—Initiation of Alcohol and Other Drug Dependence Treatment	26.43	30.35
IET—Engagement of Alcohol and Other Drug Dependence Treatment	2.64	3.76
Risk Adjusted Utilization		
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**	0.65	0.74
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**	0.57	0.78

(*) = Measures where lower rates indicate better performance.

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

HAP Empowered performed better than the statewide average in 13 of the 43 reported HEDIS measures (30 percent). Overall, **HAP Empowered** also demonstrated stronger performance in the Overuse/Appropriateness and Risk Adjusted Utilization domains, but showed greater opportunities for improvement in the Prevention and Screening, Respiratory Conditions, Diabetes, Medication Management and Care Coordination, and Access/Availability of Care domains in comparison to the statewide average. Mixed results were displayed in the remaining domains.

Validation of Quality Improvement Projects

Table 5-18 displays the validation results for **HAP Empowered**'s QIP. This table illustrates the ICO's overall application of the QIP process and success in implementing the QIP. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 5-18 show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all steps.

Table 5-18—QIP Validation Results for HAP

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	*Not Assessed*		
Implementation Total			**100% (3/3)**	**0% (0/3)**	**0% (0/3)**
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**100% (11/11)**		

Overall, 100 percent of all applicable evaluation elements received a score of *Met* for the Design and Implementation stages of the QIP process.

For the baseline measurement period, **HAP Empowered** reported that 53.8 percent of members received a follow-up visit with a mental health practitioner within 30 days of discharge. The goal for the QIP is that the ICO will demonstrate a statistically significant improvement over the baseline for the remeasurement periods.

Strengths, Weaknesses, and Overall Conclusions

HAP Empowered demonstrated both strengths and weaknesses based on the results of the SFY 2018–2019 EQR activities. **HAP Empowered** received a total compliance score of 76 percent across all 11 standards reviewed in 2019, which was one of the lowest scores across all ICOs. **HAP Empowered** scored 100 percent in the Health Information Systems standard, but did not perform as well in the 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, and Quality Assessment and Performance Improvement Program standards, as demonstrated by low to moderate performance scores (73 percent, 83 percent, 82 percent, 79 percent, 80 percent, 86 percent, 67 percent, 60 percent, 75 percent, and 73 percent, respectively), reflecting that additional focus is needed in these areas.

While **HAP Empowered** performed better than the statewide average in 13 of the 43 reported HEDIS measures, indicating strength in these areas, all performance measure domains except Risk Adjusted Utilization included at least one measure that performed below the statewide average, indicating opportunities to improve in all but one domain.

HAP Empowered also designed a scientifically sound QIP supported by using key research principles, meeting 100 percent of the requirements in the Design stage. **HAP Empowered** also met 100 percent of the requirements for data analysis and implementation of improvement strategies.

HAP Empowered's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-19—Quality, Timeliness, and Access Performance Impact for HAP

Performance Area*	Overall Performance Impact
Quality	• Strength: The Health Information Systems standard achieved full compliance, indicating the ICO maintains a health information system that collects, analyzes, integrates, and reports data, and ensures that claims data received from providers are accurate and complete. • Strength: Two of the four measures within the Cardiovascular Conditions domain, *Persistence of Beta-Blocker Treatment After a Heart Attack* and *Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy*, and one related measure within the Diabetes domain, *Statin Therapy for Patients with Diabetes—Received Statin Therapy*, performed better than the statewide average, indicating members are receiving persistent beta-blocker treatment after discharge for a heart attack, and members with diabetes and cardiovascular disease are receiving and adhering to statin therapy to lower blood cholesterol and prevent further complications of their disease. The remaining Cardiovascular measures, however, performed below the statewide average, indicating additional efforts are warranted to improve the domain overall. • Strength: Three of the four Overuse/Appropriateness measures performed above the statewide average, indicating adults 65 and older and their prescribed medications are being assessed to reduce adverse drug events. • Weakness: The Grievance and Appeal Systems standard received a performance score of 67 percent, indicating opportunities exist for the ICO to ensure that it has an effective grievance and appeal system in place for its members. • Weakness: The Subcontractual Relationships and Delegation standard received a performance score of 60 percent, suggesting the ICO has inadequate or ineffective processes in place to ensure its delegates comply with all contract obligations. • Weakness: The Practice Guidelines standard received a performance score of 75 percent, suggesting the ICO has opportunities to adopt and disseminate practice guidelines for use in making utilization management and coverage of service decisions and providing member education consistent with the guidelines. • Weakness: The Quality Assessment and Performance Improvement Program standard received a performance score of 73 percent, suggesting there are gaps in the ICO's quality-related processes that could impact the services being provided to members and the ICO's ability to accurately measure overall performance of the program. • Weakness: All seven measures within the Prevention and Screening domain performed worse than the statewide average, indicating members are not always receiving preventive screenings, such as breast cancer and colorectal cancer screenings, in order to prevent and detect diseases early, and older adults may not be receiving the care they need to optimize their quality of life. • Weakness: Two of three HEDIS measures within the Respiratory Conditions domain rated below the statewide average, indicating the ICO's providers may not be assessing for and providing appropriate treatment to members diagnosed with COPD.

Performance Area*	Overall Performance Impact
	• Weakness: All six *Comprehensive Diabetes Care* measures within the Diabetes domain performed worse than the statewide average, indicating members diagnosed with type 1 and type 2 diabetes are not receiving appropriate diabetes management necessary to control blood glucose and reduce risks for complications.
Timeliness	• Strength: Three of the four measures within the Behavioral Health domain related to follow-up care rated above the statewide average, implying the ICO has focused its efforts on members diagnosed with mental health conditions, specifically related to follow-up after hospitalization within 30 days of discharge for mental illness and follow-up after an emergency department visit for mental illness. The *Follow-Up After Hospitalization for Mental Illness—7 Days* measure fell below the statewide average, so heightened attention should be placed on ensuring members can access a mental health provider within seven days of hospitalization for mental illness. • Weakness: The *Medication Reconciliation Post-Discharge* measure rated below the statewide average, indicating members discharged from an inpatient facility do not always have medications reconciled within 30 days.
Access	• Strength: The ICO designed a QIP that has the potential to improve the health of members with mental illness and reduce readmissions through increasing appropriate follow-up care. • Strength: The *Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)* and *(65+)* measures performed better than the statewide average, indicating a lower percentage of members are being readmitted within 30 days after being discharged from an inpatient hospital stay. • Weakness: The Availability of Services standard received a performance score of 73 percent, indicating access may be impeded for some members in accordance with the access standards developed by MDHHS. • Weakness: The four *Adults' Access to Preventative/Ambulatory Health Services* measures within the Access/Availability of Care domain performed below the statewide average, indicating some members 20 years of age and older do not schedule an appointment with their providers for preventive health services. Preventive care is an important step for members to take to address serious health issues and manage chronic conditions. • Weakness: Two measures within the Access/Availability of Care domain, *Initiation of Alcohol and Other Drug Dependence Treatment* and *Engagement of Alcohol and Other Drug Dependence Treatment,* performed below the statewide average, implying that members diagnosed with a new episode of alcohol or drug dependence are not able to access treatment timely after diagnosis.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

SFY 2018–2019 is the first year that an annual detailed technical report was completed for the MI Health Link program and the contracted ICOs. Therefore, there were no previous quality improvement recommendations made to MDHHS or to **HAP Empowered** by HSAG or another EQRO prior to SFY 2018–2019. Future technical reports will include an assessment of the degree to which each ICO addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.

Recommendations for Program Improvement

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **HAP Empowered** to members, HSAG recommends that **HAP Empowered** incorporate efforts for improvement for performance measures that fell below the statewide average. To prioritize its efforts, **HAP Empowered** should identify a specific subset of the below measures and develop initiatives to improve the performance of those selected measures. The selected measures, and any subsequent initiatives and interventions, should be included as part of **HAP Empowered**'s quality improvement strategy within its QAPIP:

Domains With Measure Ratings Below the Statewide Average

- **Prevention and Screening**
  - *ABA—Adult BMI Assessment*
  - *BCS—Breast Cancer Screening*
  - *COL—Colorectal Cancer Screening*
  - *COA—Care for Older Adults—Advance Care Planning*
  - *COA—Care for Older Adults—Medication Review*
  - *COA—Care for Older Adults—Functional Status Assessment*
  - *COA—Care for Older Adults—Pain Assessment*
- **Respiratory Conditions**
  - *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid*
  - *PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator*
- **Cardiovascular Conditions**
  - *CBP—Controlling High Blood Pressure*
  - *SPC—Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%*
- **Diabetes**
  - *CDC—Comprehensive Diabetes Care—HbA1c Testing*
  - *CDC—Comprehensive Diabetes Care—Poor HbA1c Control*
  - *CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)*

- *CDC—Comprehensive Diabetes Care—Eye Exams*
- *CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy*
- *CDC—Comprehensive Diabetes Care—Blood Pressure Cont. <140/90*
- *SPD—Statin Therapy for Patients with Diabetes—Statin Adherence 80%*

- **Musculoskeletal Conditions**
  - *OMW—Osteoporosis Management in Women Who Had a Fracture*
- **Behavioral Health**
  - *AMM—Antidepressant Medication Management—Effect Acute Phase Treatment*
  - *AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment*
  - *FUH—Follow-Up After Hospitalization for Mental Illness—7 Days*
- **Medication Management and Care Coordination**
  - *MRP—Medication Reconciliation Post-Discharge*
- **Overuse/Appropriateness**
  - *PSA—Non-Recommended PSA-Based Screening of Older Men*
- **Access/Availability of Care**
  - *AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years*
  - *AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years*
  - *AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older*
  - *AAP—Adults' Access to Preventative/Ambulatory Health Services—Total*
  - *IET—Initiation of Alcohol and Other Drug Dependence Treatment*
  - *IET—Engagement of Alcohol and Other Drug Dependence Treatment*

HAP Empowered should include within its next annual QAPIP review the results of analyses for the performance measures selected from those listed above that answer the following questions:

1. What were the root causes associated with low-performing areas?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **HAP Empowered** considering or has already implemented to improve rates and performance for each identified performance measure?

Based on the information presented above, **HAP Empowered** should include the following within its quality improvement work plan:

- Measurable goals and benchmarks for each performance measure
- Mechanisms to measure performance

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- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates
- Identified opportunities for improvement
- Ongoing analysis to identify factors that impact adequacy of rates
- Quality improvement interventions that address the root cause of the deficiency
- A plan to monitor the quality improvement interventions to detect whether they effect improvement

HSAG also recommends that **HAP Empowered** implement the plans of action approved by MDHHS to bring into compliance each of the following deficient standards:

- Standard I—Availability of Services
- Standard II—Assurance of Adequate Capacity and Services
- Standard III—Coordination and Continuity of Care
- Standard IV—Coverage and Authorization of Services
- Standard V—Provider Selection
- Standard VI—Confidentiality
- Standard VII—Grievance and Appeal Systems
- Standard VIII—Subcontractual Relationships and Delegation
- Standard IX—Practice Guidelines
- Standard XI—Quality Assessment and Performance Improvement Program

HAP Empowered was required to complete plans of action to address each deficiency and submit to MDHHS within 30 days of receipt of the final compliance report. HSAG recommends that **HAP Empowered** implement internal processes to periodically review the status of each plan of action; for example, completing a progress update every 45 business days. This periodic review should include:

- Progress on implementation of each plan of action.
- Successes or barriers in remediating each deficiency.
- Revised actions steps, if necessary.

Once all plans of action are fully implemented, HSAG recommends that **HAP Empowered** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency. HSAG will also be conducting a review of those plans of action in 2020 to ensure deficiencies were mitigated.

Finally, **HAP Empowered** should take proactive steps to ensure a successful QIP. **HAP Empowered** should address any recommendations in the *2018–2019 QIP Validation Report Follow-Up After Hospitalization for Mental Illness for HAP Empowered.* HSAG also recommends the following:

- To impact the Remeasurement 1 study indicator rate, **HAP Empowered** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to

address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period may not have the time to impact the study indicator rate.

- **HAP Empowered** should document the process/steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- **HAP Empowered** should implement active, innovative improvement strategies that have the potential to directly impact study indicator outcomes.
- **HAP Empowered** should have an evaluation process to determine the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data-driven.

Meridian Health Plan

EQR Activity Results

Compliance Review

Table 5-20 presents for each standard the total number of elements as well as the number of elements that received scores of *Met*, *Not Met*, or *Not Applicable (NA)*. Table 5-20 also presents **Meridian Health Plan**'s overall compliance score for each standard, the totals across the 11 standards reviewed, and the total compliance score across all standards for the 2019 compliance review.

Table 5-20—Summary of 2019 Compliance Review Results for Meridian Health Plan (MER)

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—Availability of Services	11	8	3	0	73%
Standard II—Assurance of Adequate Capacity and Services	6	4	2	0	67%
Standard III—Coordination and Continuity of Care	17	11	6	1	65%
Standard IV—Coverage and Authorization of Services	19	13	6	1	68%
Standard V—Provider Selection	10	8	2	0	80%
Standard VI—Confidentiality	7	7	0	0	100%
Standard VII—Grievance and Appeal Systems	33	28	5	0	85%
Standard VIII—Subcontractual Relationships and Delegation	5	4	1	0	80%
Standard IX—Practice Guidelines	4	2	2	0	50%
Standard X—Health Information Systems	8	7	1	0	88%
Standard XI—Quality Assessment and Performance Improvement Program	11	7	4	0	64%
Total	**131**	**99**	**32**	**2**	**76%**

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements *Met* were given full value (1 point each). The point values were then totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each standard.

Meridian Health Plan demonstrated compliance for 99 of 131 elements, with an overall compliance score of 76 percent. **Meridian Health Plan** demonstrated strong performance, scoring 100 percent, in the Confidentiality standard.

Opportunities for improvement were identified in 10 of the 11 standards, including deficiencies related to the following requirements:

- A network of providers must be maintained and monitored, as well as supported by written agreements, to ensure the network is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities.
- All urgent and symptomatic office visits must be available to members within 24 hours.
- Network adequacy reports must be provided to MDHHS at any time there is a significant change in the ICO's operations.
- Timely notification must be provided to the contract management team when there are significant provider network changes.
- Program-level data through the Community Health Automated Medicaid Processing System (CHAMPS) and CareConnect360 or through file exacts provided by MDHHS must be reviewed as part of the initial screening process. CareConnect360 contains past Medicare and Medicaid utilization data from the MDHHS Data Warehouse. Program-level data and utilization data must be reviewed within 15 calendar days of member enrollment.
- The initial screening of each member's needs should be attempted within 15 calendar days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful.
- The IICSP must reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed. The ICO must ensure that individually identified goals are included in a member's IICSP.
- The provision of all covered services must be authorized, arranged, integrated, and coordinated for the ICO's members.
- The IICSP must be reviewed with the member according to required time frames identified in contract language related to low-, moderate-, and high-risk members.
- A Care Coordination platform must be employed that allows secure access to information and enables all members and members of the ICT to use and (where appropriate) update information. The ICO must share information with PIHPs when the ICO maintains a contract with the PIHP, across providers, and between ICOs through its Care Coordination platform.
- For termination, suspension, or reduction of previously authorized Medicaid-covered services, the notice must be mailed at least 10 days before the date of action, except under the circumstances described in rule.
- For service authorization decisions not reached within the applicable time frame for standard or expedited requests (which constitutes a denial and is thus an adverse benefit determination), the ICO must provide notice on the date that the time frames expire.
- Processes must be in place to extend standard and expedited authorization decision time frames if the member, or the provider, requests an extension; or the ICO justifies (to MDHHS upon request) a need for additional information and how the extension is in the member's interest.

- When service authorization decisions are extended, the member must be provided with written notice of the reason for the decision to extend the time frame and the member must be informed of the right to file a grievance if he or she disagrees with that decision; and the decision must be issued and carried out as expeditiously as the member's health condition requires and no later than the date the extension expires.
- Consideration of performance indicators obtained through the quality improvement plan, utilization management program, grievance and appeal system, member satisfaction surveys, and medical record reviews must be considered in the ICO's recredentialing process.
- Disclosures from all network providers and applicants must be obtained in accordance with 42 CFR §455 Subpart B and 42 CFR §1002.3, including but not limited to obtaining such information through provider enrollment forms and credentialing and recredentialing packages, and such disclosed information must be maintained in a manner that can be periodically searched by the ICO for exclusions and provided to MDHHS in accordance with the contract as well as with relevant State and federal laws and regulations.
- Members may request a State fair hearing only after receiving written notice of appeal resolution indicating the ICO is upholding the adverse benefit determination. The ICO must ensure that all member complaints are treated as grievances and are reported to MDHHS.
- Appeal processes must ensure that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and are confirmed in writing, unless the member or the provider requests expedited resolution.
- An expedited response must be provided to each member, orally or in writing, within 24 hours after the ICO receives a grievance whenever the ICO extends the appeals time frame or the ICO refuses to grant a request for an expedited appeal.
- The ICO must resolve expedited appeals and provide notice to members within 72 hours of the request for the appeal.
- The grievance and appeal resolution time frames may be extended by up to 14 calendar days if a member requests the extension, or the ICO shows (to the satisfaction of MDHHS, upon its request) that there is need for additional information and how the delay is in the member's interest.
- Subcontractors' performance must be monitored ongoing and subcontractors must have a formal review according to an established periodic schedule.
- CPGs must be disseminated to all affected providers and, upon request, to members and potential members.
- Decisions for utilization management, member education, coverage of services, and other areas to which CPGs apply must be consistent with the CPGs.
- Documentation must support that in the event of a system failure or unavailability, the contract management team would be notified upon discovery and the business continuity plan would be implemented immediately.
- The QAPIP must include mechanisms to detect both underutilization and overutilization of services, including provider profiles.

- The ICO must demonstrate efforts to prevent, detect, and remediate critical incidents—consistent with assuring member health and welfare per §441.302 and §441.730(a)—that are based, at a minimum, on the requirements of the State for home- and community-based waiver programs per §441.302(h).
- Results of quality improvement initiatives must be evaluated at least annually and include the results of activities that demonstrate the ICO's assessment of the quality of behavioral healthcare rendered. The ICO must maintain sufficient and qualified staff members to manage the quality improvement activities required under the contract and establish minimum employment standards and requirements (e.g., education, training, and experience) for employees who will be responsible for quality improvement.
- Information on the effectiveness of the ICO's QAPIP program must be disseminated to network providers annually.

Meridian Health Plan was required to develop and implement a CAP for each requirement in all standards scored *Not Met*.

Validation of Performance Measures

The PMV review of **Meridian Health Plan**'s reported data focused on enrollment and eligibility data processes, assessment and care plan processes, performance measure production, and PSV findings. Specifically, the validation processes ensured that **Meridian Health Plan** appropriately classified members in the four data elements collected for both Core Measure 2.1 and Core Measure 3.2.

Based on its review, HSAG found that the Core Measure 2.1 and Core Measure 3.2 PMV for **Meridian Health Plan** resulted in the following validation designation:

Table 5-21—Measure-Specific Validation Designation for MER

Performance Measure	Validation Designation
Core Measure 2.1: *Members with an assessment completed within 90 days of enrollment*	**REPORT (R)** Measure data were compliant with CMS' specifications and the data, as reported, were valid.
Core Measure 3.2: *Members with a care plan completed within 90 days of enrollment*	**REPORT (R)** Measure data were compliant with CMS' specifications and the data, as reported, were valid.

HEDIS Data

Table 5-22 shows each of **Meridian Health Plan**'s audited HEDIS measures, **Meridian Health Plan**'s rates for HEDIS 2018, and the MI Health Link statewide average performance rates.

Table 5-22—Measure-Specific Percentage Rates for MER

HEDIS Measure	HEDIS 2018	Statewide Average
Prevention and Screening		
ABA—Adult BMI Assessment	96.11	91.51
BCS—Breast Cancer Screening	61.80	57.80
COL—Colorectal Cancer Screening	63.99	53.14
COA—Care for Older Adults—Advance Care Planning	32.36	36.18
COA—Care for Older Adults—Medication Review	80.05	72.10
COA—Care for Older Adults—Functional Status Assessment	58.39	53.95
COA—Care for Older Adults—Pain Assessment	69.10	68.09
Respiratory Conditions		
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	24.44	26.62
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	86.32	72.48
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	91.79	88.47
Cardiovascular Conditions		
CBP—Controlling High Blood Pressure	70.07	58.89
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	100.00	90.69
SPC—Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy	75.50	76.68
SPC—Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%	79.39	71.33
Diabetes		
CDC—Comprehensive Diabetes Care—HbA1c Testing	90.51	88.82
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control**	41.61	37.39
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)	50.36	53.34
CDC—Comprehensive Diabetes Care—Eye Exams	76.89	63.18
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	95.86	94.14
CDC—Comprehensive Diabetes Care—Blood Pressure Cont. <140/90	68.37	56.81
SPD—Statin Therapy for Patients with Diabetes—Received Statin Therapy	69.15	70.97
SPD—Statin Therapy for Patients with Diabetes—Statin Adherence 80%	78.95	72.38

HEDIS Measure	HEDIS 2018	Statewide Average
Musculoskeletal Conditions		
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	78.33	64.21
OMW—Osteoporosis Management in Women Who Had a Fracture	5.88	9.56
Behavioral Health		
AMM—Antidepressant Medication Management—Effect Acute Phase Treatment	64.45	57.08
AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment	51.18	43.57
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days	17.65	23.63
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days	55.88	52.49
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days	38.97	30.48
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days	57.35	48.67
Medication Management and Care Coordination		
MRP—Medication Reconciliation Post-Discharge	51.34	39.18
Overuse/Appropriateness		
*PSA—Non-Recommended PSA-Based Screening of Older Men**	9.68	19.27
*DDE—Potentially Harmful Drug-Disease Interactions in the Elderly**	48.33	44.19
*DAE—Use of High-Risk Medications in the Elderly—One Prescription**	23.56	18.89
*DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions**	14.59	12.40
Access/Availability of Care		
AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years	75.50	85.31
AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years	79.39	94.10
AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older	69.15	90.49
AAP—Adults' Access to Preventative/Ambulatory Health Services—Total	78.95	90.73
IET—Initiation of Alcohol and Other Drug Dependence Treatment	28.57	30.35
IET—Engagement of Alcohol and Other Drug Dependence Treatment	3.42	3.76
Risk Adjusted Utilization		
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**	0.62	0.74
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**	0.67	0.78

(*) = Measures where lower rates indicate better performance.

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

Meridian Health Plan performed better than the statewide average in 26 of the 43 reported HEDIS measures (60 percent). Overall, **Meridian Health Plan** also demonstrated stronger performance in the Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Behavioral Health, Medication Management and Care Coordination, and Risk Adjusted Utilization domains, but showed greater opportunities for improvement in the Overuse/Appropriateness and Access/Availability of Care domains in comparison to the statewide average. Mixed results were displayed in the Musculoskeletal Condition domain.

Validation of Quality Improvement Projects

Table 5-23 displays the validation results for **Meridian Health Plan**'s QIP. This table illustrates the ICO's overall application of the QIP process and success in implementing the QIP. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 5-23 show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all steps.

Table 5-23—QIP Validation Results for MER

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
		Design Total	**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	*Not Assessed*		
		Implementation Total	**100% (3/3)**	**0% (0/3)**	**0% (0/3)**

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**100% (12/12)**		

Overall, 100 percent of all applicable evaluation elements received a score of *Met* for the Design and Implementation stages of the QIP process.

For the baseline measurement period, **Meridian Health Plan** reported that 23.1 percent of members received a follow-up visit with a mental health practitioner within 30 days of discharge. The goal for the QIP is that the ICO will demonstrate a statistically significant improvement over the baseline for the remeasurement periods.

Strengths, Weaknesses, and Overall Conclusions

Meridian Health Plan demonstrated both strengths and weaknesses based on the results of the SFY 2018–2019 EQR activities. **Meridian Health Plan** received a total compliance score of 76 percent across all 11 standards reviewed in 2019, which was one of the lowest scores across all ICOs. **Meridian Health Plan** scored 100 percent in the Confidentiality standard, but did not perform as well in the Availability of Services, Assurance of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Grievance and Appeal Systems, Subcontractual Relationships and Delegation, Practice Guidelines, Health Information Systems, and Quality Assessment and Performance Improvement Program standards, as demonstrated by low to moderate performance scores (73 percent, 67 percent, 65 percent, 68 percent, 80 percent, 85 percent, 80 percent, 50 percent, 88 percent, and 64 percent, respectively), reflecting that additional focus is needed in these areas.

While **Meridian Health Plan** performed better than the statewide average in 26 of the 43 reported HEDIS measures, indicating strength in these areas, eight of the 10 performance measure domains included at least one measure that performed below the statewide average, indicating opportunities to improve in most domains.

Meridian Health Plan also designed a scientifically sound QIP supported by using key research principles, meeting 100 percent of the requirements in the Design stage. The technical design of the QIP was sufficient to measure and monitor QIP outcomes. **Meridian Health Plan** also met 100 percent of the requirements for data analysis and implementation of improvement strategies.

Meridian Health Plan's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-24—Quality, Timeliness, and Access Performance Impact for MER

Performance Area*	Overall Performance Impact
Quality	• Strength: The Confidentiality standard achieved full compliance, suggesting the ICO uses and discloses member protected health information in accordance with federal privacy requirements. • Strength: Six of the seven measures within the Prevention and Screening domain performed better than the statewide average, indicating members are receiving preventive screenings, such as breast cancer and colorectal cancer screenings, in order to prevent and detect diseases early, and older adults are receiving the care they need to optimize their quality of life. One measure, *Care for Older Adults—Advance Care Planning*, performed below the statewide average and MMP National Average, suggesting additional focus in this area could further improve the care for older adults. • Strength: Two of three HEDIS measures within the Respiratory Conditions domain rated above the statewide average, indicating members diagnosed with COPD are receiving appropriate treatment. • Strength: Three measures in the Cardiovascular Conditions domain, *Controlling High Blood Pressure*, *Persistence of Beta-Blocker Treatment After a Heart Attack*, and *Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%,* and a related measure under the Diabetes domain, *Statin Therapy for Patients with Diabetes—Statin Adherence 80%*, performed better than the statewide average, suggesting members diagnosed with cardiovascular disease and diabetes are being effectively treated to lower blood cholesterol to mitigate the risk of further complications. Members are also receiving persistent beta-blocker treatment after discharge for a heart attack. • Strength: Four of the six *Comprehensive Diabetes Care* measures within the Diabetes domain performed better than the statewide average, indicating members diagnosed with type 1 and type 2 diabetes have appropriate diabetes management necessary to control blood glucose and reduce risks for complications. The ICO should, however, focus on member hemoglobin A1c (HbA1c) control to further improve performance in this domain. • Weakness: The Practice Guidelines standard received a performance score of 50 percent, suggesting the ICO has significant opportunities to adopt and disseminate practice guidelines to staff members and its providers for use in making utilization management and coverage of service decisions and providing member education consistent with the guidelines. • Weakness: The Quality Assessment and Performance Improvement Program standard received a performance score of 64 percent, suggesting there are gaps in the ICO's quality-related processes that could impact the services being provided to members and the ICO's ability to accurately measure overall performance of the program.

Performance Area*	Overall Performance Impact
Timeliness	• Strength: Five of the six measures within the Behavioral Health domain related to antidepressant medication management and follow-up care for mental illness rated above the statewide average, implying the ICO has focused its efforts on members diagnosed with mental health conditions. The *Follow-Up After Hospitalization for Mental Illness—7 Days* measure fell below the statewide average, so heightened attention should be placed on ensuring members can access a mental health provider within seven days of hospitalization for mental illness. • Strength: The *Medication Reconciliation Post-Discharge* measure rated above the statewide average, indicating members discharged from an inpatient facility have medications reconciled within 30 days.
Access	• Strength: The *Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)* and *(65+)* measures performed better than the statewide average, indicating a lower percentage of members are being readmitted within 30 days after being discharged from an inpatient hospital stay. • Strength: The ICO designed a QIP that has the potential to improve the health of members with mental illness and reduce readmissions through increasing appropriate follow-up care. • Weakness: The Availability of Services standard received a performance score of 73 percent, indicating access may be impeded for some members in accordance with the access standards developed by MDHHS. • Weakness: The Assurance of Adequate Capacity and Services standard received a performance score of 67 percent, suggesting opportunities exist in the ICO's processes and documentation to demonstrate it has the capacity to serve the expected enrollment in its service area in accordance with the MDHHS standards for access to care. • Weakness: The Coordination and Continuity of Care standard received a performance score of 65 percent, suggesting the ICO has gaps in its procedures to effectively deliver care to and coordinate services for all ICO members. • Weakness: The Coverage and Authorization of Services standard received a performance score of 68 percent, indicating the ICO may not always make authorization determinations and/or provide notice to members in accordance with State and federal rules. • Weakness: The four *Adults' Access to Preventative/Ambulatory Health Services* measures within the Access/Availability of Care domain performed below the statewide average, indicating some members 20 years of age and older do not schedule an appointment with their providers for preventive health services. Preventive care is an important step for members to take to address serious health issues and manage chronic conditions. • Weakness: Two measures within the Access/Availability of Care domain, *Initiation of Alcohol and Other Drug Dependence Treatment* and *Engagement of Alcohol and Other Drug Dependence Treatment*, performed below the statewide average, implying

Performance Area*	Overall Performance Impact
	that members diagnosed with a new episode of alcohol or drug dependence are not able to access treatment timely after diagnosis.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

SFY 2018–2019 is the first year that an annual detailed technical report was completed for the MI Health Link program and the contracted ICOs. Therefore, there were no previous quality improvement recommendations made to MDHHS or to **Meridian Health Plan** by HSAG or another EQRO prior to SFY 2018–2019. Future technical reports will include an assessment of the degree to which each ICO addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.

Recommendations for Program Improvement

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Meridian Health Plan** to members, HSAG recommends that **Meridian Health Plan** incorporate efforts for improvement for performance measures that fell below the statewide average. To prioritize its efforts, **Meridian Health Plan** should identify a specific subset of the below measures and develop initiatives to improve the performance of those selected measures. The selected measures, and any subsequent initiatives and interventions, should be included as part of **Meridian Health Plan**'s quality improvement strategy within its QAPIP:

Domains With Measure Ratings Below the Statewide Average

- **Prevention and Screening**
  - *COA—Care for Older Adults—Advance Care Planning*
- **Respiratory Conditions**
  - *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD*
- **Cardiovascular Conditions**
  - *SPC—Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy*
- **Diabetes**
  - *CDC—Comprehensive Diabetes Care—Poor HbA1c Control*
  - *CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
  - *SPD—Statin Therapy for Patients with Diabetes—Received Statin Therapy*
- **Musculoskeletal Conditions**
  - *OMW—Osteoporosis Management in Women Who Had a Fracture*

- **Behavioral Health**
  - *FUH—Follow-Up After Hospitalization for Mental Illness—7 Days*
- **Overuse/Appropriateness**
  - *DDE—Potentially Harmful Drug-Disease Interactions in the Elderly*
  - *DAE—Use of High-Risk Medications in the Elderly—One Prescription*
  - *DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions*
- **Access/Availability of Care**
  - *AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years*
  - *AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years*
  - *AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older*
  - *AAP—Adults' Access to Preventative/Ambulatory Health Services—Total*
  - *IET—Initiation of Alcohol and Other Drug Dependence Treatment*
  - *IET—Engagement of Alcohol and Other Drug Dependence Treatment*

Meridian Health Plan should include within its next annual QAPIP review the results of analyses for the performance measures selected from those listed above that answer the following questions:

1. What were the root causes associated with low-performing areas?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **Meridian Health Plan** considering or has already implemented to improve rates and performance for each identified performance measure?

Based on the information presented above, **Meridian Health Plan** should include the following within its quality improvement work plan:

- Measurable goals and benchmarks for each performance measure
- Mechanisms to measure performance
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates
- Identified opportunities for improvement
- Ongoing analysis to identify factors that impact adequacy of rates
- Quality improvement interventions that address the root cause of the deficiency
- A plan to monitor the quality improvement interventions to detect whether they effect improvement

HSAG also recommends that **Meridian Health Plan** implement the plans of action approved by MDHHS to bring into compliance each of the following deficient standards:

- Standard I—Availability of Services
- Standard II—Assurance of Adequate Capacity and Services
- Standard III—Coordination and Continuity of Care
- Standard IV—Coverage and Authorization of Services
- Standard V—Provider Selection
- Standard VII—Grievance and Appeal Systems
- Standard VIII—Subcontractual Relationships and Delegation
- Standard IX—Practice Guidelines
- Standard X—Health Information Systems
- Standard XI—Quality Assessment and Performance Improvement Program

Meridian Health Plan was required to complete plans of action to address each deficiency and submit to MDHHS within 30 days of receipt of the final compliance report. HSAG recommends that **Meridian Health Plan** implement internal processes to periodically review the status of each plan of action; for example, completing a progress update every 45 business days. This periodic review should include:

- Progress on implementation of each plan of action.
- Successes or barriers in remediating each deficiency.
- Revised actions steps, if necessary.

Once all plans of action are fully implemented, HSAG recommends that **Meridian Health Plan** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency. HSAG will also be conducting a review of those plans of action in 2020 to ensure deficiencies were mitigated.

Finally, **Meridian Health Plan** should take proactive steps to ensure a successful QIP. **Meridian Health Plan** should address any recommendations in the *2018–2019 QIP Validation Report Addressing Follow-Up After Hospitalization for Mental Illness for Meridian Health Plan.* HSAG also recommends the following:

- To impact the Remeasurement 1 study indicator rate, **Meridian Health Plan** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period may not have the time to impact the study indicator rate.
- **Meridian Health Plan** should document the process/steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- **Meridian Health Plan** should implement active, innovative improvement strategies that have the potential to directly impact study indicator outcomes.
- **Meridian Health Plan** should have an evaluation process to determine the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data-driven.

Michigan Complete Health

EQR Activity Results

Compliance Review

Table 5-25 presents for each standard the total number of elements as well as the number of elements that received scores of *Met*, *Not Met*, or *Not Applicable (NA)*. Table 5-25 also presents **Michigan Complete Health**'s overall compliance score for each standard, the totals across the 11 standards reviewed, and the total compliance score across all standards for the 2019 compliance review.

Table 5-25—Summary of 2019 Compliance Review Results for Michigan Complete Health (MCH)

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—Availability of Services	**11**	**10**	**1**	**0**	**91%**
Standard II—Assurance of Adequate Capacity and Services	**6**	**6**	**0**	**0**	**100%**
Standard III—Coordination and Continuity of Care	**17**	**14**	**3**	**1**	**82%**
Standard IV—Coverage and Authorization of Services	**19**	**13**	**6**	**1**	**68%**
Standard V—Provider Selection	**10**	**10**	**0**	**0**	**100%**
Standard VI—Confidentiality	**7**	**7**	**0**	**0**	**100%**
Standard VII—Grievance and Appeal Systems	**33**	**26**	**7**	**0**	**79%**
Standard VIII—Subcontractual Relationships and Delegation	**5**	**4**	**1**	**0**	**80%**
Standard IX—Practice Guidelines	**4**	**4**	**0**	**0**	**100%**
Standard X—Health Information Systems	**8**	**8**	**0**	**0**	**100%**
Standard XI—Quality Assessment and Performance Improvement Program	**11**	**11**	**0**	**0**	**100%**
Total	**131**	**113**	**18**	**2**	**86%**

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements *Met* were given full value (1 point each). The point values were then totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each standard.

Michigan Complete Health demonstrated compliance for 113 of 131 elements, with an overall compliance score of 86 percent. **Michigan Complete Health** demonstrated strong performance, scoring 90 percent or above in seven standards, with six of those standards achieving full compliance. These areas of strength include Availability of Services, Assurance of Adequate Capacity and Services, Provider Selection, Confidentiality, Practice Guidelines, Health Information Systems, and Quality Assessment and Performance Improvement Program.

Opportunities for improvement were identified in five of the 11 standards, including deficiencies related to the following requirements:

- Mechanisms must be established to ensure that network providers comply with MDHHS standards for timely access to care and services, network providers must be monitored regularly to determine compliance, and corrective action must be taken in case of failure to comply by a network provider.
- Legal guardians must be included in the person-centered planning process when indicated. If a legal guardian declines to participate, declining must be documented.
- Implementation of the IICSP must be monitored, including facilitation of the evaluation of the process, progress, and outcomes, as well as identifying barriers and facilitation problem resolution and follow-up.
- The IICSP must be reviewed with the member according to required time frames identified in contract language related to low-, moderate-, and high-risk members.
- For termination, suspension, or reduction of previously authorized Medicaid-covered services, the notice must be mailed at least 10 days before the date of action, except under the circumstances described in rule.
- For the denial of payment, notice must be mailed at the time of any action affecting the claim.
- For standard authorization decisions, notice must be provided as expeditiously as the member's condition requires and within MDHHS-established time frames that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days as required by rule.
- For cases in which a provider indicates or the ICO determines that the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, an expedited authorization decision must be made and notice provided as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. The ICO may extend the 72-hour time period by up to 14 calendar days as required by rule.
- If the time frame for service authorization decisions are extended, the ICO must give the member written notice of the reason for the decision to extend the time frame and must inform the member of the right to file a grievance if he or she disagrees with that decision; as well as issuing and carrying out its determination as expeditiously as the member's health condition requires and no later than the date that the extension expires.
- Appeal details must be confirmed to the member in writing when the member requests an appeal orally.
- The process for handling member grievances and appeals of adverse benefit determinations must ensure that the individuals who make decisions on grievances and appeals are individuals neither involved in any previous level of review or decision making nor subordinates of any such individual, regardless of whether or not the decision being made relates to overturning the previous decision.
- A process must be available to extend the grievance and appeal resolution time frames by up to 14 calendar days if the member requests the extension or if the ICO demonstrates need for additional information and how the delay is in the member's interest.

- The process to extend the grievance and appeal resolution time frames by up to 14 calendar days when not at the member's request must include all requirements, including making reasonable efforts to give the member prompt oral notice of the reason for the decision to extend the time frame, providing written notice within two calendar days of the oral notification, and informing the member of the right to file a grievance if he or she disagrees with the decision to extend the time frame for resolution.
- For notice of an expedited appeal resolution, the ICO must make reasonable efforts to provide oral notice.
- Denied requests for expedited appeal resolution must include transferring the appeal to the time frame for standard resolution; making reasonable efforts to give the member prompt oral notice of the denial; within two calendar days, giving the member written notice of the reason for the decision to extend the time frame, and informing the member of the right to file a grievance if he or she disagrees with that decision; and resolving the appeal as expeditiously as the member's health condition requires, and no later than the date that the extension expires.
- Subcontractors' performance must be monitored ongoing and subcontractors must have a formal review according to an established periodic schedule.

Michigan Complete Health was required to develop and implement a CAP for each requirement in all standards scored *Not Met*.

Validation of Performance Measures

The PMV review of **Michigan Complete Health**'s reported data focused on enrollment and eligibility data processes, assessment and care plan processes, performance measure production, and PSV findings. Specifically, the validation processes ensured that **Michigan Complete Health** appropriately classified members in the four data elements collected for both Core Measure 2.1 and Core Measure 3.2.

Based on its review, HSAG found that the Core Measure 2.1 and Core Measure 3.2 PMV for **Michigan Complete Health** resulted in the following validation designation:

Table 5-26—Measure-Specific Validation Designation for MCH

Performance Measure	Validation Designation
Core Measure 2.1: *Members with an assessment completed within 90 days of enrollment*	**REPORT (R)** Measure data were compliant with CMS' specifications and the data, as reported, were valid.
Core Measure 3.2: *Members with a care plan completed within 90 days of enrollment*	**REPORT (R)** Measure data were compliant with CMS' specifications and the data, as reported, were valid.

HEDIS Data

Table 5-27 shows each of **Michigan Complete Health**'s audited HEDIS measures, **Michigan Complete Health**'s rates for HEDIS 2018, and the MI Health Link statewide average performance rates.

Table 5-27—Measure-Specific Percentage Rates for MCH

HEDIS Measure	HEDIS 2018	Statewide Average
Prevention and Screening		
ABA—Adult BMI Assessment	93.19	91.51
BCS—Breast Cancer Screening	50.19	57.80
COL—Colorectal Cancer Screening	36.01	53.14
COA—Care for Older Adults—Advance Care Planning	44.04	36.18
COA—Care for Older Adults—Medication Review	68.37	72.10
COA—Care for Older Adults—Functional Status Assessment	57.91	53.95
COA—Care for Older Adults—Pain Assessment	61.07	68.09
Respiratory Conditions		
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	0.00	26.62
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	59.14	72.48
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	78.49	88.47
Cardiovascular Conditions		
CBP—Controlling High Blood Pressure	57.66	58.89
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	87.50	90.69
SPC—Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy	73.33	76.68
SPC—Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%	87.88	71.33
Diabetes		
CDC—Comprehensive Diabetes Care—HbA1c Testing	92.99	88.82
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control**	34.45	37.39
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)	56.10	53.34
CDC—Comprehensive Diabetes Care—Eye Exams	64.33	63.18
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	96.04	94.14
CDC—Comprehensive Diabetes Care—Blood Pressure Cont. <140/90	60.67	56.81
SPD—Statin Therapy for Patients with Diabetes—Received Statin Therapy	70.05	70.97
SPD—Statin Therapy for Patients with Diabetes—Statin Adherence 80%	83.97	72.38

HEDIS Measure	HEDIS 2018	Statewide Average
Musculoskeletal Conditions		
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	25.00	64.21
OMW—Osteoporosis Management in Women Who Had a Fracture	0.00	9.56
Behavioral Health		
AMM—Antidepressant Medication Management—Effect Acute Phase Treatment	73.13	57.08
AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment	50.75	43.57
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days	6.00	23.63
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days	18.00	52.49
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days	42.50	30.48
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days	55.00	48.67
Medication Management and Care Coordination		
MRP—Medication Reconciliation Post-Discharge	28.22	39.18
Overuse/Appropriateness		
*PSA—Non-Recommended PSA-Based Screening of Older Men**	16.39	19.27
*DDE—Potentially Harmful Drug-Disease Interactions in the Elderly**	29.30	44.19
*DAE—Use of High-Risk Medications in the Elderly—One Prescription**	11.45	18.89
*DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions**	9.47	12.40
Access/Availability of Care		
AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years	74.76	85.31
AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years	89.48	94.10
AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older	81.03	90.49
AAP—Adults' Access to Preventative/Ambulatory Health Services—Total	82.45	90.73
IET—Initiation of Alcohol and Other Drug Dependence Treatment	18.18	30.35
IET—Engagement of Alcohol and Other Drug Dependence Treatment	3.74	3.76
Risk Adjusted Utilization		
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**	0.70	0.74
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**	0.96	0.78

(*) = Measures where lower rates indicate better performance.
Note: Green indicates performance is better than the statewide average.

Michigan Complete Health performed better than the statewide average in 20 of the 43 reported HEDIS measures (47 percent). Overall, **Michigan Complete Health** also demonstrated stronger performance in the Diabetes, Behavioral Health, and Overuse/Appropriateness domains, but showed greater opportunities for improvement in the Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Musculoskeletal Conditions, Medication Management and Care Coordination, and Access/Availability of Care domains in comparison to the statewide average. Mixed results were displayed in the Risk Adjusted Utilization domain.

Validation of Quality Improvement Projects

Table 5-28 displays the validation results for **Michigan Complete Health**'s QIP. This table illustrates the ICO's overall application of the QIP process and success in implementing the QIP. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 5-28 show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all steps.

Table 5-28—QIP Validation Results for MCH

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**

<table>
<tr><th rowspan="2">Stage</th><th rowspan="2" colspan="2">Step</th><th colspan="3">Percentage of Applicable Elements</th></tr>
<tr><th>Met</th><th>Partially Met</th><th>Not Met</th></tr>
<tr><td rowspan="2">Implementation</td><td>VII.</td><td>Sufficient Data Analysis and Interpretation</td><td>100%
(3/3)</td><td>0%
(0/3)</td><td>0%
(1/3)</td></tr>
<tr><td>VIII.</td><td>Appropriate Improvement Strategies</td><td colspan="3">Not Assessed</td></tr>
<tr><td colspan="3">Implementation Total</td><td>100%
(3/3)</td><td>0%
(0/3)</td><td>0%
(0/3)</td></tr>
<tr><td rowspan="2">Outcomes</td><td>IX.</td><td>Real Improvement Achieved</td><td colspan="3">Not Assessed</td></tr>
<tr><td>X.</td><td>Sustained Improvement Achieved</td><td colspan="3">Not Assessed</td></tr>
<tr><td colspan="3">Outcomes Total</td><td colspan="3">Not Assessed</td></tr>
<tr><td colspan="3">Percentage Score of Applicable Evaluation Elements Met</td><td colspan="3">100%
(11/11)</td></tr>
</table>

Overall, 100 percent of all applicable evaluation elements received a score of *Met* for the Design and Implementation stages of the QIP process.

For the baseline measurement period, **Michigan Complete Health** reported that 41.5 percent of members received a follow-up visit with a mental health practitioner within 30 days of discharge. The goal for the QIP is that the ICO will demonstrate a statistically significant improvement over the baseline for the remeasurement periods. The ICO selected a Remeasurement 1 goal of 56 percent.

Strengths, Weaknesses, and Overall Conclusions

Michigan Complete Health demonstrated both strengths and weaknesses based on the results of the SFY 2018–2019 EQR activities. **Michigan Complete Health** received a total compliance score of 86 percent across all 11 standards reviewed in 2019, which was the second highest score across all ICOs. **Michigan Complete Health** scored above 90 percent in the Availability of Services, Assurance of Adequate Capacity and Services, Provider Selection, Confidentiality, Practice Guidelines, Health Information Systems, and Quality Assessment and Performance Improvement Program standards, indicating strong performance in these areas, but did not perform as well in the Coordination and Continuity of Care, Coverage and Authorization of Services, Grievance and Appeal Systems, and Subcontractual Relationships and Delegation standards, as demonstrated by low to moderate performance scores (82 percent, 68 percent, 79 percent, and 80 percent, respectively), reflecting that additional focus is needed in these areas.

While **Michigan Complete Health** performed better than the statewide average in 20 of the 43 reported HEDIS measures, indicating strength in these areas, all performance measure domains except the Overuse/Appropriateness domain, included at least one measure that performed below the statewide average, indicating opportunities to improve in most domains.

Michigan Complete Health also designed a scientifically sound QIP supported by using key research principals, meeting 100 percent of the requirements in the Design stage. Additionally, **Michigan Complete Health** met 100 percent of the requirements for data analysis and implementation of improvement strategies.

Michigan Complete Health's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-29—Quality, Timeliness, and Access Performance Impact for MCH

Performance Area*	Overall Performance Impact
Quality	• Strength: The Provider Selection standard achieved full compliance, indicating the ICO has processes and procedures in place to select and retain quality providers for its network. • Strength: The Confidentiality standard achieved full compliance, suggesting the ICO uses and discloses member protected health information in accordance with federal privacy requirements. • Strength: The Practice Guidelines standard achieved full compliance, indicating the ICO adopts and disseminates practice guidelines for use in making utilization management decisions and providing member education. • Strength: The Health Information Systems standard achieved full compliance, indicating the ICO maintains a health information system that collects, analyzes, integrates, and reports data, and ensures that claims data received from providers are accurate and complete. • Strength: The Quality Assessment and Performance Improvement Program standard received a performance score of 100 percent, indicating the ICO established and implemented an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its members. • Strength: All six *Comprehensive Diabetes Care* measures within the Diabetes domain performed better than the statewide average, indicating members diagnosed with type 1 and type 2 diabetes have appropriate diabetes management necessary to control blood glucose and reduce risks for complications. • Strength: The *Antidepressant Medication Management—Effect Acute Phase Treatment* and *Antidepressant Medication Management—Effect Continuation Phase Treatment* measures performed above the statewide average, indicating adults diagnosed with major depression are treated with and remain on their antidepressant medications, therefore, improving members' daily functioning and reducing the risk of suicide.

Performance Area*	Overall Performance Impact
	• Strength: All four of the Overuse/Appropriateness measures performed above the statewide average, indicating adults 65 and older and their prescribed medications are being assessed to reduce adverse drug events. • Weakness: Four out of seven HEDIS measures in the Prevention and Screening domain performed worse than the statewide average, indicating members are not always receiving preventive screenings, such as breast cancer and colorectal cancer screenings, in order to prevent and detect diseases early, and older adults may not be receiving the care they need to optimize their quality of life. • Weakness: All three HEDIS measures within the Respiratory Conditions domain rated below the statewide average, indicating the ICO's providers may not be assessing for and providing appropriate treatment to members diagnosed with COPD. • Weakness: Three of the four measures within the Cardiovascular Conditions domain, *Controlling High Blood Pressure*, *Persistence of Beta-Blocker Treatment After a Heart Attack*, and *Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy*, performed worse than the statewide average, indicating members with cardiovascular disease may not be managing their hypertension and receiving or adhering to statin therapy to lower blood cholesterol and prevent further complications of their disease. Additionally, members are not regularly receiving persistent beta-blocker treatment after discharge for a heart attack. • Weakness: Both measures in the Musculoskeletal Conditions domain performed below the statewide average, indicating members may not be receiving the appropriate treatment to help preserve function and prevent further damage.
Timeliness	• Strength: Two Behavioral Health measures, *Follow-Up After Emergency Department Visit for Mental Illness—7 Days* and *Follow-Up After Emergency Department Visit for Mental Illness—30 Days*, performed above the statewide average, indicating members are accessing mental health providers timely after emergency department visits for mental health conditions. • Weakness: Two Behavioral Health measures, *Follow-Up After Hospitalization for Mental Illness–7 Days* and *Follow-Up After Hospitalization for Mental Illness–30 Days*, performed below the statewide average, suggesting members hospitalized with mental health conditions are not able to access mental health providers timely after discharge. • Weakness: The *Medication Reconciliation Post-Discharge* measure rated below the statewide average, indicating members discharged from an inpatient facility do not always have medications reconciled within 30 days.

Performance Area*	Overall Performance Impact
Access	• Strength: The ICO designed a QIP that has the potential to improve the health of members with mental illness and reduce readmissions through increasing appropriate follow-up care. • Weakness: The Coverage and Authorization of Services standard received a performance score of 68 percent, indicating the ICO may not always make authorization determinations and/or provide notice to members in accordance with State and federal rules. • Weakness: The four *Adults' Access to Preventative/Ambulatory Health Services* measures within the Access/Availability of Care domain performed below the statewide average, indicating some members 20 years of age and older do not schedule an appointment with their providers for preventive health services. Preventive care is an important step for members to take to address serious health issues and manage chronic conditions. • Weakness: Two measures within the Access/Availability of Care domain, *Initiation of Alcohol and Other Drug Dependence Treatment* and *Engagement of Alcohol and Other Drug Dependence Treatment*, performed below the statewide average, implying that members diagnosed with a new episode of alcohol or drug dependence are not able to access treatment timely after diagnosis. • Weakness: The *Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)* measure rate indicated the ICO had a high percentage of members being readmitted within 30 days after being discharged from an inpatient hospital stay, suggesting members are not receiving or adhering to appropriate treatment after hospitalization.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

SFY 2018–2019 is the first year that an annual detailed technical report was completed for the MI Health Link program and the contracted ICOs. Therefore, there were no previous quality improvement recommendations made to MDHHS or to **Michigan Complete Health** by HSAG or another EQRO prior to SFY 2018–2019. Future technical reports will include an assessment of the degree to which each ICO addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.

Recommendations for Program Improvement

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Michigan Complete Health** to members, HSAG recommends that **Michigan Complete Health** incorporate efforts for improvement for performance measures that fell below the statewide average. To prioritize its efforts, **Michigan Complete Health** should identify a specific subset of the

below measures and develop initiatives to improve the performance of those selected measures. The selected measures, and any subsequent initiatives and interventions, should be included as part of **Michigan Complete Health**'s quality improvement strategy within its QAPIP:

Domains With Measure Ratings Below the Statewide Average

- **Prevention and Screening**
  - *BCS—Breast Cancer Screening*
  - *COL—Colorectal Cancer Screening*
  - *COA—Care for Older Adults—Medication Review*
  - *COA—Care for Older Adults—Pain Assessment*
- **Respiratory Conditions**
  - *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD*
  - *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid*
  - *PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator*
- **Cardiovascular Conditions**
  - *CBP—Controlling High Blood Pressure*
  - *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack*
  - *SPC—Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy*
- **Diabetes**
  - *SPD—Statin Therapy for Patients with Diabetes—Received Statin Therapy*
- **Musculoskeletal Conditions**
  - *ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis*
  - *OMW—Osteoporosis Management in Women Who Had a Fracture*
- **Behavioral Health**
  - *FUH—Follow-Up After Hospitalization for Mental Illness–7 Days*
  - *FUH—Follow-Up After Hospitalization for Mental Illness–30 Days*
- **Medication Management and Care Coordination**
  - *MRP—Medication Reconciliation Post-Discharge*
- **Access/Availability of Care**
  - *AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years*
  - *AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years*
  - *AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older*
  - *AAP—Adults' Access to Preventative/Ambulatory Health Services—Total*
  - *IET—Initiation of Alcohol and Other Drug Dependence Treatment*
  - *IET—Engagement of Alcohol and Other Drug Dependence Treatment*

- **Risk Adjusted Utilization**
  - *PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)*

Michigan Complete Health should include within its next annual QAPIP review the results of analyses for the performance measures selected from those listed above that answer the following questions:

1. What were the root causes associated with low-performing areas?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **Michigan Complete Health** considering or has already implemented to improve rates and performance for each identified performance measure?

Based on the information presented above, **Michigan Complete Health** should include the following within its quality improvement work plan:

- Measurable goals and benchmarks for each performance measure
- Mechanisms to measure performance
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates
- Identified opportunities for improvement
- Ongoing analysis to identify factors that impact adequacy of rates
- Quality improvement interventions that address the root cause of the deficiency
- A plan to monitor the quality improvement interventions to detect whether they effect improvement

HSAG also recommends that **Michigan Complete Health** implement the plans of action approved by MDHHS to bring into compliance each of the following deficient standards:

- Standard I—Availability of Services
- Standard III—Coordination and Continuity of Care
- Standard IV—Coverage and Authorization of Services
- Standard VII—Grievance and Appeal Systems
- Standard VIII—Subcontractual Relationships and Delegation

Michigan Complete Health was required to complete plans of action to address each deficiency and submit to MDHHS within 30 days of receipt of the final compliance report. HSAG recommends that **Michigan Complete Health** implement internal processes to periodically review the status of each plan of action; for example, completing a progress update every 45 business days. This periodic review should include:

- Progress on implementation of each plan of action.
- Successes or barriers in remediating each deficiency.
- Revised actions steps, if necessary.

Once all plans of action are fully implemented, HSAG recommends that **Michigan Complete Health** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency. HSAG will also be conducting a review of those plans of action in 2020 to ensure deficiencies were mitigated.

Finally, **Michigan Complete Health** should take proactive steps to ensure a successful QIP. **Michigan Complete Health** should address any recommendation*s* in the *2018–2019 QIP Validation Report Follow-Up After Hospitalization for Mental Illness for Michigan Complete Health.* HSAG also recommends the following:

- To impact the Remeasurement 1 study indicator rate, **Michigan Complete Health** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period may not have the time to impact the study indicator rate.
- **Michigan Complete Health** should document the process/steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- **Michigan Complete Health** should implement active, innovative improvement strategies that have the potential to directly impact study indicator outcomes.
- **Michigan Complete Health** should have an evaluation process to determine the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data-driven.

Molina Healthcare of Michigan

EQR Activity Results

Compliance Review

Table 5-30 presents for each standard the total number of elements as well as the number of elements that received scores of *Met*, *Not Met*, or *Not Applicable (NA)*. Table 5-30 also presents **Molina Healthcare of Michigan**'s overall compliance score for each standard, the totals across the 11 standards reviewed, and the total compliance score across all standards for the 2019 compliance review.

Table 5-30—Summary of 2019 Compliance Review Results for Molina Healthcare of Michigan (MOL)

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—Availability of Services	11	10	1	0	91%
Standard II—Assurance of Adequate Capacity and Services	6	5	1	0	83%
Standard III—Coordination and Continuity of Care	17	14	3	1	82%
Standard IV—Coverage and Authorization of Services	19	16	3	1	84%
Standard V—Provider Selection	10	10	0	0	100%
Standard VI—Confidentiality	7	7	0	0	100%
Standard VII—Grievance and Appeal Systems	33	19	14	0	58%
Standard VIII—Subcontractual Relationships and Delegation	5	4	1	0	80%
Standard IX—Practice Guidelines	4	4	0	0	100%
Standard X—Health Information Systems	8	8	0	0	100%
Standard XI—Quality Assessment and Performance Improvement Program	11	8	3	0	73%
Total	**131**	**105**	**26**	**2**	**80%**

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements *Met* were given full value (1 point each). The point values were then totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each standard.

Molina Healthcare of Michigan demonstrated compliance for 105 of 131 elements, with an overall compliance score of 80 percent. **Molina Healthcare of Michigan** demonstrated strong performance, scoring 90 percent or above in five standards, with four of those standards achieving full compliance. These areas of strength include Availability of Services, Provider Selection, Confidentiality, Practice Guidelines, and Health Information Systems.

Opportunities for improvement were identified in seven of the 11 standards, including deficiencies related to the following requirements:

- All urgent and symptomatic office visits must be available to members within 24 hours.
- Timely notification must be provided to the contract management team when there are significant provider network changes.
- Program-level data and utilization data must be reviewed within 15 calendar days of member enrollment.
- Every member must have an IICSP unless the member refuses and such refusal is documented. The ICO must ensure that the IICSP reflects the services and supports, both paid and unpaid, that will assist the member to achieve identified goals; the frequency of services; and the providers of those services and supports, including natural supports. The ICO must ensure that the IICSP is distributed to the member and other people involved in the plan.
- The IICSP must be reviewed with the member according to required time frames identified in contract language related to low-, moderate-, and high-risk members.
- The NABD must include all required content.
- For termination, suspension, or reduction of previously authorized Medicaid-covered services, the notice must be mailed at least 10 days before the date of action, except under the circumstances described in rule.
- In the case that the ICO fails to adhere to the notice and timing requirements for resolving grievances and appeals, the member is deemed to have exhausted the ICO's appeals process. The member may initiate a State fair hearing.
- When a provider or an authorized representative requests an appeal, files a grievance, or requests a State fair hearing on behalf of a member, the ICO must require written consent from the member.
- A member can file a grievance, either orally or in writing, with the ICO at any time. Additionally, if the grievance is filed with a provider, providers must forward the grievance to the ICO.
- Appeal details must be confirmed to the member in writing when the member requests an appeal orally.
- Parties to the appeal and State fair hearing include the member and his or her representative or the legal representative of a deceased member's estate; and, in State fair hearings, the ICO.
- An expedited response must be provided to each member, orally or in writing, within 24 hours after the ICO receives a grievance whenever the ICO extends the appeals time frame or the ICO refuses to grant a request for an expedited appeal.
- The grievance notice must meet the standards described at 42 CFR §438.10. The disposition of each grievance must not include appeal rights.
- For notice of an expedited appeal resolution, reasonable efforts must be made to provide oral notice to the member.
- The written notice of appeal resolution must include information about the member's right to request a State fair hearing and how to do so within 120 days of the notice of appeal resolution.

- Denied requests for expedited appeal resolution must include transferring the appeal to the time frame for standard resolution; making reasonable efforts to give the member prompt oral notice of the denial; within two calendar days, giving the member written notice of the reason for the decision to extend the time frame, and informing the member of the right to file a grievance if he or she disagrees with that decision; and resolving the appeal as expeditiously as the member's health condition requires, and no later than the date that the extension expires.
- Accurate and complete information about the grievance and appeal system must be provided to all providers and subcontractors at the time they enter into contracts with the ICO.
- If the ICO or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the ICO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.
- If the ICO or the State fair hearing officer reverses a decision to deny authorization of services and the member had received the disputed services while the appeal was pending, the ICO or MDHHS must pay for those services, in accordance with State policy and regulations.
- Subcontractors' performance must be monitored ongoing and subcontractors must have a formal review according to an established periodic schedule.
- The quality improvement program for the MI Health Link program must be separate from the programs for Medicaid, Medicare, or commercial lines of business.
- The ICO must demonstrate efforts to prevent, detect, and remediate critical incidents—consistent with assuring member health and welfare per §441.302 and §441.730(a)—that are based, at a minimum, on the requirements of the State for home- and community-based waiver programs per §441.302(h).
- Information on the effectiveness of the ICO's QAPIP program must be disseminated to network providers annually.

Molina Healthcare of Michigan was required to develop and implement a CAP for each requirement in all standards scored *Not Met*.

Validation of Performance Measures

The PMV review of **Molina Healthcare of Michigan**'s reported data focused on enrollment and eligibility data processes, assessment and care plan processes, performance measure production, and PSV findings. Specifically, the validation processes ensured that **Molina Healthcare of Michigan** appropriately classified members in the four data elements collected for both Core Measure 2.1 and Core Measure 3.2.

Based on its review, HSAG found that the Core Measure 2.1 and Core Measure 3.2 PMV for **Molina Healthcare of Michigan** resulted in the following validation designation:

Table 5-31—Measure-Specific Validation Designation for MOL

Performance Measure	Validation Designation
Core Measure 2.1: *Members with an assessment completed within 90 days of enrollment*	**REPORT (R)** Measure data were compliant with CMS' specifications and the data, as reported, were valid.
Core Measure 3.2: *Members with a care plan completed within 90 days of enrollment*	**REPORT (R)** Measure data were compliant with CMS' specifications and the data, as reported, were valid.

HEDIS Data

Table 5-32 shows each of **Molina Healthcare of Michigan**'s audited HEDIS measures, **Molina Healthcare of Michigan**'s rates for HEDIS 2018, and the MI Health Link statewide average performance rates.

Table 5-32—Measure-Specific Percentage Rates for MOL

HEDIS Measure	HEDIS 2018	Statewide Average
Prevention and Screening		
ABA—Adult BMI Assessment	96.84	91.51
BCS—Breast Cancer Screening	61.51	57.80
COL—Colorectal Cancer Screening	64.23	53.14
COA—Care for Older Adults—Advance Care Planning	37.71	36.18
COA—Care for Older Adults—Medication Review	75.18	72.10
COA—Care for Older Adults—Functional Status Assessment	57.91	53.95
COA—Care for Older Adults—Pain Assessment	80.29	68.09
Respiratory Conditions		
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	23.29	26.62
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	70.34	72.48
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	92.78	88.47
Cardiovascular Conditions		
CBP—Controlling High Blood Pressure	52.31	58.89
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	94.55	90.69
SPC—Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy	75.93	76.68

HEDIS Measure	HEDIS 2018	Statewide Average
SPC—Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%	70.02	71.33
Diabetes		
CDC—Comprehensive Diabetes Care—HbA1c Testing	91.00	88.82
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control**	28.95	37.39
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)	61.31	53.34
CDC—Comprehensive Diabetes Care—Eye Exams	68.37	63.18
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	95.38	94.14
CDC—Comprehensive Diabetes Care—Blood Pressure Cont. <140/90	55.47	56.81
SPD—Statin Therapy for Patients with Diabetes—Received Statin Therapy	71.96	70.97
SPD—Statin Therapy for Patients with Diabetes—Statin Adherence 80%	74.50	72.38
Musculoskeletal Conditions		
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	57.72	64.21
OMW—Osteoporosis Management in Women Who Had a Fracture	17.14	9.56
Behavioral Health		
AMM—Antidepressant Medication Management—Effect Acute Phase Treatment	54.96	57.08
AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment	44.76	43.57
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days	34.47	23.63
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days	60.00	52.49
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days	18.26	30.48
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days	36.99	48.67
Medication Management and Care Coordination		
MRP—Medication Reconciliation Post-Discharge	37.71	39.18
Overuse/Appropriateness		
*PSA—Non-Recommended PSA-Based Screening of Older Men**	24.96	19.27
*DDE—Potentially Harmful Drug-Disease Interactions in the Elderly**	45.45	44.19
*DAE—Use of High-Risk Medications in the Elderly—One Prescription**	18.26	18.89
*DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions**	12.83	12.40

HEDIS Measure	HEDIS 2018	Statewide Average
Access/Availability of Care		
AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years	88.41	85.31
AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years	95.91	94.10
AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older	92.73	90.49
AAP—Adults' Access to Preventative/Ambulatory Health Services—Total	93.08	90.73
IET—Initiation of Alcohol and Other Drug Dependence Treatment	32.59	30.35
IET—Engagement of Alcohol and Other Drug Dependence Treatment	4.05	3.76
Risk Adjusted Utilization		
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**	0.80	0.74
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**	0.87	0.78

(*) = Measures where lower rates indicate better performance.

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

Molina Healthcare of Michigan performed better than the statewide average in 27 of the 43 reported HEDIS measures (63 percent). Overall, **Molina Healthcare of Michigan** also demonstrated stronger performance in the Prevention and Screening, Diabetes, and Access/Availability of Care domains, but showed greater opportunities for improvement in the Respiratory Conditions, Cardiovascular Conditions, Medication Management and Care Coordination, Overuse/Appropriateness, and Risk Adjusted Utilization domains in comparison to the statewide average. Mixed results were displayed in the Musculoskeletal Conditions and Behavioral Health domains.

Validation of Quality Improvement Projects

Table 5-33 displays the validation results for **Molina Healthcare of Michigan**'s QIP. This table illustrates the ICO's overall application of the QIP process and success in implementing the QIP. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 5-33 show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all steps.

Table 5-33—QIP Validation Results for MOL

Stage	Step		Percentage of Applicable Elements		
			Met	***Partially Met***	***Not Met***
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	*Not Assessed*		
Implementation Total			**100% (3/3)**	**0% (0/3)**	**0% (0/3)**
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**100% (11/11)**		

Overall, 100 percent of all applicable evaluation elements received a score of *Met* for the Design and Implementation stages of the QIP process.

For the baseline measurement period, **Molina Healthcare of Michigan** reported that 55.6 percent of members received a follow-up visit with a mental health practitioner within 30 days of discharge. The goal for the QIP is that the ICO will demonstrate a statistically significant improvement over the baseline for the remeasurement periods.

HSAG HEALTH SERVICES ADVISORY GROUP

Strengths, Weaknesses, and Overall Conclusions

Molina Healthcare of Michigan demonstrated both strengths and weaknesses based on the results of the SFY 2018–2019 EQR activities. **Molina Healthcare of Michigan** received a total compliance score of 80 percent across all 11 standards reviewed in 2019, which was similar to the aggregated performance score across all ICOs. **Molina Healthcare of Michigan** scored above 90 percent in the Availability of Services, Provider Selection, Confidentiality, Practice Guidelines, and Health Information Systems standards, indicating strong performance in these areas, but did not perform as well in the Assurance of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Grievance and Appeal Systems, Subcontractual Relationships and Delegation, and Quality Assessment and Performance Improvement Program standards, as demonstrated by low to moderate performance scores (83 percent, 82 percent, 84 percent, 58 percent, 80 percent, and 73 percent, respectively), reflecting that additional focus is needed in these areas.

While **Molina Healthcare of Michigan** performed better than the statewide average in 27 of the 43 reported HEDIS measures, indicating strength in these areas, eight of 10 performance measure domains included at least one measure that performed below the statewide average, indicating opportunities to improve in these domains.

Molina Healthcare of Michigan also designed a scientifically sound QIP supported by using key research principals, meeting 100 percent of the requirements in the Design stage. The ICO also met 100 percent of the requirements for data analysis and implementation of improvement strategies.

Molina Healthcare of Michigan's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-34—Quality, Timeliness, and Access Performance Impact for MOL

Performance Area*	Overall Performance Impact
Quality	• Strength: The Provider Selection standard achieved full compliance, indicating the ICO has processes and procedures in place to select and retain quality providers for its network. • Strength: The Confidentiality standard achieved full compliance, suggesting the ICO uses and discloses member protected health information in accordance with federal privacy requirements. • Strength: The Practice Guidelines standard achieved full compliance, indicating the ICO adopts and disseminates practice guidelines for use in making utilization management decisions and providing member education. • Strength: The Health Information Systems standard achieved full compliance, indicating the ICO maintains a health information system that collects, analyzes, integrates, and reports data, and ensures that claims data received from providers are accurate and complete.

Performance Area*	Overall Performance Impact
	• Strength: All seven measures within the Prevention and Screening domain performed better than the statewide average, indicating members are receiving preventive screenings, such as breast cancer and colorectal cancer screenings, in order to prevent and detect diseases early, and older adults are receiving the care they need to optimize their quality of life. • Strength: Five of the six *Comprehensive Diabetes Care* measures within the Diabetes domain performed better than the statewide average, indicating members diagnosed with type 1 and type 2 diabetes have appropriate diabetes management necessary to control blood glucose and reduce risks for complications. The ICO should, however, focus on blood pressure control to further improve performance in this domain. • Weakness: The Grievance and Appeal Systems standard received a performance score of 58 percent, indicating opportunities exist for the ICO to ensure that it has an effective grievance and appeal system in place for its members. • Weakness: The Quality Assessment and Performance Improvement Program standard received a performance score of 73 percent, suggesting there are gaps in the ICO's quality-related processes that could impact the services being provided to members and the ICO's ability to accurately measure overall performance of the program. • Weakness: Two of three HEDIS measures within the Respiratory Conditions domain rated below the statewide average, indicating the ICO's providers may not be assessing for and providing appropriate treatment to members diagnosed with COPD. • Weakness: Three of the four measures within the Cardiovascular Conditions domain, *Controlling High Blood Pressure*, *Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy*, and *Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%*, performed worse than the statewide average, indicating members with cardiovascular disease may not be managing their hypertension and receiving or adhering to statin therapy to lower blood cholesterol and prevent further complications of their disease. • Weakness: Three of the four Overuse/Appropriateness measures performed below the statewide average, indicating adults 65 and older and their prescribed medications are potentially not being assessed to reduce adverse drug events.
Timeliness	• Strength: Two Behavioral Health measures, *Follow-Up After Hospitalization for Mental Illness—7 Days* and *Follow-Up After Hospitalization for Mental Illness—30 Days*, performed above the statewide average, implying the ICO has focused its efforts on ensuring members hospitalized with mental health conditions are able to access mental health providers timely after discharge. • Weakness: Two Behavioral Health measures, *Follow-Up After Emergency Department Visit for Mental Illness—7 Days* and *Follow-Up After Emergency Department Visit for Mental Illness—30 Days*, performed below the statewide average, indicating members may not be accessing mental health providers timely after emergency department visits for mental health conditions.

Performance Area*	Overall Performance Impact
	• Weakness: The *Medication Reconciliation Post-Discharge* measure rated below the statewide average, indicating members discharged from an inpatient facility do not always have medications reconciled within 30 days.
Access	• Strength: The ICO designed a QIP that has the potential to improve the health of members with mental illness and reduce readmissions through increasing appropriate follow-up care. • Strength: The four *Adults' Access to Preventative/Ambulatory Health Services* measures within the Access/Availability of Care domain performed above the statewide average, indicating members 20 years of age and older schedule an appointment with their providers for preventive health services. Preventive care is an important step for members to take to address serious health issues and manage chronic conditions. • Strength: Two measures within the Access/Availability of Care domain, *Initiation of Alcohol and Other Drug Dependence Treatment* and *Engagement of Alcohol and Other Drug Dependence Treatment*, performed above the statewide average, implying that members diagnosed with a new episode of alcohol or drug dependence are accessing treatment timely after diagnosis. • Weakness: The *Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)* and *(65+)* measures performed worse than the statewide average, indicating a higher percentage of members are being readmitted within 30 days after being discharged from an inpatient hospital stay.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

SFY 2018–2019 is the first year that an annual detailed technical report was completed for the MI Health Link program and the contracted ICOs. Therefore, there were no previous quality improvement recommendations made to MDHHS or to **Molina Healthcare of Michigan** by HSAG or another EQRO prior to SFY 2018–2019. Future technical reports will include an assessment of the degree to which each ICO addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.

Recommendations for Program Improvement

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Molina Healthcare of Michigan** to members, HSAG recommends that **Molina Healthcare of Michigan** incorporate efforts for improvement for performance measures that fell below the statewide average. To prioritize its efforts, **Molina Healthcare of Michigan** should identify a specific subset of the below measures and develop initiatives to improve the performance of those

selected measures. The selected measures, and any subsequent initiatives and interventions, should be included as part of **Molina Healthcare of Michigan**'s quality improvement strategy within its QAPIP:

Domains With Measure Ratings Below the Statewide Average

- **Respiratory Conditions**
  - *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD*
  - *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid*
- **Cardiovascular Conditions**
  - *CBP—Controlling High Blood Pressure*
  - *SPC—Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy*
  - *SPC—Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%*
- **Diabetes**
  - *CDC—Comprehensive Diabetes Care—Blood Pressure Cont. <140/90*
- **Musculoskeletal Conditions**
  - *ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis*
- **Behavioral Health**
  - *AMM—Antidepressant Medication Management—Effect Acute Phase Treatment*
  - *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days*
  - *FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days*
- **Medication Management and Care Coordination**
  - *MRP—Medication Reconciliation Post-Discharge*
- **Overuse/Appropriateness**
  - *PSA—Non-Recommended PSA-Based Screening of Older Men*
  - *DDE—Potentially Harmful Drug-Disease Interactions in the Elderly*
  - *DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions*
- **Risk Adjusted Utilization**
  - *PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)*
  - *PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)*

Molina Healthcare of Michigan should include within its next annual QAPIP review the results of analyses for the performance measures selected from those listed above that answer the following questions:

1. What were the root causes associated with low-performing areas?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?

4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **Molina Healthcare of Michigan** considering or has already implemented to improve rates and performance for each identified performance measure?

Based on the information presented above, **Molina Healthcare of Michigan** should include the following within its quality improvement work plan:

- Measurable goals and benchmarks for each performance measure
- Mechanisms to measure performance
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates
- Identified opportunities for improvement
- Ongoing analysis to identify factors that impact adequacy of rates
- Quality improvement interventions that address the root cause of the deficiency
- A plan to monitor the quality improvement interventions to detect whether they effect improvement

HSAG also recommends that **Molina Healthcare of Michigan** implement the plans of action approved by MDHHS to bring into compliance each of the following deficient standards:

- Standard I—Availability of Services
- Standard II—Assurance of Adequate Capacity and Services
- Standard III—Coordination and Continuity of Care
- Standard IV—Coverage and Authorization of Services
- Standard VII—Grievance and Appeal Systems
- Standard VIII—Subcontractual Relationships and Delegation
- Standard XI—Quality Assessment and Performance Improvement Program

Molina Healthcare of Michigan was required to complete plans of action to address each deficiency and submit to MDHHS within 30 days of receipt of the final compliance report. HSAG recommends that **Molina Healthcare of Michigan** implement internal processes to periodically review the status of each plan of action; for example, completing a progress update every 45 business days. This periodic review should include:

- Progress on implementation of each plan of action.
- Successes or barriers in remediating each deficiency.
- Revised actions steps, if necessary.

Once all plans of action are fully implemented, HSAG recommends that **Molina Healthcare of Michigan** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency. HSAG will also be conducting a review of those plans of action in 2020 to ensure deficiencies were mitigated.

Finally, **Molina Healthcare of Michigan** should take proactive steps to ensure a successful QIP. **Molina Healthcare of Michigan** should address any recommendation*s* in the *2018–2019 QIP Validation Report Follow-Up After Hospitalization for Mental Illness for Molina Healthcare of Michigan.* HSAG also recommends the following:

- **Molina Healthcare of Michigan** must ensure that all validation feedback is addressed, and necessary corrections are made prior to the next annual submission.
- To impact the Remeasurement 1 study indicator rate, **Molina Healthcare of Michigan** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period may not have the time to impact the study indicator rate.
- **Molina Healthcare of Michigan** should document the process/steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- **Molina Healthcare of Michigan** should implement active, innovative improvement strategies that have the potential to directly impact study indicator outcomes.
- **Molina Healthcare of Michigan** should have an evaluation process to determine the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data-driven.

Upper Peninsula Health Plan

EQR Activity Results

Compliance Review

Table 5-35 presents for each standard the total number of elements as well as the number of elements that received scores of *Met*, *Not Met*, or *Not Applicable (NA)*. Table 5-35 also presents **Upper Peninsula Health Plan**'s overall compliance score for each standard, the totals across the 11 standards reviewed, and the total compliance score across all standards for the 2019 compliance review.

Table 5-35—Summary of 2019 Compliance Review Results for Upper Peninsula Health Plan (UPP)

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—Availability of Services	11	9	2	0	82%
Standard II—Assurance of Adequate Capacity and Services	6	6	0	0	100%
Standard III—Coordination and Continuity of Care	17	12	5	1	71%
Standard IV—Coverage and Authorization of Services	19	16	3	1	84%
Standard V—Provider Selection	10	9	1	0	90%
Standard VI—Confidentiality	7	7	0	0	100%
Standard VII—Grievance and Appeal Systems	33	29	4	0	88%
Standard VIII—Subcontractual Relationships and Delegation	5	4	1	0	80%
Standard IX—Practice Guidelines	4	4	0	0	100%
Standard X—Health Information Systems	8	7	1	0	88%
Standard XI—Quality Assessment and Performance Improvement Program	11	9	2	0	82%
Total	**131**	**112**	**19**	**2**	**85%**

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements *Met* were given full value (1 point each). The point values were then totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each standard.

Upper Peninsula Health Plan demonstrated compliance for 112 of 131 elements, with an overall compliance score of 85 percent. **Upper Peninsula Health Plan** demonstrated strong performance, scoring 90 percent or above in four standards, with three of those standards achieving full compliance. These areas of strength include Assurance of Adequate Capacity and Services, Provider Selection, Confidentiality, and Practice Guidelines.

Opportunities for improvement were identified in eight of the 11 standards, including deficiencies related to the following requirements:

- All urgent and symptomatic office visits must be available to members within 24 hours.
- A strategy must be developed and implemented that uses a combination of initial screenings, assessments, referrals, administrative claims data, etc. to help prioritize and determine the care coordination needs of each member. The ICO must determine the parameters and definitions for members defined as "high risk" as well as definitions for low- or moderate-risk members.
- Unless the member refuses, the meeting to develop the IICSP must be conducted in person. A member's care management record must record that a member was offered an in-person visit and whether the member declined the in-person visit.
- The IICSP must include the member's prioritized list of concerns, goals, objectives, and strengths and reflect the services and supports, both paid and unpaid, that will assist the member achieve identified goals; the frequency of services; and the providers of those services, including natural supports. The IICSP must be distributed to the member and other people involved in the plan, and each IICSP must include the required content of a service plan.
- Implementation of the IICSP must be monitored, including facilitation of the evaluation of the process, progress, and outcomes, as well as identifying barriers and facilitation problem resolution and follow-up.
- The IICSP must be reviewed with the member according to required time frames identified in contract language related to low-, moderate-, and high-risk members. In-person visits to review the IICSP must be offered and/or completed according to contract requirements.
- For termination, suspension, or reduction of previously authorized Medicaid-covered services, the notice must be mailed at least 10 days before the date of action, except under the circumstances described in rule.
- For the denial of payment, notice must be mailed at the time of any action affecting the claim.
- Consideration of performance indicators obtained through the quality improvement plan, utilization management program, grievance and appeal system, member satisfaction surveys, and medical record reviews must be considered in the ICO's recredentialing process.
- Written consent of the member for a provider or an authorized representative to request an appeal or file a grievance, or request a State fair hearing, on behalf of a member must be obtained.
- Appeal details must be confirmed to the member in writing when the member requests an appeal orally.
- For expedited appeals, reasonable efforts to provide oral notice must be provided to the member.
- Subcontractors' performance must be monitored ongoing and subcontractors must have a formal review according to an established periodic schedule.
- Documentation must support that in the event of a system failure or unavailability, the contract management team would be notified upon discovery and the business continuity plan would be implemented immediately.

- The QAPIP for the MI Health Link program must be separate from the programs for Medicaid, Medicare, or commercial lines of business.
- Information on the effectiveness of the ICO's QAPIP program must be disseminated to network providers annually and to members upon request.

Upper Peninsula Health Plan was required to develop and implement a CAP for each requirement in all standards scored *Not Met*.

Validation of Performance Measures

The PMV review of **Upper Peninsula Health Plan**'s reported data focused on enrollment and eligibility data processes, assessment and care plan processes, performance measure production, and PSV findings. Specifically, the validation processes ensured that **Upper Peninsula Health Plan** appropriately classified members in the four data elements collected for both Core Measure 2.1 and Core Measure 3.2.

Based on its review, HSAG found that the Core Measure 2.1 and Core Measure 3.2 PMV for **Upper Peninsula Health Plan** resulted in the following validation designation:

Table 5-36—Measure-Specific Validation Designation for UPP

Performance Measure	Validation Designation
Core Measure 2.1: *Members with an assessment completed within 90 days of enrollment*	**REPORT (R)** Measure data were compliant with CMS' specifications and the data, as reported, were valid.
Core Measure 3.2: *Members with a care plan completed within 90 days of enrollment*	**REPORT (R)** Measure data were compliant with CMS' specifications and the data, as reported, were valid.

HEDIS Data

Table 5-37 shows each of **Upper Peninsula Health Plan**'s audited HEDIS measures, **Upper Peninsula Health Plan**'s rates for HEDIS 2018, and the MI Health Link statewide average performance rates.

Table 5-37—Measure-Specific Percentage Rates for UPP

HEDIS Measure	HEDIS 2018	Statewide Average
Prevention and Screening		
ABA—Adult BMI Assessment	96.11	91.51
BCS—Breast Cancer Screening	66.10	57.80
COL—Colorectal Cancer Screening	59.12	53.14
COA—Care for Older Adults—Advance Care Planning	54.50	36.18
COA—Care for Older Adults—Medication Review	91.73	72.10

HEDIS Measure	HEDIS 2018	Statewide Average
COA—Care for Older Adults—Functional Status Assessment	78.59	53.95
COA—Care for Older Adults—Pain Assessment	92.21	68.09
Respiratory Conditions		
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	20.00	26.62
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	70.13	72.48
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	90.26	88.47
Cardiovascular Conditions		
CBP—Controlling High Blood Pressure	79.81	58.89
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	78.57	90.69
SPC—Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy	79.38	76.68
SPC—Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%	54.33	71.33
Diabetes		
CDC—Comprehensive Diabetes Care—HbA1c Testing	92.15	88.82
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control**	20.07	37.39
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)	68.61	53.34
CDC—Comprehensive Diabetes Care—Eye Exams	72.08	63.18
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	91.79	94.14
CDC—Comprehensive Diabetes Care—Blood Pressure Cont. <140/90	80.11	56.81
SPD—Statin Therapy for Patients with Diabetes—Received Statin Therapy	71.90	70.97
SPD—Statin Therapy for Patients with Diabetes—Statin Adherence 80%	55.63	72.38
Musculoskeletal Conditions		
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	68.00	64.21
OMW—Osteoporosis Management in Women Who Had a Fracture	21.05	9.56
Behavioral Health		
AMM—Antidepressant Medication Management—Effect Acute Phase Treatment	53.17	57.08
AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment	49.21	43.57
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days	31.88	23.63
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days	55.07	52.49
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days	35.29	30.48

HEDIS Measure	HEDIS 2018	Statewide Average
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days	69.12	48.67
Medication Management and Care Coordination		
MRP—Medication Reconciliation Post-Discharge	67.64	39.18
Overuse/Appropriateness		
*PSA—Non-Recommended PSA-Based Screening of Older Men**	17.07	19.27
*DDE—Potentially Harmful Drug-Disease Interactions in the Elderly**	52.98	44.19
*DAE—Use of High-Risk Medications in the Elderly—One Prescription**	23.06	18.89
*DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions**	16.68	12.40
Access/Availability of Care		
AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years	90.60	85.31
AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years	95.21	94.10
AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older	94.99	90.49
AAP—Adults' Access to Preventative/Ambulatory Health Services—Total	94.28	90.73
IET—Initiation of Alcohol and Other Drug Dependence Treatment	19.75	30.35
IET—Engagement of Alcohol and Other Drug Dependence Treatment	2.52	3.76
Risk Adjusted Utilization		
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**	0.70	0.74
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**	0.74	0.78

(*) = Measures where lower rates indicate better performance.

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

Upper Peninsula Health Plan performed better than the statewide average in 31 of the 43 reported HEDIS measures (72 percent). Overall, **Upper Peninsula Health Plan** also demonstrated stronger performance in the Prevention and Screening, Diabetes, Musculoskeletal Conditions, Behavioral Health, Medication Management and Care Coordination, Access/Availability of Care, and Risk Adjusted Utilization domains, but showed greater opportunities for improvement in the Respiratory Conditions and Overuse/Appropriateness domains in comparison to the statewide average. Mixed results were displayed in the Cardiovascular Conditions domain.

Validation of Quality Improvement Projects

Table 5-38 displays the validation results for **Upper Peninsula Health Plan**'s QIP. This table illustrates the ICO's overall application of the QIP process and success in implementing the QIP. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 5-38 show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all steps.

Table 5-38—QIP Validation Results for UPP

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	*Not Assessed*		
Implementation Total			**100% (3/3)**	**0% (0/3)**	**0% (0/3)**
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**100% (11/11)**		

Overall, 100 percent of all applicable evaluation elements received a score of *Met* for the Design and Implementation stages of the QIP process.

For the baseline measurement period, **Upper Peninsula Health Plan** reported that 74.2 percent of members received a follow-up visit with a mental health practitioner within 30 days of discharge. The goal for the QIP is that the ICO will demonstrate a statistically significant improvement over the baseline for the remeasurement periods.

Strengths, Weaknesses, and Overall Conclusions

Upper Peninsula Health Plan demonstrated both strengths and weaknesses based on the results of the SFY 2018–2019 EQR activities. **Upper Peninsula Health Plan** received a total compliance score of 85 percent across all 11 standards reviewed in 2019, which was the third highest score across all ICOs. **Upper Peninsula Health Plan** scored at or above 90 percent in the Assurance of Adequate Capacity and Services, Provider Selection, Confidentiality, and Practice Guidelines standards, indicating strong performance in these areas, but did not perform as well in the Availability of Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Grievance and Appeal Systems, Subcontractual Relationships and Delegation, Health Information Systems, and Quality Assessment and Performance Improvement Program standards, as demonstrated by low to moderate performance scores (82 percent, 71 percent, 84 percent, 88 percent, 80 percent, 88 percent, and 82 percent, respectively), reflecting that additional focus is needed in these areas.

While **Upper Peninsula Health Plan** performed better than the statewide average in 31 of the 43 reported HEDIS measures, indicating strength in these areas, six performance measure domains included at least one measure that performed below the statewide average, indicating opportunities to improve in these domains.

Upper Peninsula Health Plan also designed a scientifically sound QIP supported by using key research principles, meeting 100 percent of the requirements in the Design stage. **Upper Peninsula Health Plan** also met 100 percent of the requirements for data analysis and implementation of improvement strategies, indicating strength in overall project performance.

Upper Peninsula Health Plan's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-39—Quality, Timeliness, and Access Performance Impact for UPP

Performance Area*	Overall Performance Impact
Quality	• Strength: The Confidentiality standard achieved full compliance, suggesting the ICO uses and discloses member protected health information in accordance with federal privacy requirements. • Strength: The Practice Guidelines standard achieved full compliance, indicating the ICO adopts and disseminates practice guidelines for use in making utilization management decisions and providing member education. • Strength: All seven measures within the Prevention and Screening domain performed better than the statewide average, indicating members are receiving preventive screenings, such as breast cancer and colorectal cancer screenings, in order to prevent and detect diseases early, and older adults are receiving the care they need to optimize their quality of life. • Strength: Five of the six *Comprehensive Diabetes Care* measures within the Diabetes domain performed better than the statewide average, indicating members diagnosed with type 1 and type 2 diabetes have appropriate diabetes management necessary to control blood glucose and reduce risks for complications. The ICO should, however, focus on medical attention for diabetic nephropathy to further improve performance in this domain. • Strength: Both measures in the Musculoskeletal Conditions domain performed above the statewide average, indicating members are receiving the appropriate treatment to help preserve function and prevent further damage. • Weakness: Two of three HEDIS measures within the Respiratory Conditions domain rated below the statewide average, indicating the ICO's providers may not be assessing for and providing appropriate treatment to members diagnosed with COPD. • Weakness: The *Statin Therapy for Patients with Cardiovascular Disease—Received Statin Adherence 80%* measure rated 17 percentage points below the statewide average, while the *Statin Therapy for Patients with Diabetes—Statin Adherence 80%* measure rated close to 16.75 percentage points below the statewide average, indicating significant opportunities to reduce risk factors associated with clinical atherosclerotic cardiovascular disease through ongoing use of statins. • Weakness: Three of the four Overuse/Appropriateness measures performed below the statewide average, indicating adults 65 and older and their prescribed medications are not being assessed to reduce adverse drug events.
Timeliness	• Strength: Five of six measures within the Behavioral Health domain rated above the statewide average, implying the ICO has focused its efforts on members diagnosed with mental health conditions, specifically related to follow-up after hospitalization and emergency department visits for mental illness.

Performance Area*	Overall Performance Impact
Access	• Strength: The Assurance of Adequate Capacity and Services standard achieved full compliance, suggesting the ICO has the network capacity to serve the members in its service area. • Strength: The four *Adults' Access to Preventative/Ambulatory Health Services* measures within the Access/Availability of Care domain performed above the statewide average, indicating members 20 years of age and older schedule an appointment with their providers for preventive health services. Preventive care is an important step for members to take to address serious health issues and manage chronic conditions. • Strength: The *Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)* and *(65+)* measures performed better than the statewide average, indicating a lower percentage of members are being readmitted within 30 days after being discharged from an inpatient hospital stay. • Weakness: The Coordination and Continuity of Care standard received a performance score of 71 percent, suggesting the ICO has gaps in its procedures to effectively deliver care to and coordinate services for all ICO members. • Weakness: Two measures within the Access/Availability of Care domain, *Initiation of Alcohol and Other Drug Dependence Treatment* and *Engagement of Alcohol and Other Drug Dependence Treatment,* performed below the statewide average, implying that members diagnosed with a new episode of alcohol or drug dependence are not able to access treatment timely after diagnosis.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

SFY 2018–2019 is the first year that an annual detailed technical report was completed for the MI Health Link program and the contracted ICOs. Therefore, there were no previous quality improvement recommendations made to MDHHS or to **Upper Peninsula Health Plan** by HSAG or another EQRO prior to SFY 2018–2019. Future technical reports will include an assessment of the degree to which each ICO addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.

Recommendations for Program Improvement

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Upper Peninsula Health Plan** to members, HSAG recommends that **Upper Peninsula Health Plan** incorporate efforts for improvement for performance measures that fell below the statewide average. To prioritize its efforts, **Upper Peninsula Health Plan** should identify a specific subset of the below measures and develop initiatives to improve the performance of those selected measures. The

selected measures, and any subsequent initiatives and interventions, should be included as part of **Upper Peninsula Health Plan**'s quality improvement strategy within its QAPIP:

Domains With Measure Ratings Below the Statewide Average

- **Respiratory Conditions**
  - *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD*
  - *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid*
- **Cardiovascular Conditions**
  - *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack*
  - *SPC—Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%*
- **Diabetes**
  - *CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy*
  - *SPD—Statin Therapy for Patients with Diabetes—Statin Adherence 80%*
- **Behavioral Health**
  - *AMM—Antidepressant Medication Management—Effect Acute Phase Treatment*
- **Overuse/Appropriateness**
  - *DDE—Potentially Harmful Drug-Disease Interactions in the Elderly*
  - *DAE—Use of High-Risk Medications in the Elderly—One Prescription*
  - *DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions*
- **Access/Availability of Care**
  - *IET—Initiation of Alcohol and Other Drug Dependence Treatment*
  - *IET—Engagement of Alcohol and Other Drug Dependence Treatment*

Upper Peninsula Health Plan should include within its next annual QAPIP review the results of analyses for the performance measures selected from those listed above that answer the following questions:

1. What were the root causes associated with low-performing areas?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **Upper Peninsula Health Plan** considering or has already implemented to improve rates and performance for each identified performance measure?

Based on the information presented above, **Upper Peninsula Health Plan** should include the following within its quality improvement work plan:

- Measurable goals and benchmarks for each performance measure
- Mechanisms to measure performance
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates
- Identified opportunities for improvement
- Ongoing analysis to identify factors that impact adequacy of rates
- Quality improvement interventions that address the root cause of the deficiency
- A plan to monitor the quality improvement interventions to detect whether they effect improvement

HSAG also recommends that **Upper Peninsula Health Plan** implement the plans of action approved by MDHHS to bring into compliance each of the following deficient standards:

- Standard I—Availability of Services
- Standard III—Coordination and Continuity of Care
- Standard IV—Coverage and Authorization of Services
- Standard V—Provider Selection
- Standard VII—Grievance and Appeal Systems
- Standard VIII—Subcontractual Relationships and Delegation
- Standard X—Health Information Systems
- Standard XI—Quality Assessment and Performance Improvement Program

Upper Peninsula Health Plan was required to complete plans of action to address each deficiency and submit to MDHHS within 30 days of receipt of the final compliance report. HSAG recommends that **Upper Peninsula Health Plan** implement internal processes to periodically review the status of each plan of action; for example, completing a progress update every 45 business days. This periodic review should include:

- Progress on implementation of each plan of action.
- Successes or barriers in remediating each deficiency.
- Revised actions steps, if necessary.

Once all plans of action are fully implemented, HSAG recommends that **Upper Peninsula Health Plan** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency. HSAG will also be conducting a review of those plans of action in 2020 to ensure deficiencies were mitigated.

Finally, **Upper Peninsula Health Plan** should take proactive steps to ensure a successful QIP. **Upper Peninsula Health Plan** should address any recommendation*s* in the *2018–2019 QIP Validation Report*

Follow-Up After Hospitalization for Mental Illness for Upper Peninsula Health Plan. HSAG also recommends the following:

- **Upper Peninsula Health Plan** must ensure that all validation feedback is addressed, and necessary corrections are made prior to the next annual submission.
- To impact the Remeasurement 1 study indicator rate, **Upper Peninsula Health Plan** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period may not have the time to impact the study indicator rate.
- **Upper Peninsula Health Plan** should document the process/steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- **Upper Peninsula Health Plan** should implement active, innovative improvement strategies that have the potential to directly impact study indicator outcomes.
- **Upper Peninsula Health Plan** should have an evaluation process to determine the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data-driven.

6. ICO Comparative Information With Recommendations for MDHHS

In addition to performing a comprehensive assessment of the performance of each ICO, HSAG compared the findings and conclusions established for each ICO to assess the MI Health Link program. The overall findings of the seven ICOs were used to identify the overall strengths and weaknesses of the MI Health Link program and to identify areas in which MDHHS could leverage or modify the MI Health Link Quality Strategy to promote improvement.

EQR Activity Results

This section provides the summarized results for the mandatory EQR activities across the seven ICOs.

Compliance Review

HSAG calculated the MI Health Link program's overall performance in each of the 11 performance areas. Table 6-1 compares the MI Health Link program's average compliance score in each of the 11 performance areas with the compliance score achieved by each ICO. The percentages of requirements met for each of the 11 standards reviewed during the 2019 compliance review are provided.

Table 6-1—Summary of 2019 Compliance Review Results

Standard	AET	AMI	HAP	MER	MCH	MOL	UPP	MI Health Link Program
Standard I—Availability of Services	**82%**	**82%**	**73%**	**73%**	**91%**	**91%**	**82%**	**82%**
Standard II—Assurance of Adequate Capacity and Services	**100%**	**67%**	**83%**	**67%**	**100%**	**83%**	**100%**	**86%**
Standard III—Coordination and Continuity of Care	**82%**	**71%**	**82%**	**65%**	**82%**	**82%**	**71%**	**76%**
Standard IV—Coverage and Authorization of Services	**95%**	**68%**	**79%**	**68%**	**68%**	**84%**	**84%**	**78%**
Standard V—Provider Selection	**90%**	**80%**	**80%**	**80%**	**100%**	**100%**	**90%**	**89%**
Standard VI—Confidentiality	**86%**	**100%**	**86%**	**100%**	**100%**	**100%**	**100%**	**96%**
Standard VII—Grievance and Appeal Systems	**88%**	**73%**	**67%**	**85%**	**79%**	**58%**	**88%**	**77%**
Standard VIII—Subcontractual Relationships and Delegation	**100%**	**80%**	**60%**	**80%**	**80%**	**80%**	**80%**	**80%**
Standard IX—Practice Guidelines	**100%**	**75%**	**75%**	**50%**	**100%**	**100%**	**100%**	**86%**
Standard X—Health Information Systems	**100%**	**88%**	**100%**	**88%**	**100%**	**100%**	**88%**	**95%**

Standard	AET	AMI	HAP	MER	MCH	MOL	UPP	MI Health Link Program
Standard XI—Quality Assessment and Performance Improvement Program	91%	82%	73%	64%	100%	73%	82%	81%
Total Compliance Score	**90%**	**76%**	**76%**	**76%**	**86%**	**80%**	**85%**	**81%**

Total Compliance Score—Elements scored *Met* were given full value (1 point each). The point values were then totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each ICO's standards and for the MI Health Link program.

The MI Health Link program received an average compliance performance score across all seven ICOs of 81 percent. The program demonstrated strong performance, scoring 90 percent or above in two standards. Areas of program strength include Confidentiality and Health Information Systems. Performance in the Confidentiality standard indicated the ICOs had the appropriate policies, processes, and systems in place to ensure members' health information was being protected, shared, and accessed as required in accordance with privacy requirements in 45 CFR parts 160 and 164, subparts A and E. Additionally, the ICOs demonstrated they maintained health information systems that collected, analyzed, integrated, and reported data that provided them the capability to meet federal and MDHHS contract requirements.

Opportunities for improvement were identified in all 11 standards. Full compliance was not achieved by any of the seven ICOs in four of the standards: Availability of Services, Coordination and Continuity of Care, Coverage and Authorization of Services, and Grievance and Appeal Systems. Additionally, only one plan, **Aetna Better Health of Michigan,** achieved full compliance in the Subcontractual Relationships and Delegation standard, while only **Michigan Complete Health** achieved full compliance in the Quality Assessment and Performance Improvement Program standard.

Three areas of the program require significant opportunities for statewide improvement, as demonstrated by the ICOs receiving an aggregated score of less than 80 percent. These areas include Coordination and Continuity of Care, Coverage and Authorization of Services, and Grievance and Appeal Systems.

Performance Measures

The SFY 2018–2019 PMV of Core Measure 2.1, *members with an assessment completed within 90 days of enrollment,* and Core Measure 3.2, *members with a care plan completed within 90 days of enrollment,* resulted in all seven ICOs receiving validation designations of REPORT (R) for both measures, indicating the measure data was compliant with CMS' specifications and the data, as reported, were valid.

Table 6-2 provides the validation designations for the MI Health Link PMV of Core Measure 2.1 and Core Measure 3.2.

Table 6-2—Comparison of Overall Validation Designations

ICO	Core Measure 2.1	Core Measure 3.2
AET	***REPORT (R)***	***REPORT (R)***
AMI	***REPORT (R)***	***REPORT (R)***
HAP	***REPORT (R)***	***REPORT (R)***
MER	***REPORT (R)***	***REPORT (R)***
MCH	***REPORT (R)***	***REPORT (R)***
MOL	***REPORT (R)***	***REPORT (R)***
UPP	***REPORT (R)***	***REPORT (R)***

HEDIS Data

Table 6-3 shows the MI Health Link program's statewide average HEDIS results in comparison to the MMP National Average in 10 HEDIS performance measure domains. Table 6-4 provides an ICO to ICO comparison with the MMP National Average in 10 HEDIS measure domains.

Table 6-3—Comparison of Overall Measure Percentage Rates

HEDIS Measure	MI Health Link Statewide Average	MMP National Average
Prevention and Screening		
ABA—Adult BMI Assessment	91.51	86.2
BCS—Breast Cancer Screening	57.80	61.8
COL—Colorectal Cancer Screening	53.14	53.3
COA—Care for Older Adults—Advance Care Planning	36.18	44.1
COA—Care for Older Adults—Medication Review	72.10	72.5
COA—Care for Older Adults—Functional Status Assessment	53.95	62.4
COA—Care for Older Adults—Pain Assessment	68.09	73.6
Respiratory Conditions		
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	26.62	24.4
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	72.48	69.9
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	88.47	86.8

HEDIS Measure	MI Health Link Statewide Average	MMP National Average
Cardiovascular Conditions		
CBP—Controlling High Blood Pressure	58.89	61.3
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	90.69	88.1
SPC—Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy	76.68	78.5
SPC—Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%	71.33	73.5
Diabetes		
CDC—Comprehensive Diabetes Care—HbA1c Testing	88.82	90.9
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control**	37.39	37.3
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)	53.34	53.3
CDC—Comprehensive Diabetes Care—Eye Exams	63.18	66.4
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	94.14	94.4
CDC—Comprehensive Diabetes Care—Blood Pressure Cont. <140/90	56.81	59.5
SPD—Statin Therapy for Patients with Diabetes—Received Statin Therapy	70.97	70.5
SPD—Statin Therapy for Patients with Diabetes—Statin Adherence 80%	72.38	72.2
Musculoskeletal Conditions		
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	64.21	71.4
OMW—Osteoporosis Management in Women Who Had a Fracture	9.56	21.2
Behavioral Health		
AMM—Antidepressant Medication Management—Effect Acute Phase Treatment	57.08	65.0
AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment	43.57	51.3
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days	23.63	33.0
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days	52.49	54.2
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days	30.48	38.2
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days	48.67	53.0

HEDIS Measure	MI Health Link Statewide Average	MMP National Average
Medication Management and Care Coordination		
MRP—Medication Reconciliation Post-Discharge	39.18	29.4
Overuse/Appropriateness		
*PSA—Non-Recommended PSA-Based Screening of Older Men**	19.27	22.6
*DDE—Potentially Harmful Drug-Disease Interactions in the Elderly**	44.19	42.5
*DAE—Use of High-Risk Medications in the Elderly—One Prescription**	18.89	20.4
*DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions**	12.40	13.4
Access/Availability of Care		
AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years	85.31	83.6
AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years	94.10	91.9
AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older	90.49	90.1
AAP—Adults' Access to Preventative/Ambulatory Health Services—Total	90.73	89.5
IET—Initiation of Alcohol and Other Drug Dependence Treatment	30.35	37.5
IET—Engagement of Alcohol and Other Drug Dependence Treatment	3.76	6.0
Risk Adjusted Utilization		
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**	0.74	0.83
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**	0.78	0.79

(*) = Measures where lower rates indicate better performance.

Note: Green indicates the MI Health Link statewide performance is better than the MMP National Average. Red indicates the MI Health Link statewide performance is worse than the MMP National Average.

Table 6-4—ICO to ICO Comparison and MMP National Average

HEDIS Measure	MMP National Average	AET	AMI	HAP	MER	MCH	MOL	UPP
Prevention and Screening								
ABA—Adult BMI Assessment	86.2	95.86	87.35	65.19	96.11	93.19	96.84	96.11
BCS—Breast Cancer Screening	61.8	53.09	47.13	55.53	61.80	50.19	61.51	66.10
COL—Colorectal Cancer Screening	53.3	43.07	31.87	48.40	63.99	36.01	64.23	59.12
COA—Care for Older Adults—Advance Care Planning	44.1	49.64	14.11	10.95	32.36	44.04	37.71	54.50
COA—Care for Older Adults—Medication Review	72.5	76.64	44.04	52.07	80.05	68.37	75.18	91.73
COA—Care for Older Adults—Functional Status Assessment	62.4	61.80	34.06	17.03	58.39	57.91	57.91	78.59
COA—Care for Older Adults—Pain Assessment	73.6	72.99	47.93	27.25	69.10	61.07	80.29	92.21
Respiratory Conditions								
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	24.4	26.92	50.00	40.00	24.44	0.00	23.29	20.00
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	69.9	76.47	79.17	59.48	86.32	59.14	70.34	70.13
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	86.8	85.81	80.21	87.93	91.79	78.49	92.78	90.26
Cardiovascular Conditions								
CBP—Controlling High Blood Pressure	61.3	59.37	49.39	48.39	70.07	57.66	52.31	79.81
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	88.1	88.89	83.33	91.30	100.0	87.50	94.55	78.57
SPC—Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy	78.5	76.79	77.22	78.48	75.50	73.33	75.93	79.38
SPC—Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%	73.5	69.30	80.33	68.82	79.39	87.88	70.02	54.33
Diabetes								
CDC—Comprehensive Diabetes Care—HbA1c Testing	90.9	88.32	85.40	79.83	90.51	92.99	91.00	92.15
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control**	37.3	28.47	42.09	79.16	41.61	34.45	28.95	20.07
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)	53.3	60.34	48.42	16.18	50.36	56.10	61.31	68.61
CDC—Comprehensive Diabetes Care—Eye Exams	66.4	48.91	58.15	52.14	76.89	64.33	68.37	72.08

HEDIS Measure	MMP National Average	AET	AMI	HAP	MER	MCH	MOL	UPP
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	94.4	94.89	90.51	91.72	95.86	96.04	95.38	91.79
CDC—Comprehensive Diabetes Care—Blood Pressure Cont. <140/90	59.5	62.29	53.28	17.51	68.37	60.67	55.47	80.11
SPD—Statin Therapy for Patients with Diabetes—Received Statin Therapy	70.5	68.68	66.84	76.78	69.15	70.05	71.96	71.90
SPD—Statin Therapy for Patients with Diabetes—Statin Adherence 80%	72.2	69.43	82.44	66.76	78.95	83.97	74.50	55.63
Musculoskeletal Conditions								
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	71.4	78.13	54.17	64.44	78.33	25.00	57.72	68.00
OMW—Osteoporosis Management in Women Who Had a Fracture	21.2	8.00	0.00	0.00	5.88	0.00	17.14	21.05
Behavioral Health								
AMM—Antidepressant Medication Management—Effect Acute Phase Treatment	65.0	59.18	48.15	51.43	64.45	73.13	54.96	53.17
AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment	51.3	41.33	35.19	32.38	51.18	50.75	44.76	49.21
FUH—Follow-Up After Hospitalization for Mental Illness–7 Days	33.0	24.22	3.45	20.22	17.65	6.00	34.47	31.88
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days	54.2	56.52	27.59	57.30	55.88	18.00	60.00	55.07
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days	38.2	35.58	23.28	35.00	38.97	42.50	18.26	35.29
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days	53.0	48.08	37.93	51.67	57.35	55.00	36.99	69.12
Medication Management and Care Coordination								
MRP—Medication Reconciliation Post-Discharge	29.4	36.25	12.41	30.90	51.34	28.22	37.71	67.64
Overuse/Appropriateness								
*PSA—Non-Recommended PSA-Based Screening of Older Men**	22.6	19.95	18.91	20.15	9.68	16.39	24.96	17.07
*DDE—Potentially Harmful Drug-Disease Interactions in the Elderly**	42.5	42.93	44.83	37.68	48.33	29.30	45.45	52.98

HEDIS Measure	MMP National Average	AET	AMI	HAP	MER	MCH	MOL	UPP
*DAE—Use of High-Risk Medications in the Elderly—One Prescription**	20.4	21.21	12.95	15.33	23.56	11.45	18.26	23.06
*DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions**	13.4	11.63	9.08	9.92	14.59	9.47	12.83	16.68
Access/Availability of Care								
AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years	83.6	85.03	76.76	82.00	75.50	74.76	88.41	90.60
AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years	91.9	93.34	89.47	93.24	79.39	89.48	95.91	95.21
AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older	90.1	89.63	83.42	87.73	69.15	81.03	92.73	94.99
AAP—Adult' Access to Preventative/Ambulatory Health Services—Total	89.5	90.06	84.09	88.44	78.95	82.45	93.08	94.28
IET—Initiation of Alcohol and Other Drug Dependence Treatment	37.5	36.09	41.98	26.43	28.57	18.18	32.59	19.75
IET—Engagement of Alcohol and Other Drug Dependence Treatment	6.0	4.26	5.56	2.64	3.42	3.74	4.05	2.52
Risk Adjusted Utilization								
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**	0.83	0.76	0.86	0.65	0.62	0.70	0.80	0.70
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**	0.79	0.75	0.98	0.57	0.67	0.96	0.87	0.74

(*) = Measures where lower rates indicate better performance.

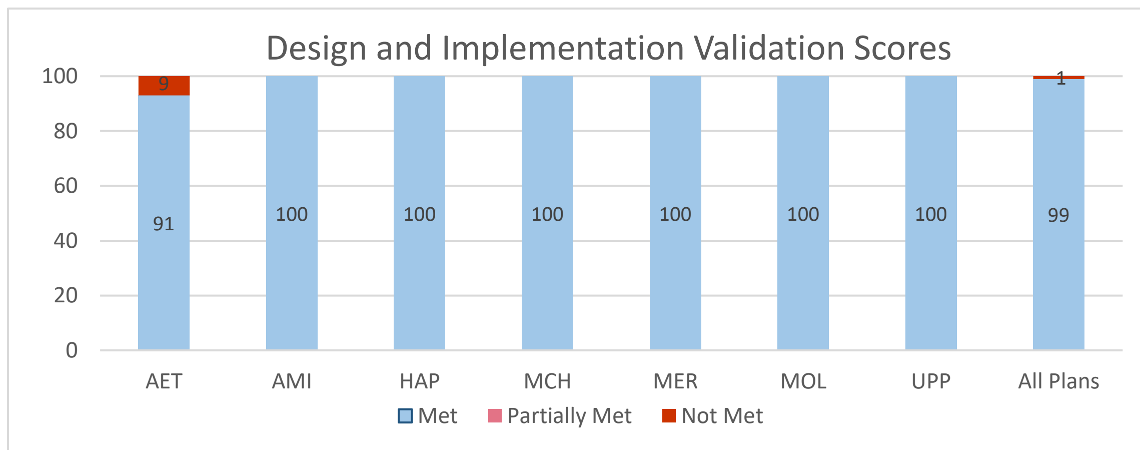
Note: Green indicates ICO performance is better than the MMP National Average. Red indicates ICO performance is worse than the MMP National Average.

The MI Health Link program performed better than the MMP National Average in 17 of the 43 reported HEDIS measures (40 percent), while the program demonstrated worse performance in 24 measures (56 percent). Statewide performance in two measures within the Diabetes domain, *Comprehensive Diabetes Care—Poor HbA1c Control* and *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*, were comparable to national performance.

Quality Improvement Project

For the SFY 2018–2019 validation, the ICOs provided baseline data and completed Steps I through VII for their ongoing State-mandated QIP topic: *Follow-Up After Hospitalization for Mental Illness*. Figure 6.1 below provides a comparison of the validation scores, by ICO.

Figure 6.1—Comparison of Validation by ICO



The results from the SFY 2018–2019 validation reflected strong performance for all ICOs. **Aetna Better Health of Michigan** had the lowest validation scores for the Design and Implementation stages (Steps I through VII). **Aetna Better Health of Michigan** can improve the validation score by ensuring all documentation requirements are included and HSAG's feedback is addressed in the next annual submission.

Table 6-5 provides a comparison of the overall validation status, by ICO.

Table 6-5—Comparison of Overall Validation Status by ICO

Overall QIP Validation Status, by ICO	
AET	*Met*
AMI	*Met*
HAP	*Met*
MCH	*Met*
MER	*Met*
MOL	*Met*
UPP	*Met*

The results from the SFY 2018–2019 validation reflected strong performance, with all ICOs receiving a *Met* validation status. All but one ICO received a 100 percent validation score across all evaluation

criteria. **Aetna Better Health of Michigan** received a *Met* validation score for 91 percent of the evaluation elements and an overall *Met* validation status. **Aetna Better Health of Michigan** can improve these validation scores by ensuring all documentation requirements are included and HSAG's feedback is addressed in the next annual submission.

Summary, Conclusions, and Recommendations

HSAG performed a comprehensive assessment of the performance of each ICO and of the overall strengths and weaknesses of the MI Health Link program related to the provision of healthcare services. All components of each EQR activity and the resulting findings were thoroughly analyzed and reviewed across the continuum of program areas and activities that comprise the MI Health Link program.

Strengths and Associated Conclusions

Through this all-inclusive assessment of aggregated performance, HSAG identified several areas of strength in the program.

Compliance Review

Through the SFY 2018–2019 compliance review, overall, the MI Health Link program demonstrated areas of moderate strength in managing and adhering to expectations established for the Medicaid program through State and federal requirements as demonstrated by a statewide aggregated score of 81 percent. Most of the State and federal requirements assessed relate to or impact the quality of, timeliness of, and access to care and services provided by each ICO to its members. The highest-performing plan was **Aetna Better Health of Michigan** with an overall average performance score of 90 percent. Three additional ICOs scored at or above 80 percent, including **Michigan Complete Health** (86 percent), **Upper Peninsula Health Plan** (85 percent), and **Molina Healthcare of Michigan** (80 percent). Additionally, statewide average scores in each of the following standards were above 90 percent, demonstrating strong performance:

- Confidentiality—the ICOs have appropriate processes and procedures in place to use and disclose individually identifiable health information in accordance with privacy requirements in 45 CFR parts 160 and 164, subparts A and E.
- Health Information Systems—the ICOs maintained adequate systems to collect, analyze, integrate, and report data, including claim and encounter data.

Performance Measures

The individual ICO processes were evaluated to determine how effective each plan was at collecting and reporting on data related to Core Measure 2.1 and Core Measure 3.2. The validation processes confirmed that all ICOs were able to successfully report data for the identified measures.

In addition to comparing each ICO's HEDIS rates to the statewide average, the statewide average was compared against the MMP National Average to determine how well the Michigan ICOs were performing nationally against other MMPs. Several performance measure domains demonstrated strong performance, as indicated by the following:

- **Respiratory Conditions**—All rates in this domain (*Use of Spirometry Testing in the Assessment and Diagnosis of COPD*, *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid*, and *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator*) ranked above the MMP National Average. Except for **Michigan Complete Health**, the ICOs performed above the MMP National Average in at least two of the three measures within this domain.
- **Medication Management and Care Coordination**—The one rate in this domain (*Medication Reconciliation Post-Discharge*) was more than 9 percentage points higher than the MMP National Average due to above average performance from five of the seven ICOs.
- **Overuse/Appropriateness**—Four rates are included in this domain. Three of the rates (*Non-Recommended PSA-Based Screening of Older Men*, *Use of High-Risk Medications in the Elderly—One Prescription*, and *Use of High-Risk Medications in the Elderly—At Least Two Prescriptions*) performed better than the MMP National Average.
- **Access/Availability of Care**—Four out of six measures within this domain ranked higher than the MMP National Average. These rates included *Adults' Access to Preventative/Ambulatory Health Services—20–44 Years*, *Adults' Access to Preventative/Ambulatory Health Services—45–64 Years*, *Adults' Access to Preventative/Ambulatory Health Services—65 and Older*, and *Adults' Access to Preventative/Ambulatory Health Services—Total*. However, apart from the *Adults' Access to Preventative/Ambulatory Health Services—45–64 Years* measure, more than half of all ICOs did not rank above the MMP National Average in five of the six measures within this domain. Additionally, for two of the measures, *Initiation of Alcohol and Other Drug Dependence Treatment* and *Engagement of Alcohol and Other Drug Dependence Treatment*, all ICOs except **AmeriHealth Michigan, Inc.** in the *Initiation of Alcohol and Other Drug Dependence Treatment* measure, failed to achieve the MMP National Average. Therefore, opportunities still exist for improvement in this area.
- **Risk Adjusted Utilization**—The two rates within this domain (*Plan All-Cause Readmissions—Observed to Expected Ratio [Ages 18–64]* and *Plan All-Cause Readmissions—Observed to Expected Ratio [Ages 65+]*) ranked better than the MMP National Average. All ICOs except **AmeriHealth Michigan, Inc.** performed better than the MMP National Average for ages 18–64, while four ICOs had fewer readmissions than the MMP National Average for ages 65 and older.

Quality Improvement Project

Through their participation in the QIP, the ICOs will focus their efforts on specific quality outcomes—particularly quality and access to care and services—which should result in better health outcomes for MI Health Link members.

During the SFY 2018–2019 review period, all seven ICOs completed the Design stage of the QIP by successfully identifying an appropriate study topic, defining study questions, identifying the study population, defining study indicators to measure improvement over time, and collecting valid and reliable data on selected study indicators in order to effectively measure and monitor QIP outcomes.

As the QIP progresses, the ICOs will establish and implement interventions to improve the health of their identified populations by increasing the percentage of members receiving a follow-up visit with a mental health practitioner within 30 days of a hospitalization due to mental illness. Follow-up after inpatient discharge is important in continuity of care between treatment settings and in ensuring that members receive care and services. Members receiving appropriate follow-up care with a mental health practitioner can reduce the risk of repeat hospitalization.

Weaknesses and Associated Conclusions

HSAG's comprehensive assessment of the ICOs and the MI Health Link program also identified areas of focus that represent significant opportunities for improvement within the program. These primary areas of focus include:

- Coordination and continuity of care
- Coverage and authorization of services
- Grievance and appeal systems
- Subcontractual relationships and delegation
- Quality assessment and performance improvement program

Coordination and Continuity of Care

Through the compliance review, ICOs demonstrated they had the appropriate policies and procedures in place to deliver care and coordinate services for their members; however, results from the case file review of member records indicated opportunities related to:

- Including members' individualized concerns, goals, preferences, risk factors, and strengths in the IICSP.
- Following up on members' identified service needs to ensure there are no gaps in care or in the provision of services.
- Monitoring the IICSP in accordance with the time frames specified in contract.

Additionally, to further enhance the care management program, HSAG determined that the ICOs should strengthen internal documentation standards related to the following:

- Care manager's offering to a member a face-to-face assessment and/or IICSP review.
- Care manager's discussion with the member about the inclusion of the member's PIHP support coordinator as an ICT member.
- Member-identified concerns, goals, preferences, and strengths.
- Observable and measurable member-specific goals, with desired outcomes.
- All paid and unpaid services and supports, including provider and frequency of services. The ICO should ensure that the services and supports provided by the PIHP are incorporated into the IICSP when appropriate.
- Assessment of member-specific risk factors, and back-up plan and strategies.

Additionally, statewide performance in all six HEDIS measures within the Behavioral Health domain rated below the MMP National Average. All ICOs except **Michigan Complete Health** performed worse than the MMP National Average in *Antidepressant Medication Management—Effect Acute Phase Treatment*, while only **Molina Healthcare of Michigan** performed better than the MMP National Average in the *Follow-Up After Hospitalization for Mental Illness—7 Days* measure. For one measure, *Antidepressant Medication Management—Effect Continuation Phase Treatment*, all ICOs performed worse than the MMP National Average. Although MDHHS has implemented a QIP related to follow-up after hospitalization for mental illness, low performance in these behavioral health-related measures indicate a need for the ICOs to collaborate more closely with the PIHPs to ensure members are able to access necessary mental health treatment and services.

Coverage and Authorization of Services

While most ICOs ensured that the services being provided to members were sufficient in the amount, duration, and/or scope, and had established appropriate medical necessity criteria for approving or denying requests for services, findings from the compliance review indicated opportunities for improvement related to:

- Providing members with a 10-day advance notice when a service has been terminated, suspended, or reduced, or when exceptions to the advance notice apply, including in cases of probable fraud.
- Providing members with an adverse benefit determination notice when there has been a denial of payment.

Grievance and Appeal Systems

The ICOs demonstrated grievance and appeal systems were in place for members to file a grievance or request an appeal; however, there were significant opportunities for the program as a whole to improve in this area. Specifically, there were opportunities for improvement related to:

- Obtaining a member's written consent for a provider to request an appeal on behalf of the member.
- Obtaining a member's written, signed appeal when the request for the appeal was made verbally.

- Ensuring grievances filed with a provider are forwarded to the ICO.
- Giving members prompt oral notice when requests for expedited appeal resolutions are denied, giving written notice of the reason for that decision within two calendar days, and informing members of their right to file a grievance if they disagree with that decision.
- Providing accurate and complete information about the member grievance and appeal system to all providers and subcontractors at the time they enter into a contract.

Subcontractual Relationships and Delegation

Although there was evidence that the ICOs were periodically monitoring their delegates through deliverables and scheduled meetings, there was a significant opportunity for improvement related to the following:

- Conducting formal reviews of the ICOs' delegates according to established periodic schedules, particularly for those delegates performing member-facing managed care functions.

Quality Assessment and Performance Improvement Program

While there were mixed performance results across the MI Health Link program related to quality assessment and performance improvement, HSAG determined that, overall, there is need for enhanced focus on the ICOs' QAPIPs. Particularly, there are opportunities for improvement related to:

- Ensuring the ICOs' QAPIPs are specific to the MI Health Link program.
- Conducting qualitative and quantitative analyses of critical incidences, including those reported by delegates; identifying trends within the reports; and remediating any concerns noted through the trend analyses, such as through education and training efforts and corrective action initiatives.
- Providing the ICOs' network providers with information annually on the effectiveness of their QAPIPs, including progress in meeting performance goals and objectives, trends in service delivery, and overall health outcomes of the MI Health Link population.

Further, to enhance the QAPIPs, HSAG determined that the ICOs should:

- Implement a broader process to monitor over- and underutilization of LTSS, such as comparing claims data with the number of units identified on IICSPs over a period of time.
- Clearly identify measurable goals and objectives in the work plan. The work plan should identify the specific interventions and activities to be conducted to meet the measurable goal with targeted completion dates. Each ICO should ensure that the effectiveness of the interventions and activities in meeting the established goal or benchmark identified in the work plan is analyzed and incorporated into the annual evaluation. The ICOs could consider establishing outcome thresholds for each goal; for example, *Met*, *Not Met*, or *Partially Met*. When goals are met and sustained, the ICO should consider establishing new goals or benchmarks; when goals are not met, the ICO should conduct a barrier analysis and identify new activities to be implemented in the subsequent year's work plan.

- Enhance strategies to assess the effectiveness of behavioral health services and LTSS. The ICOs should consider adding additional specific goals and objectives for these populations in the annual work plan.
- Enhance their analyses of the strategies and activities conducted, trending results and outcomes over a period of time as appropriate, as the annual work plan evolves and new goals and objectives are established.

Significant opportunities for improvement for the MI Health Link program were identified when statewide performance was compared to the MMP National Average. Performance in four of the performance measure domains indicated more than half of the rates fell below MMP National Average. The remaining performance measure domain, Diabetes, showed mixed performance with two of the eight measures comparing to the MMP National Average, two measures performing slightly above the MMP National Average, and four measures performing below the MMP National Average. Of the measures reported, the MI Health Link program performed worse than the MMP National Average in more than half of the measures. Results include:

Prevention and Screening—Statewide performance in six of the seven rates within the domain fell below the MMP National Average. The *Adult BMI Assessment* measure was the only measure rate that was better than the MMP National Average. For four of the measures (*Breast Cancer Screening*, *Care for Older Adults—Advance Care Planning*, *Care for Older Adults—Functional Status Assessment*, and *Care for Older Adults—Pain Assessment)*, at least five of the seven ICOs performed below the MMP National Average. Only one ICO, **Upper Peninsula Health Plan**, performed better than the MMP National Average in all measures within the Prevention and Screening domain.

Cardiovascular Conditions—The *Controlling High Blood Pressure*, *Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy*, and *Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%* statewide performance rates fell below the MMP National Average. The fourth measure, *Persistence of Beta-Blocker Treatment After a Heart Attack*, performed slightly better than the MMP National Average. **Meridian Health Plan** performed better than the MMP National Average in three out of four measures while **Upper Peninsula Health Plan** exceeded the MMP National Average in two of four measures; however, the remaining ICOs performed below MMP National Average in three out of four measures within the domain.

Musculoskeletal Conditions—The two measures within this domain, *Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis* and *Osteoporosis Management in Women Who Had a Fracture*, rated below the MMP National Average. Additionally, all seven ICOs performed below the MMP National Average in the *Osteoporosis Management in Women Who Had a Fracture* measure.

Performance in these measures indicate a need for more robust quality improvement initiatives to increase low-performing areas of the program.

Quality Strategy Recommendations for the MI Health Link Program

Based on a comprehensive assessment of the ICOs' performance in providing quality, timely, and accessible care and services to Michigan's MI Health Link members, HSAG concludes that the following prevalent areas of the program demonstrate the most opportunities for improvement:

- Coordination and continuity of care
- Coverage and authorization of services
- Grievance and appeal systems
- Subcontractual relationships and delegation
- Quality assessment and performance improvement program

The MI Health Link Quality Strategy is designed to improve the health outcomes of its Medicaid members by measuring access, efficiency, and outcomes through standardized performance measures; initiating QIPs that can be expected to have a positive effect on health outcomes and member satisfaction; and close monitoring of provider networks, affiliates, and subcontractors to ensure that quality healthcare and services are being provided to Michigan residents receiving Medicaid benefits. In consideration of the goals of the MI Health Link Quality Strategy and the comparative review of findings for all activities, HSAG recommends the following quality improvement initiatives, which target the identified specific areas of opportunity.

Coordination and Continuity of Care

To improve statewide performance related to individualized service planning, HSAG recommends that MDHHS target specific areas of the IICSP periodically to monitor compliance with the person-centered planning process. MDHHS could select a random sample of care management records quarterly and conduct a focused review on high-priority areas, such as contact time frame compliance; gaps in care; and member-specific goals, preferences, and risk factors. Results of these reviews could be used to collaborate with the ICOs to conduct a barrier analysis, initiate rapid-cycle improvement strategies when appropriate, and implement action steps to improve overall statewide performance. MDHHS could increase or decrease the oversight of each ICO based on each individual ICO's performance.

To improve statewide performance related to behavioral health performance measures, HSAG recommends that MDHHS continue its collaboration efforts with the PIHPs, including workgroups and the behavioral health focused QIPs, to enhance communication and integration to improve coordination of care and services for members.

Coverage and Authorization of Services

To improve statewide performance related to utilization management—specifically, authorization denials—HSAG recommends that MDHHS require ICOs to submit a quarterly authorization denial file with specific data sets to allow MDHHS to monitor compliance with coverage denial decision requirements. For example, MDHHS could require that each submission include Type of Request

(expedited/standard), Date Request Received, Date of Member Notification, Decision Time Frame, and Type of Notice (prior authorization denial; reduction, suspension, or termination of services; denial of payment; denial due to untimeliness of decision; etc.). MDHHS could select a random sample of files from each ICO and request documentation to validate data sets reported by ICOs. Based on the findings over an incremental period of time, MDHHS could implement progressive sanctions to increase performance (education, informal CAP, formal CAP, monetary sanctions, suspend enrollment of new members, etc.).

Grievance and Appeal Systems

HSAG recommends that MDHHS conduct a review of the number and types of grievances tracked by each ICO to identify systemic trends and statewide improvement strategies. MDHHS could compare the volume of specific types of grievances across all plans to determine whether there are any outliers that need to be investigated further. If an ICO consistently reports low volumes of grievances compared to the ICOs, MDHHS could explore whether this low volume is negative or positive, such as grievances are being under-reported or the ICO has good processes and procedures in place to limit the number of grievances being reported by members. Based on this oversight of grievances, MDHHS could require the ICOs to address any negative findings whereas best practices could be shared statewide.

Subcontractual Relationships and Delegation

HSAG recommends that MDHHS stipulate to the ICOs that the formal review of each member-facing delegate, including the PIHPs, be conducted annually or another time frame specified by the State. MDHHS could also request the ICOs to annually provide a listing of their subcontractors/delegates and the date of the formal review and/or review schedule to ensure that each delegate is being assessed periodically. MDHHS could require the ICOs to provide a response to any gaps in the oversight of their delegates.

Quality Assessment and Performance Improvement Program

HSAG recommends that MDHHS assess each ICO’s QAPIP annually. This assessment should include a review of each ICO’s QAPIP description, the ICO’s work plan, and the annual evaluation of the previous year’s QAPIP. HSAG further recommends that MDHHS provide formal approval of each ICO’s QAPIP annually to ensure the goals, objectives, and initiatives align with the MI Health Link Quality Strategy.