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2017–2018 External Quality Review Technical Report for Medicaid Health Plans

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HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Purpose and Overview of Report

States with Medicaid managed care delivery systems are required to annually provide an assessment of managed care entities' 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 Michigan Medicaid managed care program. The Michigan Medicaid managed care program's managed care entities include 11 Medicaid Health Plans (MHPs) contracted with MDHHS to provide medical services to Medicaid recipients in Michigan. The MHPs include:

- Aetna Better Health of Michigan
- Blue Cross Complete of Michigan
- HAP Midwest Health Plan
- Harbor Health Plan
- McLaren Health Plan
- Meridian Health Plan of Michigan
- Molina Healthcare of Michigan
- Priority Health Choice, Inc.
- Total Health Care, Inc.
- UnitedHealthcare Community Plan
- Upper Peninsula Health Plan

Scope of External Quality Review (EQR) 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 MHPs' performance. For the 2017–2018 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 MHP. More detailed information about each activity is provided in ***Section 4*** of this report.

- **Compliance Monitoring:** MDHHS evaluated the MHPs' compliance with federal Medicaid managed care regulations using a compliance review process. HSAG examined, compiled, and

analyzed the results as presented in the MHP compliance review documentation provided by MDHHS.

- **Validation of Performance Measures:** Each MHP underwent a National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Audit™ conducted by an NCQA-licensed audit organization. HSAG performed an independent audit of the audit findings to determine the validity of each performance measure.
- **Validation of Performance Improvement Projects (PIPs):** HSAG reviewed one PIP for each MHP 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 MHPs' performance in providing quality, timely, and accessible healthcare services to Michigan Medicaid members. For each MHP reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the MHP's performance. For a more detailed and comprehensive discussion of the strengths, weaknesses, conclusions, and recommendations for each MHP, please refer to ***Section 5*** of this report.

The overall findings and conclusions for all MHPs were also compared and analyzed to develop overarching conclusions and recommendations for the Michigan Medicaid managed care program specific to the provision of medical services. For a more detailed discussion of the strengths, weaknesses, conclusions, and recommendations for the Michigan Medicaid managed care 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 monitoring review activity, the program demonstrated areas of high performance in managing and adhering to expectations established for the Medicaid program through State and federal requirements. Specifically, the overall statewide average performance score for the six program standards reviewed was 94 percent. Only one standard, Providers, scored below 90 percent.

Additionally, as demonstrated through the performance measure activities, 34 of the 59 statewide rates with available national benchmarks demonstrated improvement from HEDIS 2017 to HEDIS 2018. Specifically, 25 measure rates from HEDIS 2017 to HEDIS 2018 in the Child & Adolescent Care, Women—Adult Care, Access to Care, Obesity, and Living With Illness domains indicated a statistically

significant improvement. These marked improvement efforts demonstrated the MHPs were providing more high-quality, accessible, and timely medical services than in the previous year.

Further, through their participation in PIPs, the MHPs are focusing efforts on quality outcomes related to disparities in timeliness of prenatal care, with an end goal to improve the health outcomes of Michigan Medicaid 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 monitoring review, performance measure validation (PMV), and PIP activities. Access to care and pregnancy care are key areas of opportunity for the Michigan Medicaid managed care program.

Access to Care

Although more than half of the statewide performance measure rates with national benchmarks demonstrated improvement from HEDIS 2017 to HEDIS 2018, 24 statewide rates demonstrated a decline in performance during this time frame. Eleven measure rates showed a statistically significant decline in performance including rates in the Access to Care domain, with rates in this area also ranking below the national Medicaid 50th percentile, including *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months* and *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years*. The *Ambulatory Care—Total (Per 1,000 Member Months), ED Visits—Total* in the Utilization domain also ranked below the national Medicaid 50th percentile, suggesting some members may be using the emergency department (ED) for care due to challenges accessing a primary care provider (PCP).

In addition to having an adequate network of providers available to see members in a timely manner, the MHPs must also ensure that members have accurate information available to make educated decisions about their healthcare, including current provider directory data from which to choose available providers. The 2017–2018 compliance monitoring review revealed an opportunity to improve the information available in the MHPs' provider directories. The lowest-scoring program area statewide was the Providers standard, with all 11 MHPs receiving findings related to the MHP Provider Directory category due to discrepancies between the information published in the provider directory and the information shared by provider offices through random calls. These inaccuracies in provider information could lead to potential access issues and dissatisfied members.

Pregnancy Care

As demonstrated through the PMV activity, performance within the Pregnancy Care domain indicated additional opportunities for improvement. Both rates under the *Prenatal and Postpartum Care* HEDIS performance measure demonstrated statistically significant declines from the prior year. Additionally, the *Timeliness of Prenatal Care* rate was below the national Medicaid 50th percentile, with only two MHPs performing at or above the national Medicaid 50th percentile. Although MDHHS has

implemented a PIP related to timeliness of prenatal care, the program still has opportunities to improve pregnancy care.

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 Access to Care and Pregnancy Care.

Access to Care

- Complete, accurate healthcare provider data are necessary for members to have adequate information that facilitates provider selection and access to care in a timely manner. MDHHS could consider enhancing its provider data validation activities by conducting a review of each MHP's provider data systems to assess the collection, maintenance, and publication of data, and implement mechanisms to improve the accuracy of provider data.
- To improve overall population health and increase the percentage of children, adolescents, and adults receiving regular preventive care from their PCPs, MDHHS could consider implementing a quality improvement (QI) initiative to target specific population groups and interventions.
- Along with MDHHS' current practice to award financial incentives for high performance related to Access to Care measures, MDHHS could also consider establishing incremental sanctions for MHPs who do not meet MDHHS-established minimum performance thresholds.

Pregnancy Care

- Reduction of Michigan infant mortality and achievement of the best possible health for infants are priorities for MDHHS and the MHPs. To ensure the program addresses these priorities, MDHHS, along with the MHPs, should leverage the existing Low Birth Weight Project initiative and the *Addressing Disparities in Prenatal Care* PIP by incorporating and comparing data analyses from different data sources, such as the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP *Live Births Weighing Less Than 2,500 Grams (LBW-CH)* measure and *Prenatal and Postpartum Care* HEDIS performance measures to identify and tailor initiatives to a specific subpopulation.

Aetna Better Health of Michigan

Based on the aggregated results of the 2017–2018 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 92 percent across all program areas reviewed during the 2017–2018 compliance review, which was below the statewide average.
- **Aetna Better Health of Michigan** scored 100 percent compliance in the Administrative, Quality, and Management Information System (MIS) standards, indicating strong performance in these program areas.
- **Aetna Better Health of Michigan** scored 87 percent and 88 percent, respectively, in the Providers and Program Integrity standards, indicating that additional focus is needed in these program areas.
- **Aetna Better Health of Michigan** was fully compliant with four out of six evaluated Information Systems (IS) standards relevant to the scope of the PMV performed by the health plan's certified HEDIS compliance auditor. During review of the IS standards, the auditor identified no issues that impacted **Aetna Better Health of Michigan**'s HEDIS performance measure reporting.
- **Aetna Better Health of Michigan** had 10 out of 58 HEDIS measure rates that ranked at or above the national Medicaid 75th percentile, eight of which ranked at or above the national Medicaid 90th percentile. Measure rates that ranked at or above the national Medicaid 90th percentile were in the Women—Adult Care, Obesity, and Living With Illness domains.
- **Aetna Better Health of Michigan** had 40 out of 58 HEDIS measure rates that ranked below the national Medicaid 50th percentile, 27 of which fell below the national Medicaid 25th percentile. Most HEDIS measure rates that fell below the national Medicaid 25th percentile were in the Child & Adolescent Care, Access to Care, and Pregnancy Care domains, indicating opportunities for improvement in these areas.
- **Aetna Better Health of Michigan** received a *Met* score in 53 percent of the applicable Design and Implementation stages reviewed during the 2017–2018 PIP, *Addressing Disparities in Timeliness of Prenatal Care*.

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 QI strategy to address the performance measures requiring improvement, listed in ***Section 5***. **Aetna Better Health of Michigan** should incorporate these improvement efforts in its QI strategy within the Quality Assessment and Performance Improvement Plan (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 2017–2018 compliance monitoring review. Further, **Aetna Better Health of Michigan** should take proactive

steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner.

Blue Cross Complete of Michigan

Based on the aggregated results of the 2017–2018 EQR activities, **Blue Cross Complete of Michigan** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **Blue Cross Complete of Michigan** received a total compliance score of 97 percent across all program areas reviewed during the 2017–2018 compliance review, which was above the statewide average. Additionally, **Blue Cross Complete of Michigan** and three other MHPs were the highest-performing plans.
- **Blue Cross Complete of Michigan** scored 100 percent compliance in the Administrative, Members, Quality, MIS, and Program Integrity standards, indicating strong performance in these program areas.
- **Blue Cross Complete of Michigan** scored 87 percent in the Providers standard, indicating that additional focus is needed in this program area.
- **Blue Cross Complete of Michigan** was fully compliant with all evaluated IS standards relevant to the scope of the PMV performed by the health plan's certified HEDIS compliance auditor. During review of the IS standards, the auditor identified no issues that impacted **Blue Cross Complete of Michigan**'s HEDIS performance measure reporting.
- **Blue Cross Complete of Michigan** had nine out of 59 HEDIS measure rates that ranked at or above the national Medicaid 75th percentile, five of which ranked at or above the national Medicaid 90th percentile. Measure rates that ranked at or above the national Medicaid 90th percentile were in the Child & Adolescent Care and Living With Illness domains.
- **Blue Cross Complete of Michigan** had 24 out of 59 HEDIS measure rates that ranked below the national Medicaid 50th percentile, four of which fell below the national Medicaid 25th percentile. The HEDIS measure rates that fell below the national Medicaid 25th percentile were in the Access to Care, Pregnancy Care, and Living With Illness domains, indicating opportunities for improvement in these areas.
- **Blue Cross Complete of Michigan** received a *Met* score in 100 percent of the applicable Design and Implementation stages reviewed during the 2017–2018 PIP, *Addressing Disparities in Timeliness of Prenatal Care*.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Blue Cross Complete of Michigan** to members, HSAG recommends that **Blue Cross Complete of Michigan** develop a QI strategy to address the performance measures requiring improvement, listed in ***Section 5***. **Blue Cross Complete of Michigan** should incorporate these improvement efforts in its QI 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.

Blue Cross Complete of Michigan should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2017–2018 compliance monitoring review. Further, **Blue Cross Complete of Michigan** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner.

HAP Midwest Health Plan

Based on the aggregated results of the 2017–2018 EQR activities, **HAP Midwest Health Plan** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **HAP Midwest Health Plan** received a total compliance score of 86 percent across all program areas reviewed during the 2017–2018 compliance review, which was below the statewide average and was the overall lowest-performing plan across all MHPs.
- **HAP Midwest Health Plan** scored 100 percent compliance in the Members standard, indicating strong performance in this program area.
- **HAP Midwest Health Plan** scored 83 percent and 75 percent, respectively, in the Providers and Program Integrity standards, indicating that additional focus is needed in these program areas.
- **HAP Midwest Health Plan** was fully compliant with all IS standards relevant to the scope of the PMV performed by the health plan's certified HEDIS compliance auditor. During review of the IS standards, the auditor identified no issues that impacted **HAP Midwest Health Plan**'s HEDIS performance measure reporting.
- **HAP Midwest Health Plan** had nine out of the 42 reportable measure rates ranked at or above the national Medicaid 75th percentile, with five rates ranking at or above the national Medicaid 90th percentile. All five measure rates that ranked at or above the national Medicaid 90th percentile were in the Living With Illness domain.
- **HAP Midwest Health Plan** had 23 out of 42 reportable measure rates that ranked below the national Medicaid 50th percentile, 14 of which were below the national Medicaid 25th percentile. Measure rates that fell below the national Medicaid 25th percentile spanned multiple domains, including Child & Adolescent Care, Women—Adult Care, Access to Care, Pregnancy Care, and Living With Illness, indicating opportunities for improvement in these areas.
- **HAP Midwest Health Plan** received a *Met* score in 100 percent of the applicable Design and Implementation stages reviewed during the 2017–2018 PIP, *Addressing Disparities in Timeliness of Prenatal Care*.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **HAP Midwest Health Plan** to members, HSAG recommends that **HAP Midwest Health Plan** develop a QI strategy to address the performance measures requiring improvement, listed in ***Section 5***. **HAP Midwest Health Plan** should incorporate these improvement efforts in its QI 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 Midwest Health Plan** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2017–2018 compliance monitoring review. Further, **HAP Midwest Health Plan** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner.

Harbor Health Plan

Based on the aggregated results of the 2017–2018 EQR activities, **Harbor Health Plan** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **Harbor Health Plan** received a total compliance score of 89 percent across all program areas reviewed during the 2017–2018 compliance review, which was below the statewide average.
- **Harbor Health Plan** scored 100 percent compliance in the Quality standard, indicating strong performance in this program area.
- **Harbor Health Plan** scored 73 percent and 89 percent, respectively, in the Providers and Program Integrity standards, indicating that additional focus is needed in these program areas.
- **Harbor Health Plan** was fully compliant with all IS standards relevant to the scope of the PMV performed by the health plan's certified HEDIS compliance auditor. During review of the IS standards, the auditor identified no issues that impacted **Harbor Health Plan**'s HEDIS performance measure reporting.
- **Harbor Health Plan** had 10 out of 53 measure rates that ranked at or above the national Medicaid 75th percentile, four of which ranked at or above the national Medicaid 90th percentile.
- **Harbor Health Plan** had 39 out of 53 measure rates that ranked below the national Medicaid 50th percentile, 33 of which were below the national Medicaid 25th percentile. Opportunities for improvement exist for **Harbor Health Plan**, especially in the domains of Child & Adolescent Care, Access to Care, Pregnancy Care, and Living With Illness, where most measure rates in each domain fell below the national Medicaid 25th percentile.
- **Harbor Health Plan** received a *Met* score in 100 percent of the applicable Design and Implementation stages reviewed during the 2017–2018 PIP, *Addressing Disparities in Timeliness of Prenatal Care*.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Harbor Health Plan** to members, HSAG recommends that **Harbor Health Plan** develop a QI strategy to address the performance measures requiring improvement, listed in ***Section 5***. **Harbor Health Plan** should incorporate these improvement efforts in its QI 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. **Harbor Health Plan** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2017–2018 compliance monitoring review. Further, **Harbor Health Plan** should take proactive steps to ensure a successful PIP,

including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner.

McLaren Health Plan

Based on the aggregated results of the 2017–2018 EQR activities, **McLaren Health Plan** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **McLaren Health Plan** received a total compliance score of 96 percent across all program areas reviewed during the 2017–2018 compliance review, which was above the statewide average.
- **McLaren Health Plan** scored 100 percent compliance in the Members, Quality, and MIS standards, indicating strong performance in these program areas.
- **McLaren Health Plan** scored 87 percent in the Providers standard, indicating that additional focus is needed in this program area.
- **McLaren Health Plan** was fully compliant with all IS standards relevant to the scope of the PMV performed by the health plan's certified HEDIS compliance auditor. During review of the IS standards, the auditor identified no issues that impacted **McLaren Health Plan**'s HEDIS performance measure reporting.
- **McLaren Health Plan** had 14 out of 58 measure rates that ranked at or above the national Medicaid 75th percentile. No measure rates ranked above the 90th percentile.
- **McLaren Health Plan** had 27 out of 58 measure rates that ranked below the national Medicaid 50th percentile, five of which were below the national Medicaid 25th percentile. Opportunities for improvement exist within the Child & Adolescent Care, Access to Care, Obesity, and Pregnancy Care domains, where at least half of the measure rates in each domain fell below the national Medicaid 50th percentile.
- **McLaren Health Plan** received a *Met* score in 100 percent of the applicable Design and Implementation stages reviewed during the 2017–2018 PIP, *Addressing Disparities in Timeliness of Prenatal Care*.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **McLaren Health Plan** to members, HSAG recommends that **McLaren Health Plan** develop a QI strategy to address the performance measures requiring improvement, listed in ***Section 5***. **McLaren Health Plan** should incorporate these improvement efforts in its QI 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. **McLaren Health Plan** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2017–2018 compliance monitoring review. Further, **McLaren Health Plan** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner.

Meridian Health Plan of Michigan

Based on the aggregated results of the 2017–2018 EQR activities, **Meridian Health Plan of Michigan** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **Meridian Health Plan of Michigan** received a total compliance score of 96 percent across all program areas reviewed during the 2017–2018 compliance review, which was above the statewide average.
- **Meridian Health Plan of Michigan** scored 100 percent compliance in the Administrative, Members, and Quality standards, indicating strong performance in these program areas. No standards received a compliance score of less than 93 percent.
- **Meridian Health Plan of Michigan** was fully compliant with all IS standards relevant to the scope of the PMV performed by the health plan's certified HEDIS compliance auditor. During review of the IS standards, the auditor identified no issues that impacted **Meridian Health Plan of Michigan**'s HEDIS performance measure reporting.
- **Meridian Health Plan of Michigan** had 17 out of 59 measure rates that ranked at or above the national Medicaid 75th percentile, with five rates ranking at or above the national Medicaid 90th percentile.
- **Meridian Health Plan of Michigan** had nine out of 59 measure rates that ranked below the national Medicaid 50th percentile, four of which fell below the national Medicaid 25th percentile. Opportunities for improvement exist in the Child & Adolescent Care, Living With Illness, and Utilization domains, where some measure rates fell below the national Medicaid 25th percentile.
- **Meridian Health Plan of Michigan** received a *Met* score in 100 percent of the applicable Design and Implementation stages reviewed during the 2017–2018 PIP, *Addressing Disparities in Timeliness of Prenatal Care*.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Meridian Health Plan of Michigan** to members, HSAG recommends that **Meridian Health Plan of Michigan** develop a QI strategy to address the performance measures requiring improvement, listed in ***Section 5***. **Meridian Health Plan of Michigan** should incorporate these improvement efforts in its QI 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 of Michigan** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2017–2018 compliance monitoring review. Further, **Meridian Health Plan of Michigan** should take proactive steps to ensure a successful PIP, 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 2017–2018 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 92 percent across all program areas reviewed during the 2017–2018 compliance review, which was below the statewide average.
- **Molina Healthcare of Michigan** scored 100 percent compliance in the Administrative and MIS standards, indicating strong performance in these program areas.
- **Molina Healthcare of Michigan** scored 87 percent and 88 percent, respectively, in the Providers and Program Integrity standards, indicating that additional focus is needed in these program areas.
- **Molina Healthcare of Michigan** was fully compliant with all IS standards relevant to the scope of the PMV performed by the health plan's certified HEDIS compliance auditor. During review of the IS standards, the auditor identified no issues that impacted **Molina Healthcare of Michigan**'s HEDIS performance measure reporting.
- **Molina Healthcare of Michigan** had 19 out of 59 measure rates that ranked at or above the national Medicaid 75th percentile, four of which ranked at or above the national Medicaid 90th percentile.
- **Molina Healthcare of Michigan** had 12 out of 59 measure rates that ranked below the national Medicaid 50th percentile, two of which were below the national Medicaid 25th percentile and were in the Pregnancy Care and Living With Illness domains, indicating opportunities for improvement in these areas.
- **Molina Healthcare of Michigan** received a *Met* score in 100 percent of the applicable Design and Implementation stages reviewed during the 2017–2018 PIP, *Addressing Disparities in Timeliness of Prenatal Care*.

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** develop a QI strategy to address the performance measures requiring improvement, listed in ***Section 5***. **Molina Healthcare of Michigan** should incorporate these improvement efforts in its QI 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 2017–2018 compliance monitoring review. Further, **Molina Healthcare of Michigan** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner.

Priority Health Choice, Inc.

Based on the aggregated results of the 2017–2018 EQR activities, **Priority Health Choice, Inc.** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **Priority Health Choice, Inc.** received a total compliance score of 97 percent across all program areas reviewed during the 2017–2018 compliance review, which was above the statewide average. Additionally, **Priority Health Choice, Inc.** and three other MHPs were the highest-performing plans.
- **Priority Health Choice, Inc.** scored 100 percent compliance in the Administrative, Members, Quality, and MIS standards, indicating strong performance in these program areas.
- **Priority Health Choice, Inc.** scored 87 percent in the Providers standard, indicating that additional focus is needed in this program area.
- **Priority Health Choice, Inc.** was fully compliant with all IS standards relevant to the scope of the PMV performed by the health plan's certified HEDIS compliance auditor. During review of the IS standards, the auditor identified no issues that impacted **Priority Health Choice, Inc.**'s HEDIS performance measure reporting.
- **Priority Health Choice, Inc.** had 41 out of 58 measure rates that ranked at or above the national Medicaid 75th percentile, 27 of which ranked at or above the national Medicaid 90th percentile. Measure rates that ranked at or above the 90th percentile spanned across Child & Adolescent Care, Access to Care, Obesity, and Living With Illness domains.
- **Priority Health Choice, Inc.** had eight out of 58 measure rates that ranked below the national Medicaid 50th percentile, three of which fell below the national Medicaid 25th percentile in the Child & Adolescent Care and Living with Illness domains, indicating opportunities for improvement in these areas.
- **Priority Health Choice, Inc.** received a *Met* score in 100 percent of the applicable Design and Implementation stages reviewed during the 2017–2018 PIP, *Addressing Disparities in Timeliness of Prenatal Care*.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Priority Health Choice, Inc.** to members, HSAG recommends that **Priority Health Choice, Inc.** develop a QI strategy to address the performance measures requiring improvement, listed in ***Section 5***. **Priority Health Choice, Inc.** should incorporate these improvement efforts in its QI 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. **Priority Health Choice, Inc.** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2017–2018 compliance monitoring review. Further, **Priority Health Choice, Inc.** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner.

Total Health Care, Inc.

Based on the aggregated results of the 2017–2018 EQR activities, **Total Health Care, Inc.** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **Total Health Care, Inc.** received a total compliance score of 94 percent across all program areas reviewed during the 2017–2018 compliance review, which equaled the statewide average.
- **Total Health Care, Inc.** scored 100 percent compliance in the Administrative, Members, Quality, and MIS standards, indicating strong performance in these program areas.
- **Total Health Care, Inc.** scored 87 percent in the Providers standard, indicating that additional focus is needed in this program area.
- **Total Health Care, Inc.** was fully compliant with all IS standards relevant to the scope of the PMV performed by the health plan's certified HEDIS compliance auditor. During review of the IS standards, the auditor identified no issues that impacted **Total Health Care, Inc.**'s HEDIS performance measure reporting.
- **Total Health Care, Inc.** had 12 out of 58 measure rates that ranked at or above the national Medicaid 75th percentile, four of which ranked at or above the national Medicaid 90th percentile.
- **Total Health Care, Inc.** had 36 out of 58 measure rates that ranked below the national Medicaid 50th percentile, 14 of which were below the national Medicaid 25th percentile. Measure rates that fell below the national Medicaid 25th percentile spanned multiple domains including Child & Adolescent Care, Access to Care, Pregnancy Care, and Living With Illness. Opportunities for improvement exist for **Total Health Care, Inc.**, especially in the Access to Care and Pregnancy Care domains, where most of the measures in each domain fell below the national Medicaid 50th percentile.
- **Total Health Care, Inc.** received a *Met* score in 94 percent of the applicable Design and Implementation stages reviewed during the 2017–2018 PIP, *Addressing Disparities in Timeliness of Prenatal Care*. **Total Health Care, Inc.** has opportunities for improvement related to documentation completeness and addressing HSAG's validation feedback in the Implementation stage.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Total Health Care, Inc.** to members, HSAG recommends that **Total Health Care, Inc.** develop a QI strategy to address the performance measures requiring improvement, listed in ***Section 5***. **Total Health Care, Inc.** should incorporate these improvement efforts in its QI 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. **Total Health Care, Inc.** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2017–2018 compliance monitoring review. Further, **Total Health Care, Inc.** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner.

UnitedHealthcare Community Plan

Based on the aggregated results of the 2017–2018 EQR activities, **UnitedHealthcare Community Plan** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **UnitedHealthcare Community Plan** received a total compliance score of 97 percent across all program areas reviewed during the 2017–2018 compliance review, which was above the statewide average. Additionally, **UnitedHealthcare Community Plan** and three other MHPs were the highest-performing plans.
- **UnitedHealthcare Community Plan** scored 100 percent compliance in the Administrative, Members, Quality, and MIS standards, indicating strong performance in these program areas.
- **UnitedHealthcare Community Plan** scored 87 percent in the Providers standard, indicating that additional focus is needed in this program area.
- **UnitedHealthcare Community Plan** was fully compliant with all IS standards relevant to the scope of the PMV performed by the health plan's certified HEDIS compliance auditor. During review of the IS standards, the auditor identified no issues that impacted **UnitedHealthcare Community Plan**'s HEDIS performance measure reporting.
- **UnitedHealthcare Community Plan** had 24 out of 59 measure rates that ranked at or above the national Medicaid 75th percentile, seven of which ranked at or above the national Medicaid 90th percentile. Measures that ranked at or above the 90th percentile were in the Access to Care, Obesity, and Living With Illness domains.
- **UnitedHealthcare Community Plan** had 10 out of 59 measure rates that ranked below the national Medicaid 50th percentile. Although no measure rates fell below the national Medicaid 25th percentile, opportunities for improvement for **UnitedHealthcare Community** could be extended to include those measures that fell below the national Medicaid 50th percentile, such as measures within the Access to Care and Pregnancy Care domains.
- **UnitedHealthcare Community Plan** received a *Met* score in 88 percent of the applicable Design and Implementation stages reviewed during the 2017–2018 PIP, *Addressing Disparities in Timeliness of Prenatal Care*. The technical design of the PIP was sufficient to measure and monitor PIP outcomes; however, opportunities for improvement exist related to **UnitedHealthcare Community Plan**'s documentation and omission of requirements in Step VI, Reliably Collect Data and Step VII, Sufficient Data Analysis and Interpretation of Results.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **UnitedHealthcare Community Plan** to members, HSAG recommends that **UnitedHealthcare Community Plan** develop a QI strategy to address the performance measures discussed in ***Section 5***. **UnitedHealthcare Community Plan** should incorporate these improvement efforts in its QI 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. **UnitedHealthcare Community Plan** should also develop comprehensive and effective plans of action to mitigate any

deficiencies identified during the 2017–2018 compliance monitoring review. Further, **UnitedHealthcare Community Plan** should take proactive steps to ensure a successful PIP, 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 2017–2018 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 97 percent across all program areas reviewed during the 2017–2018 compliance review, which was above the statewide average. Additionally, **Upper Peninsula Health Plan** and three other MHPs were the highest-performing plans.
- **Upper Peninsula Health Plan** scored 100 percent compliance in the Administrative, Members, Quality, and MIS standards, indicating strong performance in these program areas. No standards received a compliance score of less than 95 percent.
- **Upper Peninsula Health Plan** was fully compliant with all IS standards relevant to the scope of the PMV performed by the health plan's certified HEDIS compliance auditor. During review of the IS standards, the auditor identified no issues that impacted **Upper Peninsula Health Plan**'s HEDIS performance measure reporting.
- **Upper Peninsula Health Plan** had 26 out of 56 measure rates that ranked at or above the national Medicaid 75th percentile, 11 of which ranked at or above the national Medicaid 90th percentile. Measures that ranked above the national Medicaid 90th percentile were in the Child & Adolescent Care, Obesity, Pregnancy Care, and Living With Illness domains.
- **Upper Peninsula Health Plan** had 14 out of 56 measure rates that ranked below the national Medicaid 50th percentile, with only one measure rate falling below the national Medicaid 25th percentile. Although only one measure rate fell below the national Medicaid 25th percentile, opportunities for improvement for **Upper Peninsula Health Plan** could be extended to include those measures that fell below the national Medicaid 50th percentile.
- **Upper Peninsula Health Plan** received a *Met* score in 100 percent of the applicable Design and Implementation stages reviewed during the 2017–2018 PIP, *Addressing Disparities in Timeliness of Prenatal Care*.

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** develop a QI strategy to address the performance measures requiring improvement, listed in ***Section 5***. **Upper Peninsula Health Plan** should incorporate these improvement efforts in its QI 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 2017–2018 compliance monitoring review. Further, **Upper Peninsula Health Plan** should take proactive steps to ensure a successful PIP, 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 MHPs are required to conduct EQR activities of the MHPs 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 MHP'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 the Centers for Medicare & Medicaid Services' (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 MHP's strengths and weaknesses and presents conclusions drawn about the quality of, timeliness of, and access to care furnished by the MHPs.
- Includes recommendations for improving the quality of, timeliness of, and access to care and services furnished by the MHPs, including recommendations for each individual MHP and recommendations for MDHHS to target Michigan's Quality Strategy to improve the quality of care provided by the Michigan Medicaid managed care program.
- Contains methodological and comparative information for all MHPs.
- Assesses the degree to which each MHP has addressed the recommendations for QI made by the EQRO during the 2016–2017 EQR.

This report is composed of six sections: Executive Summary, Introduction to the Annual Technical Report, Overview of the Michigan Medicaid Managed Care Program, External Quality Review Activities, Assessment of MHP Performance, and MHP Comparative Information With Recommendations for Michigan Department of Health and Human Services (MDHHS).

Section 1—Executive Summary

The Executive Summary section presents a high-level overview of the EQR activities, conclusions, and recommendations for the MDHHS managed care program and the MHPs.

Section 2—Introduction to the Annual Technical Report

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

Section 3—Overview of Michigan Medicaid Managed Care Program

The Overview of the Michigan Medicaid managed care program section gives a description of the Michigan Medicaid managed care program; brief descriptions of each of the MHPs that contract with MDHHS to provide services to members; and a brief overview of Michigan's Quality Strategy and goals for the health of Michigan's Medicaid population.

Section 4—External Quality Review Activities

The EQR 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 MHP Performance

The Assessment of MHP Performance section presents the MHP-specific results for each of the EQR activities conducted during the 2017–2018 review period.

Section 6—MHP Comparative Information With Recommendations for Michigan Department of Health and Human Services (MDHHS)

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

3. Overview of Michigan Medicaid Managed Care Program

Managed Care in Michigan and Overview of MHPs

The MDHHS oversees the health insurance programs for the State of Michigan. Most individuals in Michigan receiving full Medicaid benefits are enrolled in managed care through the Comprehensive Health Care Program and must choose an MHP that services their county of residence. MHPs are responsible for providing, arranging, and reimbursing most medical services, including acute, primary, and specialty services, and prescription drugs. Coverage for mental health and substance use disorder services, and long-term services and supports for Medicaid members with mental illnesses, substance use disorders, or developmental disabilities is provided through the Managed Specialty Supports and Services program through regional Prepaid Inpatient Health Plans (PIHPs). In 2014, Michigan also implemented a new 1115 demonstration to expand its Medicaid managed care program to include adults with income up to 133 percent of the federal poverty level. This program called the Healthy Michigan Plan (HMP) provides comprehensive benefits through both the MHPs and PIHPs.

Overview of MHPs

During the 2017–2018 review period, MDHHS contracted with 11 qualified MHPs. These MHPs are responsible for the provision of services to Medicaid managed care members. Table 3-1 provides a profile for each MHP.

Table 3-1—MHP Profiles

Medicaid Health Plan	Total Number of Members[3-1]	Covered Services[3-2]	Number of Counties Served[3-3]
Aetna Better Health of Michigan	37,577	All MHPs cover medically necessary services such as the following: • Ambulance • Doctor visits • Emergency care • Family planning and pregnancy care • Health checkups • Hearing and speech	16
Blue Cross Complete of Michigan	206,143		32
HAP Midwest Health Plan	3,263		7
Harbor Health Plan	8,310		3
McLaren Health Plan	199,445		68
Meridian Health Plan of Michigan	491,376		68
Molina Healthcare of Michigan	340,631		68

[3-1] Michigan Department of Health and Human Services. *Medicaid and Healthy Michigan Enrollees.* December 2018. Available at: https://www.michigan.gov/documents/mdhhs/JE02122018_641495_7.pdf. Accessed on: January 2, 2019.
[3-2] Michigan Department of Health and Human Services. *A Guide to Michigan Medicaid Health Plans*. January 2018. Available at: https://www.michigan.gov/documents/QualityCheckupJan03_59423_7.pdf. Accessed on: January 2, 2019.
[3-3] Michigan Department of Health and Human Services. *Michigan Medicaid Health Plan Listing by County.* October 20, 2016. Available at: http://www.michigan.gov/documents/mdch/MHP_Service_Area_Listing_326102_7.pdf. Accessed on: Jan 9, 2019.

Medicaid Health Plan	Total Number of Members[3-1]	Covered Services[3-2]	Number of Counties Served[3-3]
Priority Health Choice, Inc.	123,420	• Home health and hospice care • Hospital care, including surgery • Immunizations • Laboratory and x-rays • Medical supplies • Prescriptions • Mental health • Physical and occupational therapy • Vision	21
Total Health Care, Inc.	50,632		3
UnitedHealthcare Community Plan	245,790		64
Upper Peninsula Health Plan	43,721		15

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.

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 MHPs in achieving the goals of the Medicaid program and Michigan's strategic priorities. Examples of MDHHS' quality initiatives include:

- **Performance Monitoring Standards—**To monitor health plan performance in the areas of quality, access, customer service, and reporting, MDHHS has established performance monitoring standards that address MDHHS administrative measures, HMP measures, HMP dental measures, CMS Core Set measures, HEDIS measures including health equity measures, and managed care quality measures. For each performance area, MDHHS established specific measures, goals, minimum performance standards, data sources used for monitoring, and monitoring intervals. The established measures and goals align with the MDHHS' strategic priorities and reflect State and national issues and focus areas.
- **Population Health Management—**The MHPs provide the spectrum of primary and preventive care and use the principles of population health management to prevent chronic disease and coordinate care along the continuum of health and wellbeing. Effective utilization of these principles maintains and/or improves the physical and psychosocial wellbeing of Medicaid members through cost-effective and tailored health solutions, incorporating all risk levels along the care continuum. Population health management also includes an overarching emphasis on health promotion and disease prevention and incorporates community-based health and wellness strategies with a strong focus on social determinants of health, creating health equity, and supporting efforts to build more resilient communities. MDHHS determined that housing stability was a prevalent issue associated with high ED utilizers. Homelessness was also the focus of engagement efforts between MDHHS and the National Governor's Association to determine the relationship between housing stability and healthcare costs. With the goal to improve the health of the Michigan Medicaid population and to address social determinants of health, MDHHS launched a pilot project to focus on the integration between healthcare, housing, and Medicaid. As part of this project, each MHP is required to conduct a baseline analysis activity to develop an in-depth understanding of its population that includes a review of literature, data collection, gathering of member input, and analysis. Population health management interventions are subsequently developed to target findings from the analysis. At six-month intervals, the MHPs report the results of the interventions and ongoing assessments to MDHHS.
- **Low Birth Weight Project—**In 2017, low birth weight (LBW) was identified as a target outcome associated with the 2018 Pay for Performance (P4P) initiative for the MHPs. The LBW P4P initiative supports and aligns with the Medicaid Health Equity Project, initiated to promote health equity and monitor racial and ethnic disparities within the Michigan managed care population. In fiscal year (FY) 2018, the project goal is to involve the MHPs, existing home visiting programs, and community health worker programs to design and implement an initiative that will improve infant health outcomes by addressing health disparities and health inequities with a particular focus on reducing the *Live Births Weighing Less Than 2,500 Grams (LBW-CH)* measure. Project activities include identifying evidence-based, integrated models that address LBW through management of medical and social determinants of health and incorporating parties who focus on maternity care to identify and implement models of choice through collaborative processes. The interventions will focus on preconception, timeliness of prenatal care, and postpartum care. As part of this project, each MHP conducts a baseline analysis activity to develop an in-depth understanding of LBW that includes a review of literature, data collection, and analysis. LBW interventions are then developed to target findings from the analysis. At six and 12-month intervals, the MHPs report the results of the interventions and ongoing assessments to MDHHS.

- **Emergency Department (ED) Utilization FY18–FY20 Focus Bonus—**ED utilization provides a snapshot about quality and access issues faced by Michigan Medicaid members and their surrounding community. MDHHS' FY 2016 and FY 2017 ED utilization reduction efforts were designed for MHPs to create a process to develop an in-depth understanding of ED utilization relative to each MHP's population, and to develop and implement interventions addressing complex issues that impact member utilization. MDHHS is continuing its efforts to address the needs of high ED utilizers in Michigan. For the next three fiscal years, the ED utilization Focus Bonus will concentrate on one of three topics designed to lower inappropriate ED utilization in the Michigan Medicaid Managed Care population. These topics include integration with behavioral health, substance use disorder treatment, and/or dental services. Each MHP will develop initiatives to improve the effectiveness and performance of ED utilization that focus on reducing or eliminating visits associated with behavioral health, substance use disorder treatment, or dental problems and include an emphasis on the clinical and nonclinical aspects of a member's social system.
- **Cost-Sharing and Value-Based Services—**MHPs are responsible for creating and/or maintaining systems and processes to appropriately implement cost-sharing requirements and to ensure the provision of value-based services for its HMP population. The MHPs are incentivized by MDHHS for continuing to develop and maintain processes related to the collection of cost-sharing, incentives, and value-based services. As part of P4P, MHPs are reviewed on their performance related to HMP measures; tracking and confirmation that incentives are applied as required; and implementing wellness programs for HMP members.
- **Integration of Behavioral Health and Physical Health Services—**To ensure collaboration and integration among the MHPs and PIHPs, MDHHS developed joint expectations for both entities. These expectations include implementing joint care management processes and working collaboratively to meet set standards for follow-up after hospitalization for mental illness within 30 days of discharge. These efforts are designed to improve Medicaid member's health status, improve the member's experience of care, and reduce unnecessary costs.
- **Alternative Payment Model—**Consistent with MDHHS' initiatives to move provider reimbursement from fee-for-service to value-based payment models, the MHPs will use value-based payment models to reward providers for outcomes, including the quality of services provided, promoting the provision of appropriate services, and reducing the total cost of services provided to Medicaid members. With the ultimate goal of improving quality and outcomes while better managing costs, each MHP submitted an implementation plan to MDHHS describing its planned efforts for increasing the use of alternative payment models. In FY 2019, MDHHS will include a review of each MHP's progress toward increasing use of alternative payment models, improving quality, and reducing costs.

Compliance Monitoring

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the MHPs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D and the quality assessment and performance improvement (QAPI) requirements described in 42 CFR §438.330. To meet this requirement, MDHHS performed annual compliance reviews of its 11 contracted MHPs.

The objectives of conducting compliance reviews are to ensure performance and adherence to contractual provisions as well as compliance with federal Medicaid managed care regulations. The reviews also aid in identifying areas of noncompliance and assist MHPs in developing corrective actions to achieve compliance with State and federal requirements.

Technical Methods of Data Collection and Analysis

MDHHS is responsible for conducting compliance activities that assess MHPs' conformity with State requirements and federal Medicaid managed care regulations. This technical report presents the results of the compliance reviews performed during the 2017–2018 contract year. MDHHS conducted a compliance review of six standards as listed below:

1. Administrative (5 criteria)
2. Providers (15 criteria)
3. Members (8 criteria)
4. Quality (13 criteria)
5. MIS (10 criteria)
6. Program Integrity (28 criteria)

MDHHS reviewers used the compliance review tool for each MHP to document their findings and to identify, when applicable, specific action(s) required of the MHP to address any areas of noncompliance with contractual requirements.

For each criterion reviewed, MDHHS assigned one of the following scores:

- *Pass*—The MHP demonstrated full compliance with the requirement(s).
- *Incomplete*—The MHP demonstrated partial compliance with the requirement(s).
- *Fail*—The MHP failed to demonstrate compliance with the requirement(s).

From the FY 2018 Compliance Review Summary reports provided by MDHHS for each MHP, HSAG calculated a total compliance score for each standard, reflecting the degree of compliance with contractual requirements related to that area, and an overall score for each MHP across all six standards. The total compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points) or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

HSAG drew conclusions and made overall assessments about the quality and timeliness of, and access to care provided by the MHPs using MDHHS-documented findings on the compliance review tools from each standard evaluated during the compliance review.

Description of Data Obtained and Related Time Period

To assess the MHPs' compliance with federal and State requirements, MDHHS obtained information from a wide range of written documents produced by the MHPs, including but not limited to the following:

- Organizational charts, clinical licenses and/or certifications, and board meeting minutes
- Policies and procedures
- Provider contracts, provider access and availability documentation, and provider appeal logs
- Member materials, including new member packets, member handbooks, member newsletters, and provider directories
- Grievance, appeal, and prior-authorization reports
- Quality Improvement Programs (QIPs) and Utilization Management (UM) Programs, Quality Improvement (QI) workplans and worksheets, utilization reports, QI effectiveness reports, and committee meeting minutes
- Auditing/monitoring findings
- Accreditation status
- Operational plans, health plan profiles, and management and financial reports
- Program integrity forms and reports

For the 2017–2018 compliance reviews, MDHHS continued using the review tool and process from the previous review cycle. Two factors may affect the comparability of findings from the 2016–2017 and 2017–2018 review cycles:

- While the standards reviewed remained the same, MDHHS added to or revised scoring criteria for all standards, increasing the total number of criteria assessed from 72 in the prior year to 79 in the 2017–2018 review cycle.
- For the Quality standard (*Performance Monitoring Reports [PMR] Review*), MDHHS reviewed MHPs' reported rates for 24 performance measures, which was a small increase from 23 performance measures in the prior year. *Plan All Cause Acute 30 Day Readmission* was removed and *Appropriate Testing for Children with Pharyngitis*, and *Comprehensive Diabetes Care: Eye Exam* were added.

The reported rates reviewed by MDHHS for the Quality standard *(PMR Review)* included the following:

- *Timeliness of Prenatal Care*
- *Postpartum Care*
- *Childhood Immunizations*
- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Adolescent Well-Care Visits*
- *Appropriate Testing for Children with Pharyngitis*
- *Children and Adolescents' Access to Care—Ages 12 to 24 Months*
- *Children and Adolescents' Access to Care—Ages 7 to 11 Years*
- *Comprehensive Diabetes Care: HbA1c Testing*
- *Comprehensive Diabetes Care: Eye Exam*
- *Breast Cancer Screening*
- *Chlamydia Screening in Women—Total*
- *Adults' Generic Drug Utilization*
- *Timely Completion of Initial Health Risk Assessment*
- *Outreach and Engagement to Facilitate Entry to Primary Care*
- *Adults' Access to Preventive/Ambulatory Health Services*
- *Blood Lead Screening for Two Year Olds*
- *Developmental Screening in the First, Second, and Third Years of Life*
- *Complaints*
- *Claims Processing*
- *Encounter Data Reporting*
- *Pharmacy Encounter Data Reporting*
- *Provider File Reporting*

Throughout the fiscal year, MHPs submitted documentation of their compliance with a specified subset of the criteria in the review tool. The assessment of compliance with the standards was distributed over multiple months or repeated at multiple points during the fiscal year. Following each month's submissions, MDHHS determined the MHPs' levels of compliance with the criteria assessed and provided feedback to the MHPs about their performance. For criteria with less than full compliance, MDHHS also specified its findings and requirements for a corrective action plan (CAP). MHPs then detailed the proposed corrective action, which was reviewed and—when acceptable—approved by MDHHS prior to implementation. MDHHS conducted an annual site visit with each MHP.

Validation of Performance Measures

Activity Objectives

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

The primary objectives of the PMV process are to:

- Evaluate the accuracy of the performance measure data collected by the MHP.
- Determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure.

To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation, to assess each MHP's support system available to report accurate HEDIS® measures.[4-1]

Technical Methods of Data Collection and Analysis

MDHHS required each MHP to collect and report a set of Medicaid HEDIS measures. Developed and maintained by NCQA, HEDIS is a set of performance measures broadly accepted in the managed care environment as an industry standard.

Each MHP underwent an NCQA HEDIS Compliance Audit™ conducted by an NCQA-licensed audit organization.[4-2] The NCQA HEDIS Compliance Audit followed NCQA audit methodology as set out in

[4-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[4-2] HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

NCQA's 2018 *Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*.[4-3] The NCQA HEDIS Compliance Audit encompasses an in-depth examination of the health plans' processes consistent with 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 2012.[4-4] To complete the validation of performance measures process according to the CMS protocol, HSAG performed an independent evaluation of the audit results and findings to determine the validity of each performance measure.

Each NCQA HEDIS Compliance Audit was conducted by a certified HEDIS compliance auditor and included the following activities:

Pre-Review Activities: Each MHP was required to complete the NCQA Record of Administration, Data Management, and Processes (Roadmap), which is comparable to the Information Systems Capabilities Assessment Tool, Appendix V of the CMS protocols. Pre-on-site conference calls were held to follow up on any outstanding questions. HSAG conducted a thorough review of the Roadmap and supporting documentation, including an evaluation of processes used for collecting, storing, validating, and reporting the performance measure data.

On-Site Review: The on-site reviews, which typically lasted one to two days, included:

- An evaluation of system compliance, focusing on the processing of claims and encounters.
- An overview of data integration and control procedures, including discussion and observation.
- A review of how all data sources were combined and the method used to produce the performance measures.
- Interviews with MHP staff members involved with any aspect of performance measure reporting.
- A closing conference at which the auditor summarized preliminary findings and recommendations.

Post-On-Site Review Activities: For each performance measure calculated and reported by the MHPs, the auditor aggregated the findings from the pre-on-site and on-site activities to determine whether the reported measures were valid, based on an allowable bias. The auditor assigned each measure one of seven audit findings: (1) *Reportable* (a reportable rate was submitted for the measure), (2) *Small Denominator* (the MHP followed the specifications, but the denominator was too small [e.g., <30] to report a valid rate), (3) *No Benefit* (the MHP did not offer the health benefits required by the measure), (4) *Not Reportable* (the MHP chose not to report the measure), (5) *Not Required* (the MHP was not

[4-3] National Committee for Quality Assurance. *Volume 5, HEDIS Compliance Audit™: Standards, Policies and Procedures*. Washington D.C; 2016.

[4-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: 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-2.pdf. Accessed on: Feb 6, 2019.

required to report the measure), (6) *Biased Rate* (the calculated rate was materially biased), or (7) *Un-Audited* (the MHP chose to report a measure that is not required to be audited).

HSAG performed a comprehensive review and analysis of the MHPs' Interactive Data Submission System (IDSS) results, data submission tools, and MHP-specific NCQA HEDIS Compliance Audit reports and performance measure reports.

HSAG ensured that the following criteria were met prior to accepting any validation results:

- An NCQA-licensed audit organization completed the audit.
- An NCQA-certified HEDIS compliance auditor led the audit.
- The audit scope included all MDHHS-selected HEDIS measures.
- The audit scope focused on the Medicaid product line.
- Data were submitted via an auditor-locked NCQA IDSS.
- A final audit opinion, signed by the lead auditor and responsible officer within the licensed organization, was produced.

Description of Data Obtained and Related Time Period

As identified in the CMS protocol, the following key types of data were obtained and reviewed as part of the validation of performance measures. Table 4-1 shows the data sources used in the validation of performance measures and the time period to which the data applied.

Table 4-1—Description of Data Sources

Data Obtained	Measurement Period
NCQA HEDIS Compliance Audit reports were obtained for each MHP, which included a description of the audit process, the results of the information systems findings, and the final audit designations for each performance measure.	Calendar Year (CY) 2017 (HEDIS 2018)
Performance measure reports, submitted by the MHPs using NCQA's IDSS, were analyzed and subsequently validated by HSAG.	CY 2017 (HEDIS 2018)
Previous performance measure reports were reviewed to assess trending patterns and the reasonability of rates.	CY 2016 (HEDIS 2017)

Validation of Performance Improvement Projects

Activity Objectives

Validating PIPs is one of the mandatory activities described at 42 CFR §438.330(b)(1). In accordance with §438.330(d), MCOs, PIHPs, PAHPs, and PCCM entities are required to have a QAPIP which includes PIPs that focus on both clinical and nonclinical areas. Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and must include the following:

- Measuring performance using objective quality indicators
- Implementing system interventions to achieve QI
- Evaluating effectiveness of the interventions
- Planning and initiating activities for increasing and sustaining improvement

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

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

1. HSAG evaluates the technical structure of the PIP to ensure that the MHP designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether or not the PIP design (e.g., study question, population, indicator[s], sampling techniques, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, identification of causes and barriers, and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the MHP improves its rates through implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results).

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

MDHHS requires that each MHP conduct one PIP subject to validation by HSAG. For this year's 2017–2018 validation, MHPs submitted baseline data for the state-mandated PIP topic, *Addressing Disparities in Timeliness of Prenatal Care.* The selected PIP topic is based on the HEDIS *Prenatal and Postpartum*

Care (PPC) measure; however, each MHP was required to use historical data to identify disparity within its population related to timeliness of prenatal care. Disparities could be one or more of the following:

- Race/Ethnicity/Language
- Enrollee Age
- Geographic Region

This topic has the potential to improve the health of pregnant members through increasing early initiation of prenatal care. Women who do not receive adequate or timely prenatal care are at an increased risk of complications and poor birth outcomes. The selected study topic addressed CMS' requirements related to quality outcomes—specifically, the quality of, timeliness of, and access to care and services.

Technical Methods of Data Collection and Analysis

The HSAG PIP Review Team consisted of, at a minimum, an analyst with expertise in statistics and study design and a clinician with expertise in performance improvement processes. The methodology used to validate PIPs was based on the CMS guidelines as outlined in *EQR Protocol 3: Validating Performance Improvement Projects (PI Ps): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[4-5] Using this protocol, HSAG, in collaboration with MDHHS, developed the PIP Summary Form. Each MHP completed this form and submitted it to HSAG for review. The PIP Summary Form standardized the process for submitting information regarding the PIPs and ensured that all CMS PIP protocol requirements were addressed.

HSAG, with MDHHS' input and approval, developed a PIP Validation Tool to ensure uniform validation of PIPs. Using this tool, HSAG evaluated each of the PIPs according to the CMS protocols. The CMS protocols identify 10 steps that should be validated for each PIP. For the 2017–2018 submissions, the MHPs reported baseline data and were validated for Step I through Step VIII in the validation tool.

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

Step I.	Review the Selected Study Topic
Step II.	Review the Study Question(s)
Step III.	Review the Identified Study Population
Step IV.	Review the Selected Study Indicator(s)

[4-5] 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/downloads/eqr-protocol-3.pdf Accessed on: Feb 6, 2018.

Step V.	Review Sampling Methods
Step VI.	Review the Data Collection Procedures
Step VII.	Review Data Analysis and Interpretation of Study Results
Step VIII.	Assess the Improvement Strategies
Step IX.	Assess for Real Improvement
Step X.	Assess for Sustained Improvement

HSAG used the following methodology to evaluate PIPs conducted by the MHPs to determine PIP validity and to rate the percentage of compliance with CMS' protocol for conducting PIPs.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable,* or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*. 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 of *Not Met* for the PIP. The MHP 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 *Point of Clarification* when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*), HSAG assigns the PIP 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 improvement project's findings on the likely validity and reliability of the results as follows:

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

The MHPs had an opportunity to resubmit a revised PIP Summary Form and additional information in response to HSAG's initial validation scores of *Partially Met* or *Not Met*, regardless of whether the evaluation element was critical or noncritical. HSAG conducted a final validation for any resubmitted PIPs. HSAG offered technical assistance to any MHP that requested an opportunity to review the initial validation scoring prior to resubmitting the PIP. Nine of 11 MHPs requested and received technical assistance from HSAG.

Upon completion of the final validation, HSAG prepared a report of its findings and recommendations for each MHP. These reports, which complied with 42 CFR §438.364, were provided to MDHHS and the MHPs.

Description of Data Obtained and Related Time Period

For 2017–2018, the MHPs submitted baseline data. The study indicator measurement period dates are listed below.

Table 4-2—Description of Data Obtained and Measurement Period

Data Obtained	Measurement Period
Baseline	November 6, 2016—November 5, 2017
Remeasurement 1	November 6, 2017—November 5, 2018
Remeasurement 2	November 6, 2018—November 5, 2019

5. Assessment of MHP Performance

Methodology

HSAG used findings across mandatory EQR activities conducted during the previous 12 months to evaluate the performance of Medicaid MHPs on providing quality, timely, and accessible healthcare services to Michigan Medicaid managed care members.

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

Aetna Better Health of Michigan

To conduct the 2017–2018 EQR, HSAG reviewed **Aetna Better Health of Michigan**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Aetna Better Health of Michigan**.

EQR Activity Results

Compliance Monitoring

Aetna Better Health of Michigan was evaluated in six program areas referred to as standards. Table 5-1 presents the total number of criteria for each standard as well as the number of criteria for each standard that received a score of *Pass*, *Incomplete*, or *Fail*. Table 5-1 also presents **Aetna Better Health of Michigan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages.

Table 5-1—Compliance Review Results for Aetna Better Health of Michigan (AET)

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	*Total Applicable*	AET	Statewide
1	Administrative	5	0	0	5	100%	97%
2	Providers	13	0	2	15	87%	87%
3	Members	7	1	0	8	94%	98%
4	Quality	13	0	0	13	100%	99%
5	MIS	10	0	0	10	100%	99%
6	Program Integrity	21	7	0	28	88%	92%
Overall		**69**	**8**	**2**	**79**	**92%**	**94%**

The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

Aetna Better Health of Michigan demonstrated compliance for 69 of 79 elements, with an overall compliance score of 92 percent, which was below the statewide average. **Aetna Better Health of Michigan** demonstrated strong performance, scoring above 90 percent in four standards, with three standards (Administrative, Quality, and MIS) achieving full compliance. Program areas of strength include the Administrative, Members, Quality, and MIS standards.

Opportunities for improvement were identified in three of the six standards, which are briefly described below:

- *MHP Provider Directory*—MDHHS conducted a random sample of calls to PCPs to check for accurate provider availability. The findings, as reported by MDHHS, are summarized below:

Table 5-2—Provider Directory Findings

February 2018	August 2018
• 53 percent of providers had the correct information listed in the online directory and confirmed they were accepting new patients • Five providers were unable to be reached	• 31 percent of providers had the correct information listed in the online directory and confirmed they were accepting new patients • 78 percent of providers matched what was submitted on the Provider Network File (4275) for "accepting new patients" • 71 percent of providers appeared to have matching contact information online and on the 4275 • One provider was unable to be reached

- *Member Material—ID Card and Member Handbook*—**Aetna Better Health of Michigan**'s report that was submitted did not indicate that identification (ID) cards were mailed first class.
- *Tips and Grievances Form*—Errors and/or discrepancies were noted on the form for two quarters.
- *Data Mining/Algorithm Form*—Errors and/or discrepancies were noted on the form for two quarters.
- *Audits Form*—Errors and/or discrepancies were noted on the form for one quarter.
- *Provider Disenrollments Form*—Errors and/or discrepancies were noted on the form for one quarter.
- *Overpayments Collected Form*—Errors and/or discrepancies were noted on the form for one quarter.

Aetna Better Health of Michigan was required to develop and implement a CAP for each requirement in all program areas that received an *Incomplete* or a *Fail* finding.

Validation of Performance Measures

Aetna Better Health of Michigan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the 2018 HEDIS Compliance Audit Report findings, **Aetna Better Health of Michigan** was fully compliant with four of six IS standards, including:

- IS 1.0: Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry
- IS 3.0: Practitioner Data—Data Capture, Transfer and Entry
- IS 4.0: Medical Record Review Processes—Training, Sampling, Abstraction and Oversight
- IS 5.0: Supplemental Data—Capture, Transfer and Entry

Aetna Better Health of Michigan was not fully compliant with the remaining two standards:

- IS 2.0: Enrollment Data—Data Capture, Transfer and Entry: The MHP had a timeliness issue related to the processing of newborn enrollments. Temporary newborn enrollments were not promptly terminated and were erroneously included in the HEDIS reports. This issue was corrected by the MHP and reviewed by the auditor, who determined no impact to reporting.
- IS 7.0: Data Integration—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity: **Aetna Better Health of Michigan** did not have a mechanism in place to monitor or ensure that all data feeds were received for loading. However, data transfers to the HEDIS repository were completed accurately, and the rates submitted were reportable and were not materially biased.

According to the auditors' review, sufficient data validations were in place to ensure that only accurate data were used for HEDIS reporting. **Aetna Better Health of Michigan** followed the NCQA HEDIS 2018 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 5-3 displays each of the measures, the rate for each measure for 2018, and the categorized performance for 2018 relative to national HEDIS 2017 Medicaid results for **Aetna Better Health of Michigan**.

Table 5-3—Scores for Performance Measures for Aetna Better Health of Michigan

Measure	HEDIS 2018	2018 Performance Level
Child & Adolescent Care		
Childhood Immunization Status		
Combination 2	63.26%	★
Combination 3	57.18%	★
Combination 4	56.69%	★
Combination 5	48.91%	★
Combination 6	23.36%	★
Combination 7	48.42%	★
Combination 8	23.11%	★
Combination 9	20.68%	★
Combination 10	20.44%	★
Well-Child Visits in the First 15 Months of Life		
Six or More Visits	49.39%	★
Lead Screening in Children		
Lead Screening in Children	72.99%	★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	67.84%	★★

Measure	HEDIS 2018	2018 Performance Level
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	51.82%	★★★
Immunizations for Adolescents		
Combination 1	81.75%	★★★
Appropriate Treatment for Children With Upper Respiratory Infection		
Appropriate Treatment for Children With Upper Respiratory Infection	91.65%	★★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	70.68%	★★
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	23.14%	★
Continuation and Maintenance Phase	47.06%	★
Women—Adult Care		
Breast Cancer Screening[1]		
Breast Cancer Screening	55.55%	NC
Cervical Cancer Screening		
Cervical Cancer Screening	60.26%	★★★
Chlamydia Screening in Women		
Ages 16 to 20 Years	70.30%	★★★★★
Ages 21 to 24 Years	73.39%	★★★★★
Total	71.48%	★★★★★
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	89.30%	★
Ages 25 Months to 6 Years	80.69%	★
Ages 7 to 11 Years	84.97%	★
Ages 12 to 19 Years	82.70%	★
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44 Years	68.58%	★
Ages 45 to 64 Years	80.70%	★
Ages 65+ Years	82.93%	★★
Total	73.20%	★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	37.03%	★★★★
Obesity		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	87.78%	★★★★★
Counseling for Nutrition—Total	75.06%	★★★

Measure	HEDIS 2018	2018 Performance Level
Counseling for Physical Activity—Total	65.34%	★★★
Adult BMI Assessment		
Adult BMI Assessment	94.34%	★★★★★
Pregnancy Care		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	72.26%	★
Postpartum Care	53.28%	★
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	78.59%	★
*HbA1c Poor Control (>9.0%)**	45.99%	★★
HbA1c Control (<8.0%)	45.74%	★★
Eye Exam (Retinal) Performed	47.93%	★★
Medical Attention for Nephropathy	91.24%	★★★
Blood Pressure Control (<140/90 mm Hg)	47.69%	★
Medication Management for People With Asthma		
Medication Compliance 50%—Total[2]	57.17%	★★
Medication Compliance 75%—Total	29.47%	★★
Asthma Medication Ratio		
Total	57.46%	★★
Controlling High Blood Pressure		
Controlling High Blood Pressure	49.76%	★★
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit	81.10%	★★★★
Discussing Cessation Medications	61.81%	★★★★★
Discussing Cessation Strategies	57.71%	★★★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	47.10%	★
Effective Continuation Phase Treatment	33.39%	★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	87.76%	★★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	64.29%	★

Measure	HEDIS 2018	2018 Performance Level
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NC
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	53.53%	★
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	87.26%	★★
Diuretics	86.24%	★★
Total[1]	86.79%	NC
Health Plan Diversity[3]		
Race/Ethnicity Diversity of Membership		
Total—White	26.57%	NC
Total—Black or African American	60.54%	NC
Total—American-Indian and Alaska Native	0.15%	NC
Total—Asian	0.65%	NC
Total—Native Hawaiian and Other Pacific Islander	0.06%	NC
Total—Some Other Race	0.00%	NC
Total—Two or More Races	0.00%	NC
Total—Unknown	4.43%	NC
Total—Declined	7.61%	NC
Total—Hispanic or Latino	3.14%	NC
Language Diversity of Membership		
Spoken Language Preferred for Health Care—English	0.00%	NC
Spoken Language Preferred for Health Care—Non-English	0.00%	NC
Spoken Language Preferred for Health Care—Unknown	100.00%	NC
Spoken Language Preferred for Health Care—Declined	0.00%	NC
Preferred Language for Written Materials—English	0.00%	NC
Preferred Language for Written Materials—Non-English	0.00%	NC
Preferred Language for Written Materials—Unknown	100.00%	NC
Preferred Language for Written Materials—Declined	0.00%	NC
Other Language Needs—English	99.13%	NC
Other Language Needs—Non-English	0.76%	NC
Other Language Needs—Unknown	0.11%	NC
Other Language Needs—Declined	0.00%	NC

Measure	HEDIS 2018	2018 Performance Level
Utilization[3]		
Ambulatory Care—Total (Per 1,000 Member Months)		
*ED Visits—Total**	82.21	★
Outpatient Visits—Total	301.45	NC
Inpatient Utilization—General Hospital/Acute Care—Total		
Total Inpatient—Discharges per 1,000 Member Months—Total	8.17	NC
Total Inpatient—Average Length of Stay—Total	4.14	NC
Maternity—Discharges per 1,000 Member Months—Total	2.62	NC
Maternity—Average Length of Stay—Total	2.62	NC
Surgery—Discharges per 1,000 Member Months—Total	1.75	NC
Surgery—Average Length of Stay—Total	6.47	NC
Medicine—Discharges per 1,000 Member Months—Total	4.47	NC
Medicine—Average Length of Stay—Total	3.88	NC
Use of Opioids From Multiple Providers (Per 1,000 Members)*		
Use of Opioids From Multiple Providers—Multiple Prescribers	230.92	NC
Use of Opioids From Multiple Providers—Multiple Pharmacies	107.31	NC
Use of Opioids From Multiple Providers—Multiple Prescribers and Multiple Pharmacies	60.36	NC
Use of Opioids at High Dosage (Per 1,000 Members)*		
Use of Opioids at High Dosage	18.37	NC

[1] Due to changes in the technical specifications for this measure in HEDIS 2018, comparisons to benchmarks were not performed for this measure.
[2] Performance levels for 2018 were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.
[3] These measure indicator rates and any comparisons to benchmarks for these measures are provided for information only.
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table 5-3 shows **Aetna Better Health of Michigan** had 10 out of 58 measure rates (17.2 percent) that ranked at or above the national Medicaid 75th percentile, eight of which ranked at or above the national Medicaid 90th percentile. Measure rates that ranked at or above the national Medicaid 90th percentile were in the Women—Adult Care, Obesity, and Living With Illness domains. Conversely, 40 out of 58 measure rates (69.0 percent) fell below the national Medicaid 50th percentile, 27 of which fell below the national Medicaid 25th percentile. Most measure rates that fell below the national Medicaid 25th percentile were in the Child & Adolescent Care, Access to Care, and Pregnancy Care domains. Opportunities for improvement for **Aetna Better Health of Michigan** include a focus on Child &

Adolescent Care, Access to Care, Pregnancy Care, and Living With Illness, where several rates in each of these domains fell below the national Medicaid 25th percentile.

Validation of Performance Improvement Projects

For the 2017–2018 PIP, **Aetna Better Health of Michigan** submitted baseline data for the state-mandated topic, *Addressing Disparities in Timeliness of Prenatal Care.* **Aetna Better Health of Michigan** analyzed historical data and identified a disparity related to timeliness of prenatal care among its African-American and White populations. The goal of **Aetna Better Health of Michigan**'s PIP is to improve the timeliness of prenatal care for the African-American population and eliminate the identified disparity without a decline in performance for the White population.

Table 5-4 outlines the study indicators for the PIP.

Table 5-4—Study Indicators

PIP Topic	Study Indicators
Addressing Disparities in Timeliness of Prenatal Care	1. The percentage of eligible African-American women who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year. 2. The percentage of eligible White women who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.

Table 5-5 displays the validation results for **Aetna Better Health of Michigan**'s PIP. This table illustrates the MHP's overall application of the PIP process and success in implementing the PIP. 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 5-5 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 5-5—Performance Improvement Project Validation Results for Aetna Better Health of Michigan

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)	50% (1/2)	50% (1/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	50% (2/4)	0% (0/4)	50% (2/4)
Design Total			**70% (7/10)**	**10% (1/10)**	**20% (2/10)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	33% (1/3)	33% (1/3)	33% (1/3)
	VIII.	Appropriate Improvement Strategies	33% (2/6)	50% (3/6)	17% (1/6)
Implementation Total			**33% (3/9)**	**44% (4/9)**	**22% (2/9)**
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**53% (10/19)**	**26% (5/19)**	**21% (4/19)**

*Percentage totals may not equal 100 due to rounding.

Overall, 53 percent of all applicable evaluation elements received a score of *Met* for the Design and Implementation stages of the PIP. The MHP has opportunities for improvement related to completeness of documentation and addressing HSAG's validation feedback for stages.

For the baseline measurement period, **Aetna Better Health of Michigan** reported that 48.5 percent of eligible African-American women received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment, and 50.3 percent of eligible White women received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment. The Remeasurement 1 goal was set at 55 percent; however, the goal for the PIP is that there will no longer be a statistically significant difference between the two subgroups' rates.

Strengths, Weaknesses, and Overall Conclusions

Aetna Better Health of Michigan demonstrated both strengths and weaknesses based on the results of the 2017–2018 EQR activities. **Aetna Better Health of Michigan** received a total compliance score of 92 percent across all program areas reviewed during the 2017–2018 compliance review. **Aetna Better Health of Michigan** scored 94 percent or above in the Administrative, Members, Quality, and MIS standards, indicating generally strong performance in these program areas, but did not perform as well in the Providers and Program Integrity standards, as demonstrated by moderate performance scores (87 percent and 88 percent, respectively), reflecting that additional focus is needed in these areas. While 10 of the 58 HEDIS performance measure rates were ranked at or above the national Medicaid 75th percentile, indicating strengths in these areas, 40 HEDIS measure rates fell below the national Medicaid 50th percentile indicating opportunities for improvement primarily in Child & Adolescent Care, Access to Care, Pregnancy Care, and Living With Illness domains.

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 5-6—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: Received a performance score of 100 percent in the Administrative program area, indicating that the MHP had adequate staffing and oversight mechanisms in place to ensure the delivery of quality services to its members. • Strength: Received a performance score of 100 percent in the Quality program area, indicating that the MHP had the components of an effective QAPIP in place to assess and improve the quality of services provided to members. • Strength: Received a performance score of 100 percent in the MIS program area, indicating that the MHP maintained a health information system that is capable of collecting, analyzing, integrating, and reporting data to meet the obligations under its contract with MDHHS and, therefore, the ability to appropriately monitor the quality of services being provided to members. • Strength: All three rates under the *Chlamydia Screening in Women* HEDIS measure were at or above the national Medicaid 90th percentile, indicating women were being screened for this sexually transmitted disease.

Performance Area*	Overall Performance Impact
	• Strength: Two rates under the Obesity domain, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, BMI Percentile—Total* and *Adult BMI Assessment* were at or above the national Medicaid 90th percentile, indicating children's, adolescents', and adults' body mass indexes (BMIs) were assessed by a PCP or obstetrician-gynecologist (OB/GYN) during a medical appointment, and physicians can identify at-risk members and provide suggestions and services to assist them in obtaining and maintaining a healthier weight. • Strength: The three rates under the *Medical Assistance With Smoking and Tobacco Use Cessation* HEDIS performance measure were at or above the national Medicaid 75th percentile, with two rates (*Discussing Cessation Medications* and *Discussing Cessation Strategies*) meeting or exceeding the 90th percentile, indicating a likelihood that healthcare providers are supporting tobacco users and their efforts to quit smoking, which can lead to improvement in members' overall health. • Strength: The *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* HEDIS performance measure rate met or exceeded the national Medicaid 90th percentile, indicating members who were dispensed an antipsychotic medication had a diabetes screening to determine an increased risk of diabetes which is important for monitoring members' overall health and providing treatment as necessary. • Weakness: Received a performance score of 88 percent in the Program Integrity standard during the compliance review, indicating additional focus may be needed within the MHP's program integrity processes to ensure program requirements are compliant with federal and State regulations, and specifically, that contracted providers have been appropriately screened and meet the MHP's expectations for a quality provider. • Weakness: The *Initiation Phase* and *Continuation and Maintenance Phase* rates under the HEDIS measure *Follow-Up Care for Children Prescribed ADHD Medication* fell below the national Medicaid 25th percentile, indicating additional opportunities for prescribed ADHD medications to be more closely monitored by a pediatrician. • Weakness: Both rates under the *Antidepressant Medication Management* HEDIS performance measure fell below the national Medicaid 50th percentile, with the *Effective Acute Phase Treatment* rate falling below the 25th percentile, indicating opportunities for providers to more effectively manage the medication treatment of members diagnosed with major depression. • Weakness: All six rates under the *Comprehensive Diabetes Care* HEDIS performance measure fell below the national Medicaid 75th percentile, with three of the rates falling below the 50th percentile, and two rates (*Hemoglobin A1c [HbA1c] Testing* and *Blood Pressure Control [<140/90 mm Hg]*) falling below the 25th percentile. • Weakness: All rates under the *Medication Management for People With Asthma*, *Asthma Medication Ratio*, and *Controlling High Blood Pressure* HEDIS performance

Performance Area*	Overall Performance Impact
	measures fell between the national Medicaid 25th and 49th percentiles, indicating opportunities for better management of these chronic conditions. • Weakness: The *Diabetes Monitoring for People With Diabetes and Schizophrenia* HEDIS performance measure rate fell below the national Medicaid 25th percentile, indicating members diagnosed with schizophrenia and diabetes did not always receive an LDL-C and an HbA1c test during the year, and therefore may have an increased risk for declining health. • Weakness: The *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* HEDIS performance measure rate under the Living With Illness domain fell below the national Medicaid 25th percentile, indicating members may be at risk for relapse or even hospitalization due to medication nonadherence. • Weakness: Two rates under the *Annual Monitoring for Patients on Persistent Medications* HEDIS performance measure fell between the national Medicaid 25th and 49th percentiles, indicating members may be at risk for adverse drug events.
Timeliness	• Weakness: Although the MHP received a performance score of 94 percent in the Members program area, it failed to send member ID cards through first class mail, indicating a potential that members did not promptly receive ID cards to access services in a timely manner. • Weakness: All nine HEDIS *Childhood Immunization Status* rates fell below the national Medicaid 25th percentile, indicating children are not always receiving vaccines in a timely manner to protect them from serious and potentially life-threatening illnesses. • Weakness: Child & Adolescent Care domain measures related to well-care visits, including *Well-Child Visits in the First 15 Months of Life* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life,* fell below the national Medicaid 25th and 50th percentiles, respectively, indicating children are not seeing their PCPs as often as suggested to ensure timely assessment of their health and development. • Weakness: The two HEDIS performance measure rates under the Pregnancy Care domain, *Timeliness of Prenatal Care* and *Postpartum Care,* fell below the national Medicaid 25th percentile, indicating pregnant women are not always accessing timely prenatal care and/or having a timely postpartum visit after delivery, which could impact the health of the member and her baby before, during, and after pregnancy. • Weakness: 21 percent of the MHP's PIP Design and Implementation stages evaluation elements received a score of *Not Met*, indicating the MHP has opportunities to improve its PIP and its efforts to address disparities in timeliness of prenatal care services.

Performance Area*	Overall Performance Impact
Access	• Weakness: Received a performance score of 87 percent in the Providers program area, indicating members may experience challenges locating and accessing providers to obtain treatment. • Weakness: All four rates under the *Children and Adolescents' Access to Primary Care Practitioners* HEDIS performance measure fell below the national Medicaid 25th percentile, indicating children and adolescents between the ages of 12 months to 19 years of age were not always accessing primary care services for appropriate screenings, treatment, and preventive services. • Weakness: All four rates under the *Adults' Access to Preventive/Ambulatory Health Services* HEDIS performance measure fell below the national Medicaid 50th percentile, with three measure rates falling under the national Medicaid 25th percentile, indicating many members 20 years and older were not accessing ambulatory or preventive care services from their physicians. • Weakness: The *Ambulatory Care—Total (Per 1,000 Member Months), ED Visits—Total* HEDIS performance measure rate under the Utilization domain fell below the national Medicaid 25th percentile, indicating potential inadequate access to care resulting in preventable ED visits.

* Performance impacts may be applicable to one or more performance areas; however, for this report they were aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which MHPs addressed the EQR recommendations made from the prior year's technical report. During the 2016–2017 EQR, HSAG made the following recommendations to **Aetna Better Health of Michigan**, and **Aetna Better Health of Michigan** addressed these recommendations by taking the following actions:

Compliance Monitoring

For the 2016–2017 review period, HSAG recommended that **Aetna Better Health of Michigan** develop QI initiatives to address the opportunities for improvement identified during the annual compliance review. HSAG also recommended that **Aetna Better Health of Michigan** focus on the Providers standard, its lowest-scoring standard, with two *Incomplete* findings, two *Fail* findings, and a compliance score of 80 percent. Additionally, HSAG recommended that **Aetna Better Health of Michigan** consider conducting Plan-Do-Study-Act (PDSA) cycles or initiating PIPs for performance measures that fell below minimum performance standards during consecutive review periods.

The 2016–2017 compliance review identified opportunities for improvement for the Providers, Members, Quality, and Program Integrity standards. **Aetna Better Health of Michigan**'s 2017–2018 compliance review findings indicate that four of the eight deficiencies in the following categories were sufficiently addressed: *Provider Subcontract: Health Benefit, Administrative and/or Transportation*, *Provider Network—MHP demonstrates that covered services are available and accessible*, *CHSCS*

Collaboration, and *PMR Review*. Four of the eight deficiencies during the 2016–2017 review period received similar findings during the 2017–2018 review period and are described in Table 5-7. These findings indicate that **Aetna Better Health of Michigan** partially addressed the prior year's recommendations.

Table 5-7—Congruent Year-Over-Year Findings

Criteria	2016–2017 Findings	2017–2018 Findings
MHP Provider Directory	**Aetna Better Health of Michigan**'s online provider directory and/or provider availability was not current based on the information obtained from calls made to PCPs in February and August 2017 to check for accurate provider availability.	**Aetna Better Health of Michigan** received similar findings, as the provider directory and/or provider availability was not current based on a random sample of calls made to PCPs in February and August 2018 to check for accurate provider availability.
Member Material—ID Card and Member Handbook	**Aetna Better Health of Michigan** did not submit a copy of a health plan ID card to verify it included the Medicaid ID number, or evidence that the cards were mailed within 10 business days from notification of enrollment.	**Aetna Better Health of Michigan** received a similar finding as the report that was submitted did not indicate that ID cards were mailed first class.
Provider Disenrollments Form	**Aetna Better Health of Michigan**'s Provider Disenrollments Form did not include information for a deceased provider who was disenrolled during the reporting period.	**Aetna Better Health of Michigan** received similar findings as the Provider Disenrollments Form contained errors and/or discrepancies for one quarter.

Validation of Performance Measures

The 2016–2017 validation of performance measures for **Aetna Better Health of Michigan** identified opportunities for improvement in the following performance measures, as their rates fell below the national Medicaid 25th percentile:

Child & Adolescent Care

- *Childhood Immunization Status—Combinations 3*, *5*, *6*, *8*, *9*, and *10*
- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*
- *Appropriate Testing for Children With Pharyngitis*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*

Access to Care

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months, Ages 25 Months to 6 years, Ages 7 to 11 Years,* and *Ages 12 to 19 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years* and *Total*

Pregnancy Care

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits*

Living With Illness

- *Diabetes Monitoring for People With Diabetes and Schizophrenia*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Total*

Utilization

- *Ambulatory Care—Total (Per 1,000 Member Months)—Emergency Department Visits, Total*

HSAG recommended that **Aetna Better Health of Michigan** focus on ensuring the completeness and accuracy of data used for calculating all HEDIS measures, and specifically, on improving the rates for measures that fell below the national Medicaid 25th percentile. Based on the results of the 2017–2018 validation, *Appropriate Testing for Children With Pharyngitis* and *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* improved to rates between the 25th and 49th percentiles; however, the remaining performance measure rates with an appropriate comparison and benchmark remained below the national Medicaid 25th percentile, indicating **Aetna Better Health of Michigan** partially addressed the prior recommendations.

Validation of Performance Improvement Projects

For the 2016–2017 validation, **Aetna Better Health of Michigan** designed a scientifically sound project supported by the use of key research principles, meeting 100 percent of the requirements in the Design stage. The technical design of the PIP was sufficient to measure and monitor PIP outcomes; therefore, there were no required follow-up recommendations.

Recommendations

As a result of the findings related to 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 improvement efforts for the following performance measures rating below the national Medicaid 25th percentile as part of its QI strategy within the QAPIP:

Child & Adolescent Care

- *Childhood Immunization Status—Combination 2*
- *Childhood Immunization Status—Combination 3*
- *Childhood Immunization Status—Combination 4*

- *Childhood Immunization Status—Combination 5*
- *Childhood Immunization Status—Combination 6*
- *Childhood Immunization Status—Combination 7*
- *Childhood Immunization Status—Combination 8*
- *Childhood Immunization Status—Combination 9*
- *Childhood Immunization Status—Combination 10*
- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*
- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*

Access to Care

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*

Pregnancy Care

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Prenatal and Postpartum Care—Postpartum Care*

Living With Illness

- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Diabetes Monitoring for People With Diabetes and Schizophrenia*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*

Utilization

- *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total*

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

1. What were the root causes associated with rates indicating low performance?
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 measure?

Based on the information presented, **Aetna Better Health of Michigan** should include the following within its QI plan:

- Measurable goals and benchmarks for each 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
- QI interventions that address the root cause of the deficiency
- A plan to monitor the QI interventions to detect whether they effect improvement

HSAG also recommends that **Aetna Better Health of Michigan** adhere to all federal managed care requirements listed under 42 CFR 438 Subpart D and the QAPIP requirements under Subpart E, State of Michigan contract requirements, and specifically, develop meaningful plans of action to bring into compliance each of the following deficient program areas:

- Providers
- Members
- Program Integrity

Aetna Better Health of Michigan should include the following in each of its plans of action, and the plans of action should be provided to MDHHS as requested:

- Detailed narrative of the deficiency
- Detailed corrective action steps to resolve each deficiency
- Any resources required to resolve the deficiency
- Due dates for completing each action step

- Assigned party responsible for completing each action step
- Any required deliverables to show that a deficiency has been resolved
- Any dependencies to resolve deficiencies

Finally, **Aetna Better Health of Michigan** should take proactive steps to ensure a successful PIP. As the PIP progresses, **Aetna Better Health of Michigan** should ensure the following:

- Address all validation feedback documented in *Points of Clarification*, *Partially Met*, and *Not Met* validation scores and make necessary corrections prior to the next annual submission.
- Develop and implement innovative, non-passive interventions targeted to the two subgroups for the PIP.
- Reevaluate whether it should use mailers as an intervention for an improvement project.
- Follow the approved PIP methodology to calculate and report data accurately in next year's annual submission.
- To impact the Remeasurement 1 study indicator rate, 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 will not have enough time to impact the study indicator rate.
- Document the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators, and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.
- Seek technical assistance throughout the PIP process to address any questions or concerns.

Blue Cross Complete of Michigan

To conduct the 2017–2018 EQR, HSAG reviewed **Blue Cross Complete of Michigan**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Blue Cross Complete of Michigan**.

EQR Activity Results

Compliance Monitoring

Blue Cross Complete of Michigan was evaluated in six program areas referred to as standards. Table 5-8 presents the total number of criteria for each standard as well as the number of criteria for each standard that received a score of *Pass*, *Incomplete*, or *Fail*. Table 5-8 also presents **Blue Cross Complete of Michigan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages.

Table 5-8—Compliance Review Results for Blue Cross Complete of Michigan (BCC)

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	*Total Applicable*	BCC	Statewide
1	Administrative	5	0	0	5	100%	97%
2	Providers	13	0	2	15	87%	87%
3	Members	8	0	0	8	100%	98%
4	Quality	13	0	0	13	100%	99%
5	MIS	10	0	0	10	100%	99%
6	Program Integrity	28	0	0	28	100%	92%
Overall		**77**	**0**	**2**	**79**	**97%**	**94%**

The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

Blue Cross Complete of Michigan demonstrated compliance for 77 of 79 elements, with an overall compliance score of 97 percent, which was above the statewide average. **Blue Cross Complete of Michigan** demonstrated strong performance, scoring 100 percent in five standards. These program areas of strength include the Administrative, Members, Quality, MIS, and Program Integrity standards.

Opportunities for improvement were identified in one of the six standards, which is briefly described below:

- *MHP Provider Directory*—MDHHS conducted a random sample of calls to PCPs to check for accurate provider availability. The findings, as reported by MDHHS, are summarized below:

Table 5-9—Provider Directory Findings

February 2018	August 2018
• 50 percent of providers had the correct information listed in the online directory and confirmed they were accepting new patients • 6 providers were unable to be reached	• 56 percent of providers had the correct information listed in the online directory and confirmed they were accepting new patients • 84 percent of providers matched what was submitted on the 4275 for "accepting new patients" • 78 percent of providers appeared to have matching contact information online and on the 4275

Blue Cross Complete of Michigan was required to develop and implement a CAP for each requirement in all program areas that received an *Incomplete* or a *Fail* finding.

Validation of Performance Measures

Blue Cross Complete of Michigan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the 2018 HEDIS Compliance Audit Report findings, **Blue Cross Complete of Michigan** was fully compliant with all IS standards, including:

- IS 1.0: Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry
- IS 2.0: Enrollment Data—Data Capture, Transfer and Entry
- IS 3.0: Practitioner Data—Data Capture, Transfer and Entry
- IS 4.0: Medical Record Review Processes—Training, Sampling, Abstraction and Oversight
- IS 5.0: Supplemental Data—Capture, Transfer and Entry
- IS 7.0: Data Integration—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity

According to the auditors' review, **Blue Cross Complete of Michigan** followed the NCQA HEDIS 2018 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 5-10 shows each of the measures, the rate for each measure for 2018, and the categorized performance for 2018 relative to national HEDIS 2017 Medicaid results for **Blue Cross Complete of Michigan**.

Table 5-10—Scores for Performance Measures for Blue Cross Complete of Michigan

Measure	HEDIS 2018	2018 Performance Level
Child & Adolescent Care		
Childhood Immunization Status		
Combination 2	74.45%	★★
Combination 3	72.02%	★★★
Combination 4	70.32%	★★★
Combination 5	63.02%	★★★
Combination 6	41.12%	★★★
Combination 7	61.80%	★★★
Combination 8	40.39%	★★★
Combination 9	36.50%	★★★
Combination 10	36.01%	★★★
Well-Child Visits in the First 15 Months of Life		
Six or More Visits	66.67%	★★★
Lead Screening in Children		
Lead Screening in Children	76.64%	★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.86%	★★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	54.74%	★★★
Immunizations for Adolescents		
Combination 1	88.08%	★★★★★
Appropriate Treatment for Children With Upper Respiratory Infection		
Appropriate Treatment for Children With Upper Respiratory Infection	88.36%	★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	81.63%	★★★
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	48.35%	★★★
Continuation and Maintenance Phase	62.61%	★★★
Women—Adult Care		
Breast Cancer Screening[1]		
Breast Cancer Screening	60.24%	NC

Measure	HEDIS 2018	2018 Performance Level
Cervical Cancer Screening		
Cervical Cancer Screening	61.80%	★★★
Chlamydia Screening in Women		
Ages 16 to 20 Years	63.52%	★★★★
Ages 21 to 24 Years	69.29%	★★★
Total	66.43%	★★★★
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	93.83%	★★
Ages 25 Months to 6 Years	84.89%	★
Ages 7 to 11 Years	89.84%	★★
Ages 12 to 19 Years	88.42%	★★
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44 Years	75.08%	★★
Ages 45 to 64 Years	84.08%	★★
Ages 65+ Years	83.16%	★★
Total	78.57%	★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	30.84%	★★★
Obesity		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	82.24%	★★★★
Counseling for Nutrition—Total	74.94%	★★★
Counseling for Physical Activity—Total	64.72%	★★★
Adult BMI Assessment		
Adult BMI Assessment	91.73%	★★★★
Pregnancy Care		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	76.40%	★
Postpartum Care	60.58%	★★
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	86.31%	★★
*HbA1c Poor Control (>9.0%)**	43.61%	★★
HbA1c Control (<8.0%)	47.81%	★★
Eye Exam (Retinal) Performed	55.84%	★★★
Medical Attention for Nephropathy	90.33%	★★★

Measure	HEDIS 2018	2018 Performance Level
Blood Pressure Control (<140/90 mm Hg)	61.50%	★★★
Medication Management for People With Asthma		
Medication Compliance 50%—Total[2]	88.38%	★★★★★
Medication Compliance 75%—Total	73.33%	★★★★★
Asthma Medication Ratio		
Total	55.92%	★★
Controlling High Blood Pressure		
Controlling High Blood Pressure	46.96%	★
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit	77.50%	★★★
Discussing Cessation Medications	54.48%	★★★
Discussing Cessation Strategies	45.36%	★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	77.13%	★★★★★
Effective Continuation Phase Treatment	61.87%	★★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.57%	★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	63.01%	★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	75.68%	★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	55.99%	★★
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	86.11%	★★
Diuretics	85.52%	★★
Total[1]	85.85%	NC
Health Plan Diversity[3]		
Race/Ethnicity Diversity of Membership		
Total—White	45.03%	NC
Total—Black or African American	34.27%	NC
Total—American-Indian and Alaska Native	0.44%	NC
Total—Asian	1.64%	NC
Total—Native Hawaiian and Other Pacific Islander	0.08%	NC

Measure	HEDIS 2018	2018 Performance Level
Total—Some Other Race	7.17%	NC
Total—Two or More Races	0.00%	NC
Total—Unknown	8.24%	NC
Total—Declined	3.14%	NC
Total—Hispanic or Latino	5.49%	NC
Language Diversity of Membership		
Spoken Language Preferred for Health Care—English	97.48%	NC
Spoken Language Preferred for Health Care—Non-English	2.46%	NC
Spoken Language Preferred for Health Care—Unknown	0.06%	NC
Spoken Language Preferred for Health Care—Declined	0.00%	NC
Preferred Language for Written Materials—English	97.48%	NC
Preferred Language for Written Materials—Non-English	2.46%	NC
Preferred Language for Written Materials—Unknown	0.06%	NC
Preferred Language for Written Materials—Declined	0.00%	NC
Other Language Needs—English	0.00%	NC
Other Language Needs—Non-English	0.00%	NC
Other Language Needs—Unknown	100.00%	NC
Other Language Needs—Declined	0.00%	NC
Utilization[3]		
Ambulatory Care—Total (Per 1,000 Member Months)		
*ED Visits—Total**	64.19	★★
Outpatient Visits—Total	400.42	NC
Inpatient Utilization—General Hospital/Acute Care—Total		
Total Inpatient—Discharges per 1,000 Member Months—Total	7.55	NC
Total Inpatient—Average Length of Stay—Total	3.98	NC
Maternity—Discharges per 1,000 Member Months—Total	2.75	NC
Maternity—Average Length of Stay—Total	2.61	NC
Surgery—Discharges per 1,000 Member Months—Total	1.73	NC
Surgery—Average Length of Stay—Total	6.22	NC
Medicine—Discharges per 1,000 Member Months—Total	3.68	NC
Medicine—Average Length of Stay—Total	3.72	NC
Use of Opioids From Multiple Providers (Per 1,000 Members)*		
Use of Opioids From Multiple Providers—Multiple Prescribers	203.46	NC
Use of Opioids From Multiple Providers—Multiple Pharmacies	162.05	NC
Use of Opioids From Multiple Providers—Multiple Prescribers and Multiple Pharmacies	84.60	NC

Measure	HEDIS 2018	2018 Performance Level
Use of Opioids at High Dosage (Per 1,000 Members)*		
Use of Opioids at High Dosage	72.08	NC

[1] Due to changes in the technical specifications for this measure in HEDIS 2018, comparisons to benchmarks were not performed for this measure.
[2] Performance levels for 2018 were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.
[3] These measure indicator rates and any comparisons to benchmarks for these measures are provided for information only.
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
2018 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table 5-10 shows **Blue Cross Complete of Michigan** had nine out of 59 measure rates (15.3 percent) that ranked at or above the national Medicaid 75th percentile, with five rates at or above the national Medicaid 90th percentile. The measure rates that ranked at or above the 90th percentile include *Immunizations for Adolescents—Combination 1*, both *Medication Management for People With Asthma* indicators, and both *Antidepressant Medication Management* indicators. Conversely, 24 out of 59 measure rates (40.7 percent) fell below the national Medicaid 50th percentile, four of which were below the national Medicaid 25th percentile including *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years*, *Prenatal and Postpartum Care—Timeliness of Prenatal Care*, *Controlling High Blood Pressure*, and *Diabetes Monitoring for People With Diabetes and Schizophrenia*. Opportunities for improvement exist for **Blue Cross Complete of Michigan** in the Access to Care and Pregnancy Care domains, as most of the measure rates in these domains fell below the national Medicaid 50th percentile.

Validation of Performance Improvement Projects

For the 2017–2018 PIP, **Blue Cross Complete of Michigan** submitted baseline data for the state-mandated topic, *Addressing Disparities in Timeliness of Prenatal Care.* **Blue Cross Complete of Michigan** analyzed historical data and identified a disparity related to timeliness of prenatal care among its African-American and Caucasian women residing in Wayne County. The goal of **Blue Cross Complete of Michigan**'s PIP is to improve the timeliness of prenatal care for the African-American population in Wayne County and eliminate the identified disparity without a decline in performance for the Caucasian women.

Table 5-11 outlines the study indicators for the PIP.

Table 5-11—Study Indicators

PIP Topic	Study Indicators
Addressing Disparities in Timeliness of Prenatal Care	1. The percentage of eligible African-American women residing in Wayne County who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year. 2. The percentage of eligible Caucasian women residing in Wayne County who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.

Table 5-12 displays the validation results for **Blue Cross Complete of Michigan**'s PIP. This table illustrates the MHP's overall application of the PIP process and success in implementing the PIP. 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 5-12 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 5-12—Performance Improvement Project Validation Results for Blue Cross Complete of Michigan

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% (2/2)	0% (0/2)	0% (0/2)
	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% (9/9)**	**0% (0/9)**	**0% (0/9)**

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	100% (4/4)	0% (0/4)	0% (0/4)
Implementation Total			**100% (7/7)**	**0% (0/7)**	**0% (0/7)**
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% (16/16)**		

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

For the baseline measurement period, **Blue Cross Complete of Michigan** reported that 59.3 percent of eligible African-American women received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment, and 65.8 percent of eligible Caucasian women received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment. The goal for the PIP is that there will no longer be a statistically significant rate difference between the two subgroups.

Strengths, Weaknesses, and Overall Conclusions

Blue Cross Complete of Michigan demonstrated both strengths and weaknesses based on the results of the 2017–2018 EQR activities. **Blue Cross Complete of Michigan** received a total compliance score of 97 percent across all program areas reviewed during the 2017–2018 compliance review. **Blue Cross Complete of Michigan** scored 100 percent in the Administrative, Members, Quality, MIS, and Program Integrity standards, indicating strong performance in these program areas, but did not perform as well in the Providers standard, as demonstrated by moderate performance score (87 percent), reflecting that additional focus is needed in this area. While nine of the 59 HEDIS performance measure rates were ranked at or above the national Medicaid 75th percentile, indicating strengths in these areas, 24 HEDIS measure rates fell below the national Medicaid 50th percentile, indicating opportunities for improvement primarily in Child & Adolescent Care, Access to Care, Pregnancy Care, and Living With Illness domains.

Blue Cross Complete 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 5-13—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: Received a performance score of 100 percent in the Administrative program area, indicating that the MHP had adequate staffing and oversight mechanisms in place to ensure the delivery of quality services to its members. • Strength: Received a performance score of 100 percent in the Quality program area, indicating that the MHP had the components of an effective QAPIP in place to assess and improve the quality of services provided to members. • Strength: Received a performance score of 100 percent in the MIS program area, indicating that the MHP maintained a health information system that is capable of collecting, analyzing, integrating, and reporting data to meet the obligations under its contract with MDHHS and, therefore, the ability to appropriately monitor the quality of services being provided to members. • Strength: Received a performance score of 100 percent in the Program Integrity standard during the compliance review, indicating the MHP's program integrity processes are compliant with federal and State regulations, and contracted providers have been appropriately screened and meet the MHP's expectations for a quality provider. • Strength: 100 percent of the MHP's PIP Design and Implementation stages evaluation elements received a score of *Met*, indicating the MHP is on track to effectively address disparities in timeliness of prenatal care services. • Strength: All three rates under the *Chlamydia Screening in Women* HEDIS measure were between the national Medicaid 50th and 89th percentiles, with two rates between the 75th to 89th percentiles, indicating women are being screened for this sexually transmitted disease. • Strength: Two rates under the Obesity domain, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, BMI Percentile—Total* and *Adult BMI Assessment* were between the national Medicaid 75th to 89th percentiles, indicating children's, adolescents', and adults' BMIs were assessed by a PCP or OB/GYN during a medical appointment, and physicians can identify at-risk members and provide suggestions and services to assist them in obtaining and maintaining a healthier weight. • Strength: The two rates under the *Antidepressant Medication Management* HEDIS performance measure (*Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*) met or exceeded the national Medicaid 90th percentile, indicating adult members diagnosed with major depression were receiving effective medication treatment to improve their daily functioning and wellbeing. • Strength: The two rates under the *Medication Management for People With Asthma* HEDIS performance measure ranked at or above the national Medicaid 90th percentile, indicating adult and child members diagnosed with persistent asthma were

Performance Area*	Overall Performance Impact
	dispensed appropriate asthma controller medications and remained on the medications for the majority of their treatment period, likely resulting in fewer ED visits, hospital stays, and missed days of work or school. • Weakness: Although the MHP demonstrated strength in its members being dispensed and remaining on asthma controller medications through treatment, the *Asthma Medication Ratio—Total* measure rate was below the 50th percentile, indicating an opportunity to improve the ratio of controller medications to total asthma medications and reducing the prevalence of asthma attacks. • Weakness: Al six rates under the *Comprehensive Diabetes Care* HEDIS performance measure fell below the national Medicaid 75th percentile, with three of the rates falling between the 25th to 49th percentiles (*Hemoglobin A1c [HbA1c] Testing*, *HbA1c Poor Control [>9.0%]*, and *HbA1c Control [<8.0%]*). • Weakness: The *Controlling High Blood Pressure* HEDIS performance measure rate fell below the national Medicaid 25th percentile, indicating opportunities to assist members with managing their high blood pressure to help prevent heart attacks, stroke, and kidney disease. • Weakness: The *Diabetes Monitoring for People With Diabetes and Schizophrenia* HEDIS performance measure rate fell below the national Medicaid 25th percentile, indicating members diagnosed with schizophrenia and diabetes did not always receive an LDL-C and an HbA1c test during the year, and therefore may have an increased risk for declining health. • Weakness: The *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* HEDIS performance measure rate under the Living With Illness domain fell between the national Medicaid 25th and 49th percentiles, indicating adult members diagnosed with schizophrenia and cardiovascular disease did not receive an LDL-C test, and therefore did not receive appropriate screening and monitoring to detect any decline in health. • Weakness: The *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* HEDIS performance measure rate under the Living With Illness domain fell between the national Medicaid 25th and 49th percentiles, indicating members may be at risk for relapse or even hospitalization due to medication nonadherence. • Weakness: Two rates under the *Annual Monitoring for Patients on Persistent Medications* HEDIS performance measure fell between the national Medicaid 25th and 49th percentiles, indicating members may be at risk for adverse drug events.

Performance Area*	Overall Performance Impact
Timeliness	• Strength: Received a performance score of 100 percent in the Members program area, indicating members received member materials, including an ID card, in a timely manner, to have information available to access services as soon as needed. • Strength: The *Immunizations for Adolescents—Combination 1* HEDIS performance measure rate met or exceeded the National Medicaid 90th percentile, indicating adolescents 13 years of age are receiving recommended vaccinations to prevent diseases, including meningococcal meningitis, tetanus, diphtheria, pertussis, and human papillomavirus. • Weakness: All nine HEDIS *Childhood Immunization Status* performance measure rates fell below the national Medicaid 75th percentile, with one rate (*Combination 2*) falling between the national Medicaid 25th and 49th percentiles, indicating children are not always receiving vaccines in a timely manner to protect them from serious and potentially life-threatening illnesses. • Weakness: The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* HEDIS performance measure rate within the Child & Adolescent Care domain fell between the national Medicaid 25th and 49th percentiles, indicating children between the ages of 3 and 6 are not seeing their PCPs as often as suggested to ensure timely assessment of their health and development. • Weakness: The two HEDIS performance measure rates under the Pregnancy Care domain, *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Prenatal and Postpartum Care—Postpartum Care*, fell below the national Medicaid 50th percentile with *Postpartum Care* falling below the 25th percentile, indicating pregnant women are not always accessing timely prenatal care and/or having a timely postpartum visit after delivery, which could impact the health of the member and her baby before, during, and after pregnancy.
Access	• Weakness: Received a performance score of 87 percent in the Providers program area, indicating members may experience challenges locating and accessing providers to obtain treatment. • Weakness: All rates under the *Children and Adolescents' Access to Primary Care Practitioners* HEDIS performance measure fell below the national Medicaid 50th percentile, with the *Ages 25 Months to 6 Years* rate falling below the national Medicaid 25th percentile, indicating children and adolescents were not always accessing primary care services for appropriate screenings, treatment, and preventive services. • Weakness: All rates under the *Adults' Access to Preventive/Ambulatory Health Services* HEDIS performance measure fell below the national Medicaid 50th percentile, indicating many members 20 years and older were not accessing ambulatory or preventive care services from their physicians. • Weakness: The *Ambulatory Care—Total (Per 1,000 Member Months), ED Visits—Total* HEDIS performance measure rate under the Utilization domain fell between the national Medicaid 25th and 49th percentiles, indicating potential inadequate access to care resulting in preventable ED visits.

* Performance impacts may be applicable to one or more performance areas; however, for this report they were aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which MHPs addressed the EQR recommendations made from the prior year's technical report. During the 2016–2017 EQR, HSAG made the following recommendations to **Blue Cross Complete of Michigan**, and **Blue Cross Complete of Michigan** addressed these recommendations by taking the following actions:

Compliance Monitoring

For the 2016–2017 review period, HSAG recommended that **Blue Cross Complete of Michigan** develop QI initiatives to address the opportunities for improvement identified during the annual compliance review. HSAG also recommended that **Blue Cross Complete of Michigan** focus on the Providers standard, its lowest-scoring standard, with two *Fail* findings and a compliance score of 87 percent.

The 2016–2017 compliance review identified opportunities for improvement for the Providers and Program Integrity standards. **Blue Cross Complete of Michigan**'s 2017–2018 compliance review findings indicate that one of the three deficiencies in the following category was sufficiently addressed: *Tips and Grievances Form*. Two of the three deficiencies during the 2016–2017 review period received similar findings during the 2017–2018 review period and are described below. These findings indicate that **Blue Cross Complete of Michigan** partially addressed the prior year's recommendations.

Table 5-14—Congruent Year-Over-Year Findings

Category	2016–2017 Findings	2017–2018 Findings
MHP Provider Directory	**Blue Cross Complete of Michigan**'s online provider directory and/or provider availability was not current based on the information obtained from calls made to primary care providers in February and August 2017 to check for accurate provider availability.	**Blue Cross Complete of Michigan** received similar findings, as the provider directory and/or provider availability was not current based on a random sample of calls made to PCPs in February and August 2018 to check for accurate provider availability.

Validation of Performance Measures

The 2016–2017 validation of performance measures for **Blue Cross Complete of Michigan** identified opportunities for improvement in the following performance measures, as these measures fell below the national Medicaid 25th percentile:

Pregnancy Care

- *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits*

Living With Illness

- *Controlling High Blood Pressure*

HSAG recommended that **Blue Cross Complete of Michigan** focus on ensuring the completeness and accuracy of data used for calculating all HEDIS measures, and specifically on improving the rates for measures that fell below the national Medicaid 25th percentile. While the *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits* rate was not included in the 2017–2018 PMV, the *Controlling High Blood Pressure* HEDIS performance measure rate remained below the national Medicaid 25th percentile, indicating **Blue Cross Complete of Michigan** did not fully address the prior recommendations.

Validation of Performance Improvement Projects

For the 2016–2017 validation, **Blue Cross Complete of Michigan** designed a scientifically sound project supported by the use of key research principles, meeting 100 percent of the requirements in the Design stage. The technical design of the PIP was sufficient to measure and monitor PIP outcomes; therefore, there were no required follow-up recommendations.

Recommendations

As a result of the findings related to quality of, timeliness of, and access to care and services provided by **Blue Cross Complete of Michigan** to members, HSAG recommends that **Blue Cross Complete of Michigan** incorporate improvement efforts for the following performance measures rating below the national Medicaid 25th percentile as part of its QI strategy within the QAPIP:

Access to Care

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years*

Pregnancy Care

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Living With Illness

- *Controlling High Blood Pressure*
- *Diabetes Monitoring for People With Diabetes and Schizophrenia*

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

1. What were the root causes associated with rates indicating low performance?
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 **Blue Cross Complete of Michigan** considering or has already implemented to improve rates and performance for each identified measure?

Based on the information presented, **Blue Cross Complete of Michigan** should include the following within its QI plan:

- Measurable goals and benchmarks for each 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
- QI interventions that address the root cause of the deficiency
- A plan to monitor the QI interventions to detect whether they effect improvement

HSAG also recommends that **Blue Cross Complete of Michigan** adhere to all federal managed care requirements listed under 42 CFR 438 Subpart D and the QAPIP requirements under Subpart E, State of Michigan contract requirements, and specifically, develop meaningful plans of action to bring into compliance the following deficient program area:

- Providers

Blue Cross Complete of Michigan should include the following in each of its plans of action, and the plans of action should be provided to MDHHS as requested:

- Detailed narrative of the deficiency
- Detailed corrective action steps to resolve each deficiency
- Any resources required to resolve the deficiency
- Due dates for completing each action step
- Assigned party responsible for completing each action step
- Any required deliverables to show that a deficiency has been resolved
- Any dependencies to resolve deficiencies

Finally, **Blue Cross Complete of Michigan** should take proactive steps to ensure a successful PIP. As the PIP progresses, **Blue Cross Complete of Michigan** should ensure the following:

- Follow the approved PIP methodology to calculate and report data accurately in next year's annual submission.
- To impact the Remeasurement 1 study indicator rate, 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 will not have enough time to impact the study indicator rate.
- Document the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.

HAP Midwest Health Plan

To conduct the 2017–2018 EQR, HSAG reviewed **HAP Midwest Health Plan**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **HAP Midwest Health Plan**.

EQR Activity Results

Compliance Monitoring

HAP Midwest Health Plan was evaluated in six program areas referred to as standards. Table 5-15 presents the total number of criteria for each standard as well as the number of criteria for each standard that received a score of *Pass*, *Incomplete*, or *Fail*. Table 5-15 also presents **HAP Midwest Health Plan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages.

Table 5-15—Compliance Review Results for HAP Midwest Health Plan (MID)

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	*Total Applicable*	MID	Statewide
1	Administrative	4	1	0	5	90%	97%
2	Providers	12	1	2	15	83%	87%
3	Members	8	0	0	8	100%	98%
4	Quality	12	1	0	13	96%	99%
5	MIS	9	1	0	10	95%	99%
6	Program Integrity	15	12	1	28	75%	92%
Overall		**60**	**16**	**3**	**79**	**86%**	**94%**

The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

HAP Midwest Health Plan demonstrated compliance for 60 of 79 elements, with an overall compliance score of 86 percent, which was below the statewide average. **HAP Midwest Health Plan** demonstrated strong performance, scoring at or above 90 percent in four standards, with one standard (Members) achieving full compliance. These program areas of strength include the Administrative, Members, Quality, and MIS standards.

Opportunities for improvement were identified in five of the six standards, which are briefly described below:

- *Governing Body*—**HAP Midwest Health Plan** sent a list of board members with term length; however, it did not distinguish which members of the board were health plan members. The contract requires that at least one-third of **HAP Midwest Health Plan**'s governing body be representatives of its membership consisting of health plan members.
- *MHP Provider Directory*—MDHHS conducted a random sample of calls to PCPs to check for accurate provider availability. The findings, as reported by MDHHS, are summarized below:

Table 5-16—Provider Directory Findings

February 2018	August 2018
• 24 percent of providers had the correct information listed in the online directory and confirmed they were accepting new patients	• 46 percent of providers had the correct information listed in the online directory and confirmed they were accepting new patients • 90 percent of providers matched what was submitted on the 4275 for "accepting new patients" • 95 percent of providers appeared to have matching contact information online and on the 4275 • 2 providers were unable to be reached

- *Provider Network—MHP demonstrates that covered services are available and accessible*—**HAP Midwest Health Plan** did not submit much of the required information for this criterion.
- *QIP Evaluation and Work Plan; UM Program and Effectiveness Review*—MDHHS did not find where improving access to dental care was documented on the Annual Quality Program Worksheet. MDHHS could not find anything related to dental. **HAP Midwest Health Plan** also did not have any information on prior authorization decisions related to Children's Special Health Care Services (CSHCS) members.
- *Consolidated Annual Report*—**HAP Midwest Health Plan** was required to resubmit all of the PIP Disclosure Forms and appropriately respond to all questions according to the instructions.
- *Health Information Exchange/Health Information Technology (HIE/HIT)*—**HAP Midwest Health Plan** did not submit their HIE/HIT submission.
- *Tips and Grievances Form*—Errors and/or discrepancies were noted on the form for three quarters.
- *Data Mining/Algorithms Form*—Errors and/or discrepancies were noted on the form for two quarters.
- *Audits Form*—Errors and/or discrepancies were noted on the form for two quarters.
- *Provider Disenrollments*—Errors and/or discrepancies were noted on the form for three quarters.
- *Overpayments Collected Forms*—Errors and/or discrepancies were noted on the form for two quarters.
- *OIG [Office of Inspector General] Program Integrity—Compliance Plan*—**HAP Midwest Health Plan** did not submit documentation that demonstrates compliance with this criterion. **HAP Midwest Health Plan** was required to submit a Special Investigations Organization Chart that included the

titles of the individuals on the chart as well as the workflow/reporting responsibilities, indicating to whom each person on the chart reports.

HAP Midwest Health Plan was required to develop and implement a CAP for each requirement in all program areas that received an *Incomplete* or a *Fail* finding.

Validation of Performance Measures

HAP Midwest Health Plan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the 2018 HEDIS Compliance Audit Report findings, **HAP Midwest Health Plan** was fully compliant with all IS standards, including:

- IS 1.0: Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry
- IS 2.0: Enrollment Data—Data Capture, Transfer and Entry
- IS 3.0: Practitioner Data—Data Capture, Transfer and Entry
- IS 4.0: Medical Record Review Processes—Training, Sampling, Abstraction and Oversight
- IS 5.0: Supplemental Data—Capture, Transfer and Entry
- IS 7.0: Data Integration—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity

According to the auditors' review, **HAP Midwest Health Plan**'s submitted measures were prepared according to the NCQA HEDIS 2018 technical specifications. No rates were determined to be materially biased.

Table 5-17 shows each of the measures, the rate for each measure for 2018, and the categorized performance for 2018 relative to national HEDIS 2017 Medicaid results for **HAP Midwest Health Plan**.

Table 5-17—Scores for Performance Measures for HAP Midwest Health Plan

Measure	HEDIS 2018	2018 Performance Level
Child & Adolescent Care		
Childhood Immunization Status		
Combination 2	NA	NC
Combination 3	NA	NC
Combination 4	NA	NC
Combination 5	NA	NC
Combination 6	NA	NC
Combination 7	NA	NC
Combination 8	NA	NC
Combination 9	NA	NC
Combination 10	NA	NC

Measure	HEDIS 2018	2018 Performance Level
Well-Child Visits in the First 15 Months of Life		
Six or More Visits	NA	NC
Lead Screening in Children		
Lead Screening in Children	NA	NC
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	57.14%	★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	31.03%	★
Immunizations for Adolescents		
Combination 1	NA	NC
Appropriate Treatment for Children With Upper Respiratory Infection		
Appropriate Treatment for Children With Upper Respiratory Infection	81.08%	★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	NA	NC
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	NA	NC
Continuation and Maintenance Phase	NA	NC
Women—Adult Care		
Breast Cancer Screening[1]		
Breast Cancer Screening	55.41%	NC
Cervical Cancer Screening		
Cervical Cancer Screening	52.93%	★★
Chlamydia Screening in Women		
Ages 16 to 20 Years	NA	NC
Ages 21 to 24 Years	52.08%	★
Total	57.53%	★★★
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	76.09%	★
Ages 25 Months to 6 Years	66.87%	★
Ages 7 to 11 Years	74.19%	★
Ages 12 to 19 Years	70.83%	★
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44 Years	70.18%	★
Ages 45 to 64 Years	89.20%	★★★★
Ages 65+ Years	87.67%	★★★
Total	83.48%	★★★

Measure	HEDIS 2018	2018 Performance Level
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	35.09%	★★★★
Obesity		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	73.86%	★★★
Counseling for Nutrition—Total	64.20%	★★
Counseling for Physical Activity—Total	56.25%	★★
Adult BMI Assessment		
Adult BMI Assessment	91.28%	★★★★
Pregnancy Care		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	55.74%	★
Postpartum Care	59.02%	★
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	85.16%	★★
*HbA1c Poor Control (>9.0%)**	37.47%	★★★
HbA1c Control (<8.0%)	52.31%	★★★
Eye Exam (Retinal) Performed	59.37%	★★★
Medical Attention for Nephropathy	92.94%	★★★★
Blood Pressure Control (<140/90 mm Hg)	60.58%	★★
Medication Management for People With Asthma		
Medication Compliance 50%—Total[2]	77.78%	★★★★★
Medication Compliance 75%—Total	72.22%	★★★★★
Asthma Medication Ratio		
Total	25.86%	★
Controlling High Blood Pressure		
Controlling High Blood Pressure	51.14%	★★
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit	83.27%	★★★★★
Discussing Cessation Medications	60.65%	★★★★★
Discussing Cessation Strategies	48.01%	★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	52.67%	★★★
Effective Continuation Phase Treatment	33.59%	★★

Measure	HEDIS 2018	2018 Performance Level
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	72.79%	★
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	71.43%	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NC
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	71.14%	★★★★★
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	85.45%	★
Diuretics	85.65%	★★
Total[l]	85.53%	NC
Health Plan Diversity[3]		
Race/Ethnicity Diversity of Membership		
Total—White	47.76%	NC
Total—Black or African American	35.71%	NC
Total—American-Indian and Alaska Native	0.00%	NC
Total—Asian	2.04%	NC
Total—Native Hawaiian and Other Pacific Islander	0.21%	NC
Total—Some Other Race	2.72%	NC
Total—Two or More Races	0.00%	NC
Total—Unknown	11.57%	NC
Total—Declined	0.00%	NC
Total—Hispanic or Latino	2.72%	NC
Language Diversity of Membership		
Spoken Language Preferred for Health Care—English	100.00%	NC
Spoken Language Preferred for Health Care—Non-English	0.00%	NC
Spoken Language Preferred for Health Care—Unknown	0.00%	NC
Spoken Language Preferred for Health Care—Declined	0.00%	NC
Preferred Language for Written Materials—English	100.00%	NC
Preferred Language for Written Materials—Non-English	0.00%	NC
Preferred Language for Written Materials—Unknown	0.00%	NC
Preferred Language for Written Materials—Declined	0.00%	NC
Other Language Needs—English	100.00%	NC

Measure	HEDIS 2018	2018 Performance Level
Other Language Needs—Non-English	0.00%	NC
Other Language Needs—Unknown	0.00%	NC
Other Language Needs—Declined	0.00%	NC
Utilization[3]		
Ambulatory Care—Total (Per 1,000 Member Months)		
*ED Visits—Total**	71.25	★★
Outpatient Visits—Total	506.48	NC
Inpatient Utilization—General Hospital/Acute Care—Total		
Total Inpatient—Discharges per 1,000 Member Months—Total	12.18	NC
Total Inpatient—Average Length of Stay—Total	5.80	NC
Maternity—Discharges per 1,000 Member Months—Total	1.19	NC
Maternity—Average Length of Stay—Total	3.03	NC
Surgery—Discharges per 1,000 Member Months—Total	2.94	NC
Surgery—Average Length of Stay—Total	8.07	NC
Medicine—Discharges per 1,000 Member Months—Total	8.52	NC
Medicine—Average Length of Stay—Total	5.25	NC
Use of Opioids From Multiple Providers (Per 1,000 Members)*		
Use of Opioids From Multiple Providers—Multiple Prescribers	169.54	NC
Use of Opioids From Multiple Providers—Multiple Pharmacies	48.67	NC
Use of Opioids From Multiple Providers—Multiple Prescribers and Multiple Pharmacies	28.26	NC
Use of Opioids at High Dosage (Per 1,000 Members)*		
Use of Opioids at High Dosage	0.00	NC

[1] Due to changes in the technical specifications for this measure in HEDIS 2018, comparisons to benchmarks were not performed for this measure.
[2] Performance levels for 2018 were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.
[3] These measure indicator rates and any comparisons to benchmarks for these measures are provided for information only.
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table 5-17 shows that, due to small membership, 17 out of 59 measure rates (28.8 percent) for **HAP Midwest Health Plan** received an *NA (Small Denominator)* audit designation, indicating denominators were too small to report a valid rate. Nine out of the 42 reportable measure rates (21.4 percent) ranked at or above the national Medicaid 75th percentile, with five rates ranking at or above the national Medicaid 90th percentile. All five measure rates that ranked at or above the national Medicaid 90th percentile were in the Living With Illness domain, including both *Medication Management for People With Asthma* indicators, *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Medications,* and *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*. Conversely, 23 out of 42 reportable measure rates (54.8 percent) fell below the national Medicaid 50th percentile, 14 of which were below the national Medicaid 25th percentile. Measure rates that fell below the national Medicaid 25th percentile spanned multiple domains, including Child & Adolescent Care, Women—Adult Care, Access to Care, Pregnancy Care, and Living With Illness. These measure rates present opportunities for improvement for **HAP Midwest Health Plan**, especially in the area of Living With Illness where many of the measure rates fell below the national Medicaid 50th percentile.

Validation of Performance Improvement Projects

For the 2017–2018 PIP, **HAP Midwest Health Plan** submitted baseline data for the state-mandated topic, *Addressing Disparities in Timeliness of Prenatal Care.* **HAP Midwest Health Plan** analyzed historical data to identify potential disparity within its population related to timeliness of prenatal care. However, due to **HAP Midwest Health Plan**'s small population, no disparity was identified. **HAP Midwest Health Plan** determined through data analysis that its focus and goal for the PIP needed to be improving the timeliness of prenatal care for its Black population. MDHHS approved the topic selection.

Table 5-18 outlines the study indicator for the PIP.

Table 5-18—Study Indicator

PIP Topic	Study Indicator
Improving the Timeliness of Prenatal Care for Black Women	The percentage of eligible Black women who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.

Table 5-19 displays the validation results for **HAP Midwest Health Plan**'s PIP. This table illustrates the MHP's overall application of the PIP process and success in implementing the PIP. 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 5-19 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 5-19—Performance Improvement Project Validation Results for HAP Midwest Health Plan

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% (2/2)	0% (0/2)	0% (0/2)
	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% (10/10)**	**0% (0/10)**	**0% (0/10)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
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% (19/19)**		

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

For the baseline measurement period, **HAP Midwest Health Plan** reported that 48.2 percent of eligible Black women received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment. The goal for the PIP was set at 83.6 percent.

Strengths, Weaknesses, and Overall Conclusions

HAP Midwest Health Plan demonstrated both strengths and weaknesses based on the results of the 2017–2018 EQR activities. **HAP Midwest Health Plan** received a total compliance score of 86 percent across all program areas reviewed during the 2017–2018 compliance review. **HAP Midwest Health Plan** scored 90 percent or above in the Administrative, Members, Quality, and MIS standards, indicating generally strong performance in these program areas, but did not perform as well in the Providers and Program Integrity standards, as demonstrated by moderate performance scores (83 percent and 75 percent, respectively), reflecting that additional focus is needed in these areas. While nine of the 42 HEDIS performance measure rates were ranked at or above the national Medicaid 75th percentile, indicating strengths in these areas, 23 HEDIS measure rates fell below the national Medicaid 50th percentile, indicating opportunities for improvement primarily in the Living With Illness domain.

HAP Midwest 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 5-20—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: Received a performance score of 96 percent in the Quality program area, indicating that the MHP had most components of an effective QAPIP in place to assess and improve the quality of services provided to members. • Strength: Received a performance score of 95 percent in the MIS program area, indicating that overall the MHP maintained a health information system that is capable of collecting, analyzing, integrating, and reporting data to meet the obligations under its contract with MDHHS and, therefore, the ability to appropriately monitor the quality of services being provided to members. • Strength: The *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* HEDIS performance measure rate ranked at or above the national Medicaid 75th percentile, indicating many adults diagnosed with acute bronchitis were not dispensed an antibiotic which helps avoid harmful side-effects and possible resistance to antibiotics. • Strength: The rate for the *Adult BMI Assessment* HEDIS performance measure was between the national Medicaid 75th and 89th percentiles, indicating many adults received a BMI screening which help providers identify adults who are at risk and provide suggestions and services to assist them in obtaining a healthier weight. • Strength: One of six rates under the *Comprehensive Diabetes Care* (*Medical Attention for Nephropathy*) HEDIS performance measure was between the national Medicaid

Performance Area*	Overall Performance Impact
	75th and 89th percentiles, indicating many adults received medical attention for nephropathy which is essential to reduce risks for complications. • Strength: The two rates under the *Medication Management for People With Asthma* HEDIS performance measure were at or above the national Medicaid 90th percentile, indicating adults and children received appropriate medication management which could reduce the need for rescue medication as well as reduce ED visits, hospital stays, and missed days of work or school. • Strength: Two of three rates under the *Medical Assistance With Smoking and Tobacco Use Cessation* HEDIS performance measure were at or above the national Medicaid 90th percentile, indicating many adults who are tobacco smokers or users received cessation advice and discussed cessation medications to help quit tobacco and improve overall health. • Strength: The HEDIS performance measure rate for *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* was at or above the national Medicaid 90th percentile, indicating many adults with schizophrenia were dispensed and remained on an antipsychotic for most of their treatment period, which reduces the risk of relapse and complications. • Weakness: Received a performance score of 75 percent in the Program Integrity standard during the compliance review, indicating additional focus may be needed within the MHP's program integrity processes to ensure program requirements are compliant with federal and State regulations. • Weakness: The *Appropriate Treatment for Children With Upper Respiratory Infection* HEDIS performance measure fell below the national Medicaid 25th percentile, indicating many children diagnosed with an upper respiratory infection were prescribed an antibiotic inappropriately which can lead to antibiotic resistant bacteria. • Weakness: The rate for the *Cervical Cancer Screening* HEDIS performance measure fell between the national Medicaid 25th and 49th percentiles, indicating many women were not screened for this type of cancer which is highly treatable if detected early. • Weakness: One of two rates under the *Chlamydia Screening in Women* HEDIS performance measure fell below the national Medicaid 25th percentile, indicating women between the ages of 21 to 24 years were not being screened for this sexually transmitted disease. • Weakness: Two of three rates under the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* HEDIS performance measure fell between the 25th and 49th percentiles, indicating many children did not receive counseling for nutrition or physical activity from their PCP or OB/GYN, which can help lower the risk of becoming obese and developing related diseases. • Weakness: Two of six rates under the *Comprehensive Diabetes Care* HEDIS performance measure fell between the 25th and 49th percentiles, indicating many adults did not receive HbA1c testing or achieve blood pressure control which is essential to control blood glucose and reduce risks for complications.

Performance Area*	Overall Performance Impact
	• Weakness: Although the MHP demonstrated strength in its members being dispensed and remaining on asthma controller medications through treatment, the rate under the *Asthma Medication Ratio—Total* measure was below the 25th percentile, indicating an opportunity to improve the ratio of controller medications to total asthma medications and reducing the prevalence of asthma attacks. • Weakness: The *Controlling High Blood Pressure* HEDIS performance measure rate fell between the national Medicaid 25th and 49th percentiles, indicating opportunities to assist adults with managing their high blood pressure to help prevent heart attacks, stroke, and kidney disease. • Weakness: One of two rates under the *Antidepressant Medication Management* (*Effective Continuation Phase Treatment*) HEDIS performance measure fell between the national Medicaid 25th and 49th percentiles, indicating opportunities for providers to effectively manage the medication treatment of adults diagnosed with major depression. • Weakness: The rate for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* HEDIS performance measure was below the national Medicaid 25th percentile, indicating many adults diagnosed with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication did not have a diabetes screening which is important for screening and/or monitoring of these conditions. • Weakness: One of two rates under the *Annual Monitoring for Patients on Persistent Medications* (*Diuretics)* HEDIS performance measure fell between the national Medicaid 25th and 49th percentiles, and one rate (*ACE Inhibitors or ARBs*) fell below the 25th percentile, indicating many adults may be at risk for adverse drug events.
Timeliness	• Strength: Received a performance score of 100 percent in the Members program area, indicating members received member materials, including an ID card, in a timely manner, to have information available to access services as soon as needed. • Strength: 100 percent of the MHP's PIP Design and Implementation stages evaluation elements received a score of *Met*, indicating the MHP is on track to effectively address timeliness of prenatal care services. • Weakness: The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and the *Adolescent Well-Care Visits* HEDIS performance measures rates fell below the national Medicaid 25th percentile, indicating children between the ages of 3 and 6 and adolescents were not seeing their PCPs as often as suggested to ensure timely assessment of their health and development. • Weakness: The two rates under the *Prenatal and Postpartum Care* measure fell below the national Medicaid 25th percentile, indicating pregnant women were not always accessing timely prenatal care and/or having a timely postpartum visit after delivery, which could impact the health of the member and her baby before, during, and after pregnancy.

Performance Area*	Overall Performance Impact
Access	• Strength: One rate under the *Adults' Access to Preventive/Ambulatory Health Services* HEDIS performance measure fell between the national Medicaid 75th and 89th percentiles, indicating many adults between the ages of 45 and 64 were accessing ambulatory or preventive care services from their physicians. • Weakness: Received a performance score of 83 percent in the Providers program area, indicating members may experience challenges locating and accessing providers to obtain treatment. • Weakness: All four rates under the *Children and Adolescents' Access to Primary Care Practitioners* HEDIS performance measure fell below the national Medicaid 25th percentile, indicating children and adolescents of all ages were not always accessing primary care services for appropriate screenings, treatment, and preventive services. • Weakness: One of four rates under the *Adults' Access to Preventive/Ambulatory Health Services* HEDIS performance measure fell below the national Medicaid 25th percentile, indicating many adults between the ages of 20 and 44 year were not accessing ambulatory or preventive care services from their physicians. • Weakness: The *Ambulatory Care—Total (Per 1,000 Member Months), ED Visits—Total* HEDIS performance measure rate fell between the national Medicaid 25th and 49th percentiles, indicating potential inadequate access to care resulting in preventable ED visits.

* Performance impacts may be applicable to one or more performance areas; however, for this report they were aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which MHPs addressed the EQR recommendations made from the prior year's technical report. During the 2016–2017 EQR, HSAG made the following recommendations to **HAP Midwest Health Plan**, and **HAP Midwest Health Plan** addressed these recommendations by taking the following actions:

Compliance Monitoring

For the 2016–2017 review period, HSAG recommended that **HAP Midwest Health Plan** initiate QI initiatives to address the opportunities for improvement identified during the annual compliance review. HSAG also recommended that **HAP Midwest Health Plan** focus on the Administrative standard, its lowest-scoring standard, with three *Incomplete* findings and a compliance score of 70 percent, and that attention be given to the Quality standard, with four *Incomplete* findings and a compliance score of 82 percent. Additionally, HSAG recommended that **HAP Midwest Health Plan** consider initiating PDSA cycles or PIPs for performance measures that fell below standards for consecutive review periods. Lastly, HSAG recommended that enhanced efforts be made to correct the 2015–2016 deficiencies that were not adequately addressed during the 2016–2017 review period, specifically, in the *Governing Body* and *OIG Program Integrity—Compliance Plan* categories.

The 2016–2017 compliance review identified opportunities for improvement for the Administrative, Providers, Quality, and Program Integrity standards. **HAP Midwest Health Plan**'s 2017–2018 compliance review findings indicate that five of the 12 deficiencies in the following categories were sufficiently addressed: *Organization Chart*, *Administrative Position Descriptions*, *PMR Review*, *Addressing Health Disparities Population Health Mgmt (PHM)*, and *Community Health Worker (CMH) Policy and Procedure*. Seven of the 12 deficiencies during the 2016–2017 review period received similar findings during the 2017–2018 review period and are described below. These findings indicate that **HAP Midwest Health Plan** partially addressed the prior year's recommendations.

Table 5-21—Congruent Year-Over-Year Findings

Category	2016–2017 Findings	2017–2018 Findings
Governing Body	**HAP Midwest Health Plan**'s governing body membership did not include at least one-third representation of health plan members as required by contract.	**HAP Midwest Health Plan** received similar findings as a list of board members with term length was sent; however, it did not distinguish which members of the board are health plan members.
MHP Provider Directory	**HAP Midwest Health Plan**'s online provider directory and/or provider availability was not current based on the information obtained from calls made to primary care providers in February and August 2017 to check for accurate provider availability.	**HAP Midwest Health Plan** received similar findings, as the provider directory and/or provider availability was not current based on a random sample of calls made to PCPs in February and August 2018 to check for accurate provider availability.
QIP Evaluation and Work Plan; UM Program and Effectiveness Review	**HAP Midwest Health Plan**'s Annual Quality Program did not include children in foster care in relation to the Patient-Centered Medical Home (PCMH) Expansion, did not discuss members with disabilities in relation to the evaluation of access to care, or show that **HAP Midwest Health Plan** does not use UM policies and procedures to avoid providing medically necessary services.	While not the same finding, **HAP Midwest Health Plan**'s Annual Quality Program continued to not meet all requirements, specifically, access to dental care and information related to CSHCS members.
Provider Disenrollments Form	**HAP Midwest Health Plan** did not report information on the Activity Report or the Disenrollments tabs of the form, and it did not report the Date of Disenrollment and Effective Date of Disenrollment correctly for a deceased provider.	**HAP Midwest Health Plan** received similar findings as the Provider Disenrollments Form continued to contain errors and/or discrepancies for three quarters.

Category	2016–2017 Findings	2017–2018 Findings
OIG Program Integrity—Compliance Plan	**HAP Midwest Health Plan** did not provide evidence that it provided employees with accurate contact information for fraud, waste, and abuse (FWA) reporting. Additionally, **HAP Midwest Health Plan** had not addressed FWA or provided contact information for reporting in a provider newsletter since 2015. **HAP Midwest Health Plan** also had provided the incorrect mailing address for FWA reporting.	While not the same finding, **HAP Midwest Health Plan**'s Compliance Plan continued to not meet all requirements; specifically, **HAP Midwest Health Plan** was required to submit a Special Investigations Organization Chart that included the titles of the individuals on the chart as well as the workflow/reporting responsibilities, indicating to whom each person on the chart reports.

Validation of Performance Measures

The 2016–2017 validation of performance measures for **HAP Midwest Health Plan** identified opportunities for improvement in the following performance measures, as these measures fell below the national Medicaid 25th percentile:

Child & Adolescent Care

- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Adolescent Well-Care Visits*

Women—Adult Care

- *Chlamydia Screening in Women—Ages 21 to 24 Years* and *Total*

Access to Care

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years*, *Ages 7 to 11 Years,* and *Ages 12 to 19 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years*

Pregnancy Care

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits*

Living With Illness

- *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*, *Diuretics,* and *Total*

Utilization

- *Ambulatory Care—Total (Per 1,000 Member Months)—Emergency Department Visits—Total*

HSAG recommended that **HAP Midwest Health Plan** focus on ensuring the completeness and accuracy of data used for calculating all HEDIS measures, and specifically, on improving the rates for measures that fell below the national Medicaid 25th percentile. Based on the results of the 2017–2018 validation, *Chlamydia Screening in Women—Total*, *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*, *Annual Monitoring for Patients on Persistent Medications—Diuretics,* and *Ambulatory Care—Total (Per 1,000 Member Months)—Emergency Department Visits—Total* improved to rates either between the 25th and 49th percentiles or the 50th and 74th percentiles; however, the remaining performance measure rates with an appropriate comparison and benchmark remained below the national Medicaid 25th percentile, indicating **HAP Midwest Health Plan** partially addressed the prior recommendations.

Validation of Performance Improvement Projects

For the 2016–2017 validation, **HAP Midwest Health Plan** designed a scientifically sound project supported by the use of key research principles, meeting 100 percent of the requirements in the Design stage. The technical design of the PIP was sufficient to measure and monitor PIP outcomes; therefore, there were no required follow-up recommendations.

Recommendations

As a result of the findings related to quality of, timeliness of, and access to care and services provided by **HAP Midwest Health Plan** to members, HSAG recommends that **HAP Midwest Health Plan** incorporate efforts for improvement of the following performance measures rating below the national Medicaid 25th percentile as part of its QI strategy within the QAPIP:

Child & Adolescent Care

- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Adolescent Well-Care Visits*
- *Appropriate Treatment for Children With Upper Respiratory Infection*

Women—Adult Care

- *Chlamydia Screening in Women—Ages 21 to 24 Years*

Access to Care

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months*, *Ages 25 Months to 6 Years*, *Ages 7 to 11 Years,* and *Ages 12 to 19 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years*

Pregnancy Care

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

Living With Illness

- *Asthma Medication Ratio—Total*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*

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

1. What were the root causes associated with rates indicating low performance?
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 Midwest Health Plan** considering or has already implemented to improve rates and performance for each identified measure?

Based on the information presented, **HAP Midwest Health Plan** should include the following within its QI plan:

- Measurable goals and benchmarks for each 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
- QI interventions that address the root cause of the deficiency
- A plan to monitor the QI interventions to detect whether they effect improvement

HSAG also recommends that **HAP Midwest Health Plan** adhere to all federal managed care requirements listed under 42 CFR 438 Subpart D and the QAPIP requirements under Subpart E, State of Michigan contract requirements, and specifically, develop meaningful plans of action to bring into compliance each of the following deficient program areas:

- Administrative
- Providers
- Quality
- MIS
- Program Integrity

HAP Midwest Health Plan should include the following in each of its plans of action, and the plans of action should be provided to MDHHS as requested:

- Detailed narrative of the deficiency
- Detailed corrective action steps to resolve each deficiency
- Any resources required to resolve the deficiency
- Due dates for completing each action step
- Assigned party responsible for completing each action step
- Any required deliverables to show that a deficiency has been resolved
- Any dependencies to resolve deficiencies

Finally, **HAP Midwest Health Plan** should take proactive steps to ensure a successful PIP. As the PIP progresses, **HAP Midwest Health Plan** should ensure the following:

- Follow the approved PIP methodology to calculate and report data accurately in next year's annual submission.
- To impact the Remeasurement 1 study indicator rate, 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 will not have enough time to impact the study indicator rate.
- Document the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.

Harbor Health Plan

To conduct the 2017–2018 EQR, HSAG reviewed **Harbor Health Plan**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Harbor Health Plan**.

EQR Activity Results

Compliance Monitoring

Harbor Health Plan was evaluated in six program areas referred to as standards. Table 5-22 presents the total number of criteria for each standard as well as the number of criteria for each standard that received a score of *Pass*, *Incomplete*, or *Fail*. Table 5-22 also presents **Harbor Health Plan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages.

Table 5-22—Compliance Review Results for Harbor Health Plan (HAR)

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	*Total Applicable*	HAR	Statewide
1	Administrative	4	1	0	5	90%	97%
2	Providers	10	2	3	15	73%	87%
3	Members	7	1	0	8	94%	98%
4	Quality	13	0	0	13	100%	99%
5	MIS	9	1	0	10	95%	99%
6	Program Integrity	22	6	0	28	89%	92%
Overall		**65**	**11**	**3**	**79**	**89%**	**94%**

The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

Harbor Health Plan demonstrated compliance for 65 of 79 elements, with an overall compliance score of 89 percent which was below the statewide average. **Harbor Health Plan** demonstrated strong performance, scoring at or above 90 percent in four standards, with one standard (Quality) achieving full compliance. The program areas of strength include the Administrative, Members, Quality, and MIS standards.

Opportunities for improvement were identified in five of the six standards which are briefly described below:

- *Administrative Position*—**Harbor Health Plan** did not submit the change in personnel for its chief financial officer (CFO) and Management Information Systems (MIS) director within the allotted seven-day time frame according to the contract.
- *Standard Provider Contract Format Table*—**Harbor Health Plan** did not complete the Provider Contract table or submit an attestation indicating that there was no change in the contract.
- *Pharmacy Contracts*—**Harbor Health Plan** did not submit its policy and procedure for this criterion.
- *MHP Provider Directory*—MDHHS conducted a random sample of calls to PCPs to check for accurate provider availability. The findings, as reported by MDHHS, are summarized below:

Table 5-23—Provider Directory Findings

February 2018	August 2018
• 50 percent of providers had the correct information listed in the online directory and confirmed they were accepting new patients.	• 21 percent of providers had the correct information listed in the online directory and confirmed they were accepting new patients • 37 percent of providers matched what was submitted on the 4275 for "accepting new patients" • 29 percent of providers appeared to have matching contact information online and on the 4275 • 2 providers were unable to be reached

- *Provider Network—MHP demonstrates that covered services are available and accessible*—**Harbor Health Plan** did not submit the Network Access Plan.
- *Written Member Appeal Decisions Rendered*—**Harbor Health Plan** submitted logs with none of the requested information.
- *MIS Health Plan maintains an Information System that collects, analyzes, integrates, and reports data as required by MDHHS*—**Harbor Health Plan** did not include the operational plans for its provider enrollment, the newborn tracking and enrollment, or the quality report for tracking Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), immunization, and members satisfaction related to access.
- *Tips and Grievances Form*—Errors and/or discrepancies were noted on the form for one quarter.
- *Data Mining/Algorithms Form*—Errors and/or discrepancies were noted on the form for two quarters.
- *Audits Form*—Errors and/or discrepancies were noted on the form for two quarters.
- *Provider Disenrollments Form*—Errors and/or discrepancies were noted on the form for one quarter.

Harbor Health Plan was required to develop and implement a CAP for each requirement in all program areas that received an *Incomplete* or a *Fail* finding.

Validation of Performance Measures

Harbor Health Plan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the 2018 HEDIS Compliance Audit Report findings, **Harbor Health Plan** was fully compliant with all IS standards, including:

- IS 1.0: Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry
- IS 2.0: Enrollment Data—Data Capture, Transfer and Entry
- IS 3.0: Practitioner Data—Data Capture, Transfer and Entry
- IS 4.0: Medical Record Review Processes—Training, Sampling, Abstraction and Oversight
- IS 5.0: Supplemental Data—Capture, Transfer and Entry
- IS 7.0: Data Integration—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity

According to the auditors' review, **Harbor Health Plan**'s submitted measures were prepared according to the NCQA HEDIS 2018 technical specifications. No rates were determined to be materially biased.

Table 5-24 shows each of the measures, the rate for each measure for 2018, and the categorized performance for 2018 relative to national HEDIS 2017 Medicaid results for **Harbor Health Plan**.

Table 5-24—Scores for Performance Measures for Harbor Health Plan

Measure	HEDIS 2018	2018 Performance Level
Child & Adolescent Care		
Childhood Immunization Status		
Combination 2	59.48%	★
Combination 3	52.94%	★
Combination 4	51.63%	★
Combination 5	42.48%	★
Combination 6	20.92%	★
Combination 7	41.83%	★
Combination 8	20.92%	★
Combination 9	18.95%	★
Combination 10	18.95%	★

Measure	HEDIS 2018	2018 Performance Level
Well-Child Visits in the First 15 Months of Life		
Six or More Visits	43.86%	★
Lead Screening in Children		
Lead Screening in Children	72.55%	★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	61.31%	★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	30.41%	★
Immunizations for Adolescents		
Combination 1	75.00%	★★
Appropriate Treatment for Children With Upper Respiratory Infection		
Appropriate Treatment for Children With Upper Respiratory Infection	93.81%	★★★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	72.22%	★★
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	NA	NC
Continuation and Maintenance Phase	NA	NC
Women—Adult Care		
Breast Cancer Screening[1]		
Breast Cancer Screening	65.46%	NC
Cervical Cancer Screening		
Cervical Cancer Screening	47.20%	★
Chlamydia Screening in Women		
Ages 16 to 20 Years	73.47%	★★★★★
Ages 21 to 24 Years	73.83%	★★★★★
Total	73.66%	★★★★★
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	82.46%	★
Ages 25 Months to 6 Years	69.86%	★
Ages 7 to 11 Years	77.50%	★
Ages 12 to 19 Years	69.13%	★

Measure	HEDIS 2018	2018 Performance Level
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44 Years	50.05%	★
Ages 45 to 64 Years	70.72%	★
Ages 65+ Years	NA	NC
Total	58.62%	★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	30.00%	★★★
Obesity		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	70.32%	★★
Counseling for Nutrition—Total	66.67%	★★
Counseling for Physical Activity—Total	46.96%	★
Adult BMI Assessment		
Adult BMI Assessment	71.07%	★
Pregnancy Care		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	35.34%	★
Postpartum Care	46.55%	★
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	77.61%	★
*HbA1c Poor Control (>9.0%)**	53.07%	★
HbA1c Control (<8.0%)	40.18%	★
Eye Exam (Retinal) Performed	41.41%	★
Medical Attention for Nephropathy	88.04%	★
Blood Pressure Control (<140/90 mm Hg)	39.26%	★
Medication Management for People With Asthma		
Medication Compliance 50%—Total[2]	69.70%	★★★★
Medication Compliance 75%—Total	36.36%	★★★
Asthma Medication Ratio		
Total	58.54%	★★

Measure	HEDIS 2018	2018 Performance Level
Controlling High Blood Pressure		
Controlling High Blood Pressure	28.71%	★
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit	80.79%	★★★★
Discussing Cessation Medications	63.16%	★★★★★
Discussing Cessation Strategies	52.61%	★★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	57.69%	★★★★
Effective Continuation Phase Treatment	42.31%	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.33%	★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	NA	NC
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NC
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NA	NC
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	85.17%	★
Diuretics	83.83%	★
Total[1]	84.56%	NC
Health Plan Diversity[3]		
Race/Ethnicity Diversity of Membership		
Total—White	27.17%	NC
Total—Black or African American	51.38%	NC
Total—American-Indian and Alaska Native	0.12%	NC
Total—Asian	0.00%	NC
Total—Native Hawaiian and Other Pacific Islander	0.99%	NC
Total—Some Other Race	3.96%	NC
Total—Two or More Races	0.00%	NC
Total—Unknown	16.38%	NC

Measure	HEDIS 2018	2018 Performance Level
Total—Declined	0.00%	NC
Total—Hispanic or Latino	3.96%	NC
Language Diversity of Membership		
Spoken Language Preferred for Health Care—English	98.98%	NC
Spoken Language Preferred for Health Care—Non-English	0.99%	NC
Spoken Language Preferred for Health Care—Unknown	0.03%	NC
Spoken Language Preferred for Health Care—Declined	0.00%	NC
Preferred Language for Written Materials—English	0.00%	NC
Preferred Language for Written Materials—Non-English	0.00%	NC
Preferred Language for Written Materials—Unknown	100.00%	NC
Preferred Language for Written Materials—Declined	0.00%	NC
Other Language Needs—English	0.00%	NC
Other Language Needs—Non-English	0.00%	NC
Other Language Needs—Unknown	100.00%	NC
Other Language Needs—Declined	0.00%	NC
Utilization[3]		
Ambulatory Care—Total (Per 1,000 Member Months)		
*ED Visits—Total**	71.57	★★
Outpatient Visits—Total	225.08	NC
Inpatient Utilization—General Hospital/Acute Care—Total		
Total Inpatient—Discharges per 1,000 Member Months—Total	7.43	NC
Total Inpatient—Average Length of Stay—Total	4.89	NC
Maternity—Discharges per 1,000 Member Months—Total	0.88	NC
Maternity—Average Length of Stay—Total	2.40	NC
Surgery—Discharges per 1,000 Member Months—Total	1.88	NC
Surgery—Average Length of Stay—Total	6.14	NC
Medicine—Discharges per 1,000 Member Months—Total	4.30	NC
Medicine—Average Length of Stay—Total	4.82	NC
Use of Opioids From Multiple Providers (Per 1,000 Members)*		
Use of Opioids From Multiple Providers—Multiple Prescribers	255.03	NC
Use of Opioids From Multiple Providers—Multiple Pharmacies	337.81	NC
Use of Opioids From Multiple Providers—Multiple Prescribers and Multiple Pharmacies	241.61	NC

Measure	HEDIS 2018	2018 Performance Level
Use of Opioids at High Dosage (Per 1,000 Members)*		
Use of Opioids at High Dosage	5.17	NC

[1] Due to changes in the technical specifications for this measure in HEDIS 2018, comparisons to benchmarks were not performed for this measure.
[2] Performance levels for 2018 were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.
[3] These measure indicator rates and any comparisons to benchmarks for these measures are provided for information only.
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table 5-24 shows that **Harbor Health Plan** had 10 out of 53 measure rates (18.9 percent) that ranked at or above the national Medicaid 75th percentile, four of which ranked at or above the national Medicaid 90th percentile. The measure rates that ranked at or above the national 90 percentile were all three *Chlamydia Screening in Women* indicators and *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications*. Conversely, 39 out of 53 measure rates (73.6 percent) fell below the national Medicaid 50th percentile, 33 of which were below the national Medicaid 25th percentile. Opportunities for improvement exist for **Harbor Health Plan**, especially in the domains of Child & Adolescent Care, Access to Care, Pregnancy Care, and Living With Illness, where most measure rates in each domain fell below the national Medicaid 25th percentile.

Validation of Performance Improvement Projects

For the 2017–2018 PIP, **Harbor Health Plan** submitted baseline data for the state-mandated topic, *Addressing Disparities in Timeliness of Prenatal Care.* **Harbor Health Plan** analyzed historical data to identify disparity within its population related to timeliness of prenatal care. However, after thorough analysis, it was determined that **Harbor Health Plan** did not have an identified disparity. MDHHS approved **Harbor Health Plan** to focus on improving timeliness of prenatal care as defined by the HEDIS *Prenatal and Postpartum Care (PPC)* measure.

Table 5-25 outlines the study indicator for the PIP.

Table 5-25—Study Indicator

PIP Topic	Study Indicator
Improving the Timeliness of Prenatal Care	1. The percentage of eligible women who receive a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment during the measurement period.

Table 5-26 displays the validation results for **Harbor Health Plan**'s PIP. This table illustrates the MHP's overall application of the PIP process and success in implementing the PIP. 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 5-26 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 5-26—Performance Improvement Project Validation Results for Harbor Health Plan

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)**
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 both the Design and Implementation stages of the PIP.

For the baseline measurement period, **Harbor Health Plan** reported that 35.3 percent of eligible women received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment. The goal for Remeasurement 1 was set at 83.6 percent.

Strengths, Weaknesses, and Overall Conclusions

Harbor Health Plan demonstrated both strengths and weaknesses based on the results of the 2017–2018 EQR activities. **Harbor Health Plan** received a total compliance score of 89 percent across all program areas reviewed during the 2017–2018 compliance review. **Harbor Health Plan** scored 90 percent or above in the Administrative, Members, Quality, and MIS standards, indicating generally strong performance in these program areas, but did not perform as well in the Providers and Program Integrity standards, as demonstrated by moderate performance scores (73 percent and 89 percent, respectively), reflecting that additional focus is needed in these areas. While 10 of the 53 HEDIS performance measure rates were ranked at or above the national Medicaid 75th percentile, indicating strengths in these areas, 39 HEDIS measure rates fell below the national Medicaid 50th percentile indicating opportunities for improvement primarily in Child & Adolescent Care, Access to Care, Pregnancy Care, Obesity, and Living With Illness domains.

Harbor 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 5-27—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: Received a performance score of 100 percent in the Quality program area, indicating that the MHP had the components of an effective QAPIP in place to assess and improve the quality of services provided to members. • Strength: Received a performance score of 95 percent in the MIS program area, indicating that overall the MHP maintained a health information system that is capable of collecting, analyzing, integrating, and reporting data to meet the obligations under its contract with MDHHS and, therefore, the ability to appropriately monitor the quality of services being provided to members. • Strength: The *Appropriate Treatment for Children With Upper Respiratory Infection* HEDIS performance measure fell between the national Medicaid 75th and 89th percentiles, indicating many children diagnosed with an upper respiratory infection were not prescribed an antibiotic as appropriate. • Strength: All three rates under the *Chlamydia Screening in Women* HEDIS measure were at or above the national Medicaid 90th percentile, indicating many women were being screened for this sexually transmitted disease.

Performance Area*	Overall Performance Impact
	• Strength: One of two rates for *Medication Management for People With Asthma* (*Medication Compliance 50%—Total*) fell between the national Medicaid 75th and 89th percentiles, indicating many adults and children received appropriate medication management which could reduce the need for rescue medication as well as reduce ED visits, hospital stays, and missed days of work or school. • Strength: The three rates under the *Medical Assistance With Smoking and Tobacco Use Cessation* HEDIS performance measure were at or above the national Medicaid 75th percentile, with one of those rates at or above the 90th percentile, indicating many adults who were tobacco smokers or users received cessation advice and discussed cessation medications and strategies to help quit tobacco and improve overall health. • Strength: The two rates under the *Antidepressant Medication Management* HEDIS performance measure were between the national Medicaid 75th and 89th percentiles, indicating providers were effectively managing the medication treatment of members diagnosed with major depression. • Weakness: Received a performance score of 89 percent in the Program Integrity standard during the compliance review, indicating additional focus may be needed within the MHP's program integrity processes to ensure program requirements are compliant with federal and State regulations. • Weakness: The *Appropriate Testing for Children With Pharyngitis* HEDIS performance measure rate fell between the national Medicaid 25th and 49th percentiles, indicating many children diagnosed with pharyngitis and dispensed an antibiotic did not receive the appropriate testing to determine whether an antibiotic was necessary to treat the illness. • Weakness: The rate for the *Cervical Cancer Screening* HEDIS performance measure fell below the national Medicaid 25th percentile, indicating many women were not screened for this type of cancer which is highly treatable if detected early. • Weakness: The three rates under *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* and the rate for the *Adult BMI Assessment* HEDIS performance measures fell at or below the national Medicaid 49th percentile, with two of those rates falling below the 25th percentile, indicating opportunities to improve BMI screening which helps providers identify members who are at risk and provide suggestions and services to assist them in obtaining a healthier weight. • Weakness: All six rates under the *Comprehensive Diabetes Care* HEDIS performance measures fell below the national Medicaid 25th percentile, indicating opportunities to improve proper diabetes management which is essential to control blood glucose, reduce risks for complications, and prolong life. • Weakness: The rate for the *Controlling High Blood Pressure* HEDIS performance measure fell below the national Medicaid 25th percentile, indicating opportunities for controlling high blood pressure, which is an important step in preventing heart attacks, stroke, and kidney disease. • Weakness: Although the MHP demonstrated some strength in its members being dispensed and remaining on asthma controller medications through treatment, the rate

Performance Area*	Overall Performance Impact
	under the *Asthma Medication Ratio—Total* measure was between the national Medicaid 25th and 49th percentiles, indicating an opportunity to improve the ratio of controller medications to total asthma medications and reducing the prevalence of asthma attacks. • Weakness: Two rates under the *Annual Monitoring for Patients on Persistent Medications* (*ACE Inhibitors or ARBs* and *Diuretics*) HEDIS performance measure fell below the national Medicaid 25th percentile, indicating members may be at risk for adverse drug events.
Timeliness	• Strength: 100 percent of the MHP's PIP Design and Implementation stages evaluation elements received a score of *Met*, indicating the MHP is on track to effectively address timeliness of prenatal care services. • Weakness: All nine rates under the *Childhood Immunization Status* HEDIS performance measure fell below the national Medicaid 25th percentile, and the *Immunizations for Adolescents* rate fell between the 25th and 49th percentiles, indicating children and adolescents were not always receiving vaccines in a timely manner to protect them from serious and potentially life-threatening illnesses. • Weakness: The HEDIS performance measure rates were below the national Medicaid 25th percentile for these measures: *Well-Child Visits in the First 15 Months of Life; Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life;* and *Adolescent Well-Care Visits*. These results indicate children and adolescents were not seeing their PCPs as often as suggested to ensure timely assessment of their health and development. • Weakness: The two HEDIS performance measure rates for *Prenatal and Postpartum Care* fell below the national Medicaid 25th percentile, indicating pregnant women were not always accessing timely prenatal care and/or having a timely postpartum visit after delivery, which could impact the health of the member and her baby before, during, and after pregnancy.
Access	• Weakness: Received a performance score of 73 percent in the Providers program area, indicating members may experience challenges locating and accessing providers to obtain treatment. • Weakness: All four rates under the *Children and Adolescents' Access to Primary Care Practitioners* and all three rates under the *Adults' Access to Preventive/Ambulatory Health* Services HEDIS performance measures fell below the national Medicaid 25th percentile, indicating children, adolescents, and adults were not always accessing primary care services for appropriate screenings, treatment, and preventive services. • Weakness: The *Ambulatory Care—Total (Per 1,000 Member Months), ED Visits—Total* HEDIS performance measure rate fell between the national Medicaid 25th and 49th percentiles, indicating potential inadequate access to care resulting in preventable ED visits.

* Performance impacts may be applicable to one or more performance areas; however, for this report they were aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which MHPs addressed the EQR recommendations made from the prior year's technical report. During the 2016–2017 EQR, HSAG made the following recommendations to **Harbor Health Plan**, and **Harbor Health Plan** addressed these recommendations by taking the following actions:

Compliance Monitoring

For the 2016–2017 review period, HSAG recommended that **Harbor Health Plan** initiate QI initiatives to address the opportunities for improvement identified during the annual compliance review. HSAG also recommended that **Harbor Health Plan** focus on the Providers standard, its lowest-scoring standard, with three *Incomplete* findings, two *Fail* findings, and a compliance score of 77 percent, and that attention be given to the Administrative and Quality standards, both of which had compliance scores less than 90 percent. Additionally, HSAG recommended that **Harbor Health Plan** consider initiating PDSA cycles or PIPs for performance measures that fell below minimum performance standards for consecutive review periods. Lastly, HSAG recommended that enhanced efforts be made to correct the 2015–2016 deficiencies that were not adequately addressed during the 2016–2017 review period, specifically in these categories: *QIP Evaluation and Work Plan; UM Program and Effectiveness Review; PMR Review; MIS Health Plan Maintains an Information System That Collects, Analyzes, Integrates and Reports Data as Required by MDHHS; OIG Program Integrity—Compliance Plan; Data Mining/Algorithm Form;* and *Overpayments Collected Form*.

The 2016–2017 compliance review identified opportunities for improvement for the Administrative, Providers, Quality, MIS, and Program Integrity standards. **Harbor Health Plan**'s 2017–2018 compliance review findings indicate that 10 of the 15 deficiencies in the following categories were sufficiently addressed: *Organizational Chart*, *MHP Maintains Policies and Procedures That Establish a Regular Means of Communication and Providing Information to Contract and Non-Contracted Providers*, *Provider Appeals*, *PCMH Expansion*, *QIP Evaluation and Work Plan/UM Program and Effectiveness Review*, *PMR Review*, *Community Health Worker (CHW) Policy and Procedure*, *Overpayments Collected Form*, *OIG Program Integrity—Compliance Plan*, and *OIG Program Integrity—Providers Not Enrolled/Registered in MI Medicaid's Provider Enrollment System*. Five of the 15 deficiencies during the 2016–2017 review period received similar findings during the 2017–2018 review period and are described below. These findings indicate that **Harbor Health Plan** partially addressed the prior year's recommendations.

Table 5-28—Congruent Year-Over-Year Findings

Category	2016–2017 Findings	2017–2018 Findings
Administration Position Descriptions	**Harbor Health Plan** had a change in its CFO position effective March 1, 2017. However, the letter of notification to MDHHS was dated March 14, 2017, which was not in compliance with the seven-day written notification requirement for staffing changes.	**Harbor Health Plan** received a similar finding as it did not submit the change in personnel for the CFO and MIS director within the allotted seven-day time frame according to the contract.
MHP Provider Directory	**Harbor Health Plan**'s online provider directory and/or provider availability was not current based on the information obtained from calls made to primary care providers in February and August 2017 to check for accurate provider availability.	**Harbor Health Plan** received similar findings, as the provider directory and/or provider availability was not current based on a random sample of calls made to PCPs in February and August 2018 to check for accurate provider availability.
MIS Health Plan Maintains an Information System That Collects, Analyzes, Integrates and Reports Data as Required by MDHHS	With the exception of claims payment, **Harbor Health Plan** did not submit operational plans or a narrative attestation that **Harbor Health Plan** had and followed its operational plans as required by MDHHS.	**Harbor Health Plan** received similar findings, as it did not submit the operational plans for its provider enrollment, newborn tracking and enrollment, or the quality report for tracking EPSDT immunizations and member satisfaction related to access.
Data Mining/Algorithms Form	**Harbor Health Plan** did not report the data mining activity on the Data Mining/Algorithm Form correctly.	**Harbor Health Plan** received similar findings as the Data Mining/Algorithm Form continued to contain errors and/or discrepancies for two quarters.

Validation of Performance Measures

The 2016–2017 validation of performance measures for **Harbor Health Plan** identified opportunities for improvement in the following performance measures, as these measures fell below the national Medicaid 25th percentile:

Child & Adolescent Care

- *Childhood Immunization Status—Combinations 2*, *3*, *4*, *5*, *6*, *7*, *8*, *9*, and *10*
- *Appropriate Testing for Children With Pharyngitis*

Access to Care

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months, Ages 25 Months to 6 years, Ages 7 to 11 Years,* and *Ages 12 to 19 Years*

- *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years*, *Ages 45 to 64 Years,* and *Total*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*

Pregnancy Care

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits*

Living With Illness

- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Asthma Medication Ratio—Total*
- *Controlling High Blood Pressure*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

Utilization

- *Ambulatory Care—Total (Per 1,000 Member Months)—Emergency Department Visits, Total*

HSAG recommended that **Harbor Health Plan** focus on ensuring the completeness and accuracy of data used for calculating all HEDIS measures, and specifically, on improving the rates for measures that fell below the national Medicaid 25th percentile. Based on the results of the 2017–2018 validation, *Appropriate Testing for Children With Pharyngitis*, *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*, *Asthma Medication Ratio—Total, Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications,* and *Ambulatory Care—Total (Per 1,000 Member Months)—Emergency Department Visits, Total* improved to rates of either between the 25th and 49th percentiles or the 50th and 74th percentiles; however, the remaining performance measure rates with an appropriate comparison and benchmark remained below the national Medicaid 25th percentile, indicating **Harbor Health Plan** partially addressed the prior recommendations.

Validation of Performance Improvement Projects

For the 2016–2017 validation, **Harbor Health Plan** designed a scientifically sound project supported by the use of key research principles; however, the plan-specific data provided on the identified subgroups did not support that a disparity between the two subgroups existed. HSAG recommended that **Harbor Health Plan** consult with HSAG to determine a viable PIP topic before it moved forward with the PIP implementation. During 2017–2018, **Harbor Health Plan** conducted a thorough analysis and determined it did not have an identified disparity. MDHHS approved **Harbor Health Plan** to focus on improving timeliness related to the percentage of eligible women who receive a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment during the measurement period. For the 2017–2018 validation, **Harbor Health Plan** received a score of *Met* for all applicable evaluation

elements in the Design and Implementation stages, including performance related to study topic selection, indicating **Harbor Health Plan** fully addressed the prior recommendations.

Recommendations

As a result of the findings related to quality of, timeliness of, and access to care and services provided by **Harbor Health Plan** to members, HSAG recommends that **Harbor Health Plan** incorporate efforts for improvement of the following performance measures rating below the national Medicaid 25th percentile as part of its QI strategy within the QAPIP:

Child & Adolescent Care

- *Childhood Immunization Status—Combination 2*, *3*, *4*, *5*, *6*, *7*, *8*, *9*, and *10*
- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Adolescent Well-Care Visits*

Women—Adult Care

- *Cervical Cancer Screening*

Access to Care

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months*, *Ages 25 Months to 6 Years*, *Ages 7 to 11 Years,* and *Ages 12 to 19 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years*, *Ages 45 to 64 Years,* and *Total*

Obesity

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*
- *Adult BMI Assessment*

Pregnancy Care

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

Living With Illness

- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, *Medical Attention for Nephropathy*, and *Blood Pressure Control (<140/90 mm Hg)*

- *Controlling High Blood Pressure*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics*

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

1. What were the root causes associated with rates indicating low performance?
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 **Harbor Health Plan** considering or has already implemented to improve rates and performance for each identified measure?

Based on the information presented, **Harbor Health Plan** should include the following within its QI plan:

- Measurable goals and benchmarks for each 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
- QI interventions that address the root cause of the deficiency
- A plan to monitor the QI interventions to detect whether they effect improvement

HSAG also recommends that **Harbor Health Plan** adhere to all federal managed care requirements listed under 42 CFR 438 Subpart D and the QAPIP requirements under Subpart E, State of Michigan contract requirements, and specifically, develop meaningful plans of action to bring into compliance each of the following deficient program areas:

- Administrative
- Providers
- Members
- MIS
- Program Integrity

Harbor Health Plan should include the following in each of its plans of action, and the plans of action should be provided to MDHHS as requested:

- Detailed narrative of the deficiency
- Detailed corrective action steps to resolve each deficiency
- Any resources required to resolve the deficiency
- Due dates for completing each action step
- Assigned party responsible for completing each action step
- Any required deliverables to show that a deficiency has been resolved
- Any dependencies to resolve deficiencies

Finally, **Harbor Health Plan** should take proactive steps to ensure a successful PIP. As the PIP progresses, **Harbor Health Plan** should ensure the following:

- Follow the approved PIP methodology to calculate and report data accurately in next year's annual submission.
- To impact the Remeasurement 1 study indicator rate, 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 will not have enough time to impact the study indicator rate.
- Document the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.

McLaren Health Plan

To conduct the 2017–2018 EQR, HSAG reviewed **McLaren Health Plan**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **McLaren Health Plan**.

EQR Activity Results

Compliance Monitoring

McLaren Health Plan was evaluated in six program areas referred to as standards. Table 5-29 presents the total number of criteria for each standard as well as the number of criteria for each standard that received a score of *Pass*, *Incomplete*, or *Fail*. Table 5-29 also presents **McLaren Health Plan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages.

Table 5-29—Compliance Review Results for McLaren Health Plan (MCL)

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	*Total Applicable*	MCL	Statewide
1	Administrative	4	1	0	5	90%	97%
2	Providers	13	0	2	15	87%	87%
3	Members	8	0	0	8	100%	98%
4	Quality	13	0	0	13	100%	99%
5	MIS	10	0	0	10	100%	99%
6	Program Integrity	27	1	0	28	98%	92%
Overall		**75**	**2**	**2**	**79**	**96%**	**94%**

The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

McLaren Health Plan demonstrated compliance for 75 of 79 elements, with an overall compliance score of 96 percent, which was above the statewide average. **McLaren Health Plan** demonstrated strong performance, scoring at or above 90 percent in five standards, with three standards (Members, Quality, and MIS) achieving full compliance. These program areas of strength include the Administrative, Members, Quality, MIS, and Program Integrity standards.

Opportunities for improvement were identified in three of the six standards which are briefly described below:

- *Administrative Position Description*—**McLaren Health Plan** had two positions (MIS director and QI director) that did not comply with the seven-day notification period according to contract.
- *MHP Provider Directory*—MDHHS conducted a random sample of calls to PCPs to check for accurate provider availability. The findings, as reported by MDHHS, are summarized below:

Table 5-30—Provider Directory Findings

February 2018	August 2018
• 57 percent of providers had the correct information listed in the online directory and confirmed they were accepting new patients • 2 providers were unable to be reached	• 41 percent of providers had the correct information listed in the online directory and confirmed they were accepting new patients • 79 percent of providers matched what was submitted on the 4275 for "accepting new patients" • 100 percent appeared to have matching contact information online and on the 4275 • 2 providers were unable to be reached

- *Provider Disenrollments Form*—Errors and/or discrepancies were noted on the form for one quarter.

McLaren Health Plan was required to develop and implement a CAP for each requirement in all program areas that received an *Incomplete* or a *Fail* finding.

Validation of Performance Measures

McLaren Health Plan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the 2018 HEDIS Compliance Audit Report findings, **McLaren Health Plan** was fully compliant with all IS standards, including:

- IS 1.0: Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry
- IS 2.0: Enrollment Data—Data Capture, Transfer and Entry
- IS 3.0: Practitioner Data—Data Capture, Transfer and Entry
- IS 4.0: Medical Record Review Processes—Training, Sampling, Abstraction and Oversight
- IS 5.0: Supplemental Data—Capture, Transfer and Entry
- IS 7.0: Data Integration—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity

According to the auditors' review, **McLaren Health Plan**'s submitted measures were prepared according to the NCQA HEDIS 2018 technical specifications. No rates were determined to be materially biased.

Table 5-31 shows each of the measures, the rate for each measure for 2018, and the categorized performance for 2018 relative to national HEDIS 2017 Medicaid results for **McLaren Health Plan**.

Table 5-31—Scores for Performance Measures for McLaren Health Plan

Measure	HEDIS 2018	2018 Performance Level
Child & Adolescent Care		
Childhood Immunization Status		
Combination 2	73.72%	★★
Combination 3	70.80%	★★
Combination 4	68.86%	★★
Combination 5	63.02%	★★★
Combination 6	36.50%	★★
Combination 7	61.31%	★★★
Combination 8	36.01%	★★
Combination 9	33.09%	★★
Combination 10	32.60%	★★
Well-Child Visits in the First 15 Months of Life		
Six or More Visits	70.32%	★★★★
Lead Screening in Children		
Lead Screening in Children	85.16%	★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.10%	★★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	45.50%	★★
Immunizations for Adolescents		
Combination 1	84.18%	★★★★
Appropriate Treatment for Children With Upper Respiratory Infection		
Appropriate Treatment for Children With Upper Respiratory Infection	85.58%	★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	83.27%	★★★★
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	45.37%	★★★
Continuation and Maintenance Phase	57.50%	★★★
Women—Adult Care		
Breast Cancer Screening[1]		
Breast Cancer Screening	62.86%	NC
Cervical Cancer Screening		
Cervical Cancer Screening	61.80%	★★★

Measure	HEDIS 2018	2018 Performance Level
Chlamydia Screening in Women		
Ages 16 to 20 Years	53.79%	★★★
Ages 21 to 24 Years	62.43%	★★
Total	57.58%	★★★
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	92.30%	★
Ages 25 Months to 6 Years	83.68%	★
Ages 7 to 11 Years	88.57%	★★
Ages 12 to 19 Years	87.18%	★★
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44 Years	78.71%	★★
Ages 45 to 64 Years	87.89%	★★★
Ages 65+ Years	84.31%	★★
Total	82.41%	★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	29.91%	★★★
Obesity		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	81.02%	★★★★
Counseling for Nutrition—Total	63.99%	★★
Counseling for Physical Activity—Total	56.45%	★★
Adult BMI Assessment		
Adult BMI Assessment	93.67%	★★★★
Pregnancy Care		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	77.86%	★★
Postpartum Care	66.67%	★★★
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	90.27%	★★★★
*HbA1c Poor Control (>9.0%)**	43.80%	★★
HbA1c Control (<8.0%)	45.74%	★★
Eye Exam (Retinal) Performed	64.23%	★★★★
Medical Attention for Nephropathy	90.02%	★★
Blood Pressure Control (<140/90 mm Hg)	69.34%	★★★★

Measure	HEDIS 2018	2018 Performance Level
Medication Management for People With Asthma		
Medication Compliance 50%—Total[2]	66.01%	★★★★
Medication Compliance 75%—Total	43.52%	★★★★
Asthma Medication Ratio		
Total	67.03%	★★★
Controlling High Blood Pressure		
Controlling High Blood Pressure	61.56%	★★★
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit	76.54%	★★
Discussing Cessation Medications	54.55%	★★★
Discussing Cessation Strategies	46.27%	★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	58.05%	★★★★
Effective Continuation Phase Treatment	40.80%	★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.06%	★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	77.58%	★★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NC
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	70.56%	★★★★
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	85.90%	★
Diuretics	86.89%	★★
Total[1]	86.30%	NC
Health Plan Diversity[3]		
Race/Ethnicity Diversity of Membership		
Total—White	66.14%	NC
Total—Black or African American	18.23%	NC
Total—American-Indian and Alaska Native	0.51%	NC
Total—Asian	0.65%	NC
Total—Native Hawaiian and Other Pacific Islander	0.07%	NC
Total—Some Other Race	5.45%	NC

Measure	HEDIS 2018	2018 Performance Level
Total—Two or More Races	0.00%	NC
Total—Unknown	8.96%	NC
Total—Declined	0.00%	NC
Total—Hispanic or Latino	5.45%	NC
Language Diversity of Membership		
Spoken Language Preferred for Health Care—English	95.62%	NC
Spoken Language Preferred for Health Care—Non-English	0.77%	NC
Spoken Language Preferred for Health Care—Unknown	3.61%	NC
Spoken Language Preferred for Health Care—Declined	0.00%	NC
Preferred Language for Written Materials—English	0.00%	NC
Preferred Language for Written Materials—Non-English	0.00%	NC
Preferred Language for Written Materials—Unknown	100.00%	NC
Preferred Language for Written Materials—Declined	0.00%	NC
Other Language Needs—English	0.00%	NC
Other Language Needs—Non-English	0.00%	NC
Other Language Needs—Unknown	100.00%	NC
Other Language Needs—Declined	0.00%	NC
Utilization[3]		
Ambulatory Care—Total (Per 1,000 Member Months)		
*ED Visits—Total**	74.32	★
Outpatient Visits—Total	558.58	NC
Inpatient Utilization—General Hospital/Acute Care—Total		
Total Inpatient—Discharges per 1,000 Member Months—Total	8.84	NC
Total Inpatient—Average Length of Stay—Total	4.44	NC
Maternity—Discharges per 1,000 Member Months—Total	2.66	NC
Maternity—Average Length of Stay—Total	2.24	NC
Surgery—Discharges per 1,000 Member Months—Total	2.16	NC
Surgery—Average Length of Stay—Total	5.96	NC
Medicine—Discharges per 1,000 Member Months—Total	4.71	NC
Medicine—Average Length of Stay—Total	4.69	NC
Use of Opioids From Multiple Providers (Per 1,000 Members)*		
Use of Opioids From Multiple Providers—Multiple Prescribers	151.71	NC
Use of Opioids From Multiple Providers—Multiple Pharmacies	87.45	NC
Use of Opioids From Multiple Providers—Multiple Prescribers and Multiple Pharmacies	33.88	NC

Measure	HEDIS 2018	2018 Performance Level
Use of Opioids at High Dosage (Per 1,000 Members)*		
Use of Opioids at High Dosage	23.70	NC

[1] Due to changes in the technical specifications for this measure in HEDIS 2018, comparisons to benchmarks were not performed for this measure.
[2] Performance levels for 2018 were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.
[3] These measure indicator rates and any comparisons to benchmarks for these measures are provided for information only.
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table 5-31 shows **McLaren Health Plan** had 14 out of 58 measure rates (24.1 percent) that ranked at or above the national Medicaid 75th percentile. No measure rates ranked above the 90th percentile. Further, 27 out of 58 measure rates (46.6 percent) fell below the national Medicaid 50th percentile, five of which were below the national Medicaid 25th percentile including *Appropriate Treatment for Children With Upper Respiratory Infection*, *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months* and *Ages 25 Months to 6 Years*, *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*, and *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total*. Opportunities for improvement exist for **McLaren Health Plan** for Child & Adolescent Care, Access to Care, Obesity, and Pregnancy Care domains, where at least half of the measure rates in each domain fell below the national Medicaid 50th percentile.

Validation of Performance Improvement Projects

For the 2017–2018 PIP, **McLaren Health Plan** submitted baseline data for the state-mandated topic, *Addressing Disparities in Timeliness of Prenatal Care.* **McLaren Health Plan** analyzed historical data and identified a disparity related to timeliness of prenatal care among its members residing in rural areas (Regions 6 and 7). The goal of the PIP is to improve the timeliness of prenatal care for women residing in Region 7 and eliminate the identified disparity without a decline in performance for women residing in Region 6.

Table 5-32 outlines the study indicators for the PIP.

Table 5-32—Study Indicators

PIP Topic	Study Indicators
Addressing Disparities in Timeliness of Prenatal Care	1. The percentage of eligible pregnant women residing in Region 7 who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year. 2. The percentage of eligible pregnant women residing in Region 6 who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.

Table 5-33 displays the validation results for **McLaren Health Plan**'s PIP. This table illustrates the MHP's overall application of the PIP process and success in implementing the PIP. 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—Performance Improvement Project Validation Results for McLaren Health Plan

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% (2/2)	0% (0/2)	0% (0/2)
	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% (10/10)**	**0% (0/10)**	**0% (0/10)**

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	100% (4/4)	0% (0/4)	0% (0/4)
Implementation Total			**100% (7/7)**	**0% (0/7)**	**0% (0/7)**
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% (17/17)**		

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

For the baseline measurement period, **McLaren Health Plan** reported that 63.8 percent of eligible women residing in Region 7 received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment, and 71.2 percent of eligible women residing in Region 6 received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment. The goal for the PIP is that there will no longer be a statistically significant rate difference between the two subgroups.

Strengths, Weaknesses, and Overall Conclusions

McLaren Health Plan demonstrated both strengths and weaknesses based on the results of the 2017–2018 EQR activities. **McLaren Health Plan** received a total compliance score of 96 percent across all program areas reviewed during the 2017–2018 compliance review. **McLaren Health Plan** scored 90 percent or above in the Administrative, Members, Quality, MIS, and Program Integrity standards, indicating generally strong performance in these program areas, but did not perform as well in the Providers standard as demonstrated by a moderate performance score (87 percent), reflecting that additional focus is needed in this area. While 14 of the 58 HEDIS performance measure rates were ranked at or above the national Medicaid 75th percentile, indicating strengths in these areas, 27 HEDIS measure rates fell below the national Medicaid 50th percentile, indicating opportunities for improvement primarily in Child & Adolescent Care, Access to Care, Obesity, and Pregnancy Care domains.

McLaren 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 5-34—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: Received a performance score of 100 percent in the Quality program area, indicating that the MHP had the components of an effective QAPIP in place to assess and improve the quality of services provided to members. • Strength: Received a performance score of 100 percent in the MIS program area, indicating that the MHP maintained a health information system that is capable of collecting, analyzing, integrating, and reporting data to meet the obligations under its contract with MDHHS and, therefore, the ability to appropriately monitor the quality of services being provided to members. • Strength: The *Lead Screening in Children* HEDIS performance measure rate fell between the national Medicaid 75th and 89th percentiles, indicating many children were tested for lead poisoning by 2 years of age. • Strength: The *Appropriate Testing for Children With Pharyngitis* HEDIS performance measure rates fell between the national Medicaid 75th and 89th percentiles, indicating many children diagnosed with pharyngitis received appropriate testing and treatment. • Strength: One rate under the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, BMI Percentile—Total* and the rate for the *Adult BMI Assessment* HEDIS performance measures were between the national Medicaid 75th and 89th percentiles, indicating many children's, adolescents', and adults' BMIs were assessed by a PCP or OB/GYN to monitor weight problems and identify those who are at risk. • Strength: Three of six rates under the *Comprehensive Diabetes Care* HEDIS performance measures were between the national Medicaid 75th and 89th percentiles, indicating many adults received HbA1c testing and a retinal eye exam and achieved blood pressure control which is essential to control blood glucose, reduce risks for complications, and prolong life. • Strength: The two rates under the *Medication Management for People with Asthma* HEDIS performance measure fell between the national Medicaid 75th and 89th percentile, indicating many people with persistent asthma were dispensed appropriate asthma controller medications and remained on the medications for most of their treatment period, which could reduce the need for rescue medication. • Strength: One of two rates under the *Antidepressant Medication Management* HEDIS performance measure was between the national Medicaid 75th and 89th percentiles, indicating many providers were effectively managing acute phase treatment of members diagnosed with major depression. • Strength: The rate for the *Diabetes Monitoring for People With Diabetes and Schizophrenia* HEDIS performance measure was between the national Medicaid 75th and 89th percentile, indicating many adults with schizophrenia and diabetes had both a

Performance Area*	Overall Performance Impact
	LDL-C and an HbA1c test, which is important since members using antipsychotics are at increased risk of cardiovascular disease and diabetes. • Strength: The rate for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* HEDIS performance measure was between the national Medicaid 75th and 89th percentile, indicating many adults with schizophrenia were dispensed and remained on an antipsychotic for most of their treatment period, which reduces the risk of relapse and complications. • Weakness: The *Appropriate Testing for Children with Upper Respiratory Infection* HEDIS performance measure rate fell below the national Medicaid 25th percentile, indicating many children diagnosed with an upper respiratory infection were prescribed an antibiotic inappropriately which can lead to antibiotic resistant bacteria. • Weakness: One of three rates under *Chlamydia Screening in Women* HEDIS performance measure fell between the 25th and 49th percentiles, indicating many women between the ages of 21 and 24 were not being screened for this sexually transmitted disease which can lead to serious and irreversible complications if left untreated. • Weakness: Two rates under the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* HEDIS performance measure were between the national Medicaid 25th and 49th percentiles, indicating opportunities for PCPs and OB/GYNs to provide counseling on nutrition and physical activity to children and adolescents for maintaining a healthy weight and lifestyle. • Weakness: Three of six rates under the *Comprehensive Diabetes Care (HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Medical Attention for Nephropathy*) HEDIS performance measure fell between the national Medicaid 25th and 49th percentiles, indicating opportunities to improve proper diabetes management which is essential to control blood glucose, reduce risks for complications, and prolong life. • Weakness: One of three rates under the *Medical Assistance With Smoking and Tobacco Use Cessation* HEDIS performance measure fell between the national Medicaid 25th and 49th percentiles, indicating many members who are smokers did not receive cessation advice which can help users quit tobacco and improve overall health. • Weakness: The two rates under the *Annual Monitoring for Patients on Persistent Medications* HEDIS performance measure fell at or below the national Medicaid 49th percentile with one of those rates (*ACE Inhibitors or ARBs*) falling below the 25th percentile, indicating many members may be at risk of adverse drug events.

Performance Area*	Overall Performance Impact
Timeliness	• Strength: Received a performance score of 100 percent in the Members program area, indicating that members received member materials, including an ID card, in a timely manner, to have information available to access services as soon as needed. • Strength: 100 percent of the MHP's PIP Design and Implementation stages evaluation elements received a score of *Met*, indicating the MHP is on track to effectively address disparities in timeliness of prenatal care services. • Strength: The rate for *Well-Child Visits in the First 15 Months of Life* HEDIS performance measure fell between the national Medicaid 75th and 89th percentiles, indicating many children in the first 15 months of life were seeing their PCPs as often as suggested to ensure timely assessment of their physical, emotional, and social development. • Strength: The *Immunizations for Adolescents* HEDIS performances measure rate fell between the national Medicaid 75th and 89th percentiles, indicating many adolescents received vaccines in a timely manner to protect them from serious and potentially life-threatening diseases. • Weakness: Seven of nine *Childhood Immunization Status* HEDIS performance measure rates fell between the national Medicaid 25th and 49th percentiles, indicating children were not always receiving vaccines in a timely manner to protect them from serious and potentially life-threatening diseases. • Weakness: The rates for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and the *Adolescent Well-Care Visits* HEDIS performance measures fell between the national Medicaid 25th and 49th percentiles, indicating many children and adolescents were not seeing their PCP or OB/GYN as often as suggested to ensure timely assessment of their physical, emotional, and social development. • Weakness: The rate for the *Timeliness of Prenatal Care* HEDIS performance measure fell between the national Medicaid 25th and 49th percentiles, indicating pregnant women were not always accessing timely prenatal care which could impact the health of the member and her baby before, during, and after pregnancy.
Access	• Weakness: Received a performance score of 87 percent in the Providers program area, indicating members may experience challenges locating and accessing providers to obtain treatment. • Weakness: All four rates under the *Children and Adolescents' Access to Primary Care Practitioners* HEDIS performance measure fell at or below the national Medicaid 49th percentile, with two of those rates falling below the 25th percentile, indicating children were not always accessing primary care services for appropriate screenings, treatment, and preventive services. • Weakness: Two of four rates under the *Adults' Access to Preventive/Ambulatory Health Services* HEDIS performance measure fell between the 25th and 49th percentiles, indicating many adults between the ages of 20 and 44 and adults 65 years and older were not accessing ambulatory or preventive care services from their physicians. • Weakness: The *Ambulatory Care—Total (Per 1,000 Member Months), ED Visits—Total* HEDIS performance measure rate fell below the national Medicaid 25th percentile, indicating potential inadequate access to care resulting in preventable ED visits.

* Performance impacts may be applicable to one or more performance areas; however, for this report they were aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which MHPs addressed the EQR recommendations made from the prior year's technical report. During the 2016–2017 EQR, HSAG made the following recommendations to **McLaren Health Plan**, and **McLaren Health Plan** addressed these recommendations by taking the following actions:

Compliance Monitoring

For the 2016–2017 review period, HSAG recommended that **McLaren Health Plan** initiate QI initiatives to address the opportunities for improvement identified during the annual compliance review. HSAG also recommended that **McLaren Health Plan** focus on the Providers standard, its lowest-scoring standard, with two *Fail* findings and a compliance score of 87 percent. Additionally, HSAG recommended that **McLaren Health Plan** consider initiating PDSA cycles or PIPs for measures which fell below the minimum performance standards for consecutive review periods.

The 2016–2017 compliance review identified opportunities for improvement for the Providers, Members, Quality, and Program Integrity standards. **McLaren Health Plan**'s 2017–2018 compliance review findings indicate that three of the five deficiencies in the following categories were sufficiently addressed: *Written Member Appeal Decisions Rendered*, *PMR Review*, and *OIG Program Integrity—Compliance Plan*. Two of the five deficiencies during the 2016–2017 review period received similar findings during the 2017–2018 review period and are described below. These findings indicate that **McLaren Health Plan** partially addressed the prior year's recommendations.

Table 5-35—Congruent Year-Over-Year Findings

Category	2016–2017 Findings	2017–2018 Findings
MHP Provider Directory	**McLaren Health Plan**'s online provider directory and/or provider availability was not current based on the information obtained from calls made to primary care providers in February and August 2017 to check for accurate provider availability.	**McLaren Health Plan** received similar findings, as the provider directory and/or provider availability was not current based on a random sample of calls made to PCPs in February and August 2018 to check for accurate provider availability.

Validation of Performance Measures

The 2016–2017 validation of performance measures for **McLaren Health Plan** identified opportunities for improvement in the following performance measures, as these measures fell below the national Medicaid 25th percentile:

Living With Illness

- *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*, *Digoxin* and *Total*

HSAG recommended that **McLaren Health Plan** focus on ensuring the completeness and accuracy of data used for calculating all HEDIS measures, and specifically, on improving the rates for measures that fell below the national Medicaid 25th percentile. Based on the results of the 2017–2018 validation, *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* improved to rates of either between the 50th and 74th percentiles or the 75th and 89th percentiles; however, the rate for *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* remained below the national Medicaid 25th percentile, indicating **McLaren Health Plan** partially addressed the prior recommendations.

Validation of Performance Improvement Projects

For the 2016–2017 validation, **McLaren Health Plan** designed a scientifically sound project supported by the use of key research principles, meeting 100 percent of the requirements in the Design stage. The technical design of the PIP was sufficient to measure and monitor PIP outcomes; therefore, there were no required follow-up recommendations.

Recommendations

As a result of the findings related to quality of, timeliness of, and access to care and services provided by **McLaren Health Plan** to members, HSAG recommends that **McLaren Health Plan** incorporate efforts for improvement of the following performance measures rating below the national Medicaid 25th percentile as part of its QI strategy within the QAPIP:

Child & Adolescent Care

- *Appropriate Treatment for Children With Upper Respiratory Infection*

Access to Care

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months* and *Ages 25 Months to 6 Years*

Living With Illness

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*

Utilization

- *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total*

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

1. What were the root causes associated with rates indicating low performance?
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 **McLaren Health Plan** considering or has already implemented to improve rates and performance for each identified measure?

Based on the information presented above, **McLaren Health Plan** should include the following within its QI plan:

- Measurable goals and benchmarks for each 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
- QI interventions that address the root cause of the deficiency
- A plan to monitor the QI interventions to detect whether they effect improvement

HSAG also recommends that **McLaren Health Plan** adhere to all federal managed care requirements listed under 42 CFR 438 Subpart D and the QAPIP requirements under Subpart E, State of Michigan contract requirements, and specifically, develop meaningful plans of action to bring into compliance each of the following deficient program areas:

- Administration
- Providers
- Program Integrity

McLaren Health Plan should include the following in each of its plans of action, and the plans of action should be provided to MDHHS as requested:

- Detailed narrative of the deficiency
- Detailed corrective action steps to resolve each deficiency
- Any resources required to resolve the deficiency
- Due dates for completing each action step
- Assigned party responsible for completing each action step

- Any required deliverables to show that a deficiency has been resolved
- Any dependencies to resolve deficiencies

Finally, **McLaren Health Plan** should take proactive steps to ensure a successful PIP. As the PIP progresses, **McLaren Health Plan** should ensure the following:

- Follow the approved PIP methodology to calculate and report data accurately in next year's annual submission.
- To impact the Remeasurement 1 study indicator rate, 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 will not have enough time to impact the study indicator rate.
- Document the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.

Meridian Health Plan of Michigan

To conduct the 2017–2018 EQR, HSAG reviewed **Meridian Health Plan of Michigan**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Meridian Health Plan of Michigan**.

EQR Activity Results

Compliance Monitoring

Meridian Health Plan of Michigan was evaluated in six program areas referred to as standards. Table 5-36 presents the total number of criteria for each standard as well as the number of criteria for each standard that received a score of *Pass*, *Incomplete*, or *Fail*. Table 5-36 also presents **Meridian Health Plan of Michigan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages.

Table 5-36—Compliance Review Results for Meridian Health Plan of Michigan (MER)

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	*Total Applicable*	MER	Statewide
1	Administrative	5	0	0	5	100%	97%
2	Providers	14	0	1	15	93%	87%
3	Members	8	0	0	8	100%	98%
4	Quality	13	0	0	13	100%	99%
5	MIS	9	1	0	10	95%	99%
6	Program Integrity	25	3	0	28	95%	92%
Overall		**74**	**4**	**1**	**79**	**96%**	**94%**

The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

Meridian Health Plan of Michigan demonstrated compliance for 74 of 79 elements, with an overall compliance score of 96 percent, which was above the statewide average. **Meridian Health Plan of Michigan** demonstrated strong performance, scoring above 90 percent in all six standards, with three standards (Administrative, Members, and Quality) achieving full compliance. These program areas of strength include the Administrative, Providers, Members, Quality, MIS, and Program Integrity standards.

Opportunities for improvement were identified in three of the six standards which are briefly described below:

- *MHP Provider Directory*—MDHHS conducted a random sample of calls to PCPs to check for accurate provider availability. The findings, as reported by MDHHS, are summarized below:

Table 5-37—Provider Directory Findings

August 2018[5-1]
• 59 percent of providers had the correct information listed in the online directory and confirmed they were accepting new patients • 100 percent of providers matched what was submitted on the 4275 for "accepting new patients" • 84 percent of providers appeared to have matching contact information online and on the 4275 • 2 providers were unable to be reached

- *MIS Health Plan maintains an Information System that collects, analyzes, integrates and reports data as required by MDHHS*—**Meridian Health Plan of Michigan** did not include operational plans for claims payment and grievance and appeals tracking and did not include policy, procedure, or operational plans for the appropriate use of CareConnect 360 (MDHHS-supported web-based care management system).
- *Tips and Grievances Form*—Errors and/or discrepancies were noted on the form for one quarter.
- *Provider Disenrollments Form*—Errors and/or discrepancies were noted on the form for one quarter.
- *Overpayments Collected Form*—Errors and/or discrepancies were noted on the form for one quarter.

Meridian Health Plan of Michigan was required to develop and implement a CAP for each requirement in all program areas that received an *Incomplete* or a *Fail* finding.

Validation of Performance Measures

Meridian Health Plan of Michigan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the 2018 HEDIS Compliance Audit Report findings, **Meridian Health Plan of Michigan** was fully compliant with all IS standards, including:

- IS 1.0: Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry
- IS 2.0: Enrollment Data—Data Capture, Transfer and Entry
- IS 3.0: Practitioner Data—Data Capture, Transfer and Entry

[5-1] Meridian Health Plan of Michigan received a *Pass* finding in February 2018; therefore, those results are not displayed in Table 5-37.

- IS 4.0: Medical Record Review Processes—Training, Sampling, Abstraction and Oversight
- IS 5.0: Supplemental Data—Capture, Transfer and Entry
- IS 7.0: Data Integration—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity

According to the auditors' review, **Meridian Health Plan of Michigan**'s submitted measures were prepared according to the NCQA HEDIS 2018 technical specifications. No rates were determined to be materially biased.

Table 5-38 shows each of the measures, the rate for each measure for 2018, and the categorized performance for 2018 relative to national HEDIS 2017 Medicaid results for **Meridian Health Plan of Michigan**.

Table 5-38—Scores for Performance Measures for Meridian Health Plan of Michigan

Measure	HEDIS 2018	2018 Performance Level
Child & Adolescent Care		
Childhood Immunization Status		
Combination 2	78.10%	★★★
Combination 3	73.72%	★★★
Combination 4	72.02%	★★★
Combination 5	64.48%	★★★
Combination 6	41.61%	★★★
Combination 7	63.26%	★★★★
Combination 8	41.36%	★★★
Combination 9	37.96%	★★★
Combination 10	37.71%	★★★
Well-Child Visits in the First 15 Months of Life		
Six or More Visits	76.40%	★★★★★
Lead Screening in Children		
Lead Screening in Children	81.02%	★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	78.83%	★★★★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	60.34%	★★★★
Immunizations for Adolescents		
Combination 1	83.45%	★★★
Appropriate Treatment for Children With Upper Respiratory Infection		
Appropriate Treatment for Children With Upper Respiratory Infection	87.90%	★★

Measure	HEDIS 2018	2018 Performance Level
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	80.53%	★★★
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	40.71%	★★
Continuation and Maintenance Phase	47.91%	★
Women—Adult Care		
Breast Cancer Screening[1]		
Breast Cancer Screening	64.17%	NC
Cervical Cancer Screening		
Cervical Cancer Screening	65.21%	★★★
Chlamydia Screening in Women		
Ages 16 to 20 Years	62.30%	★★★★
Ages 21 to 24 Years	68.50%	★★★
Total	65.31%	★★★★
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	96.84%	★★★
Ages 25 Months to 6 Years	90.53%	★★★
Ages 7 to 11 Years	92.59%	★★★
Ages 12 to 19 Years	92.06%	★★★
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44 Years	80.45%	★★★
Ages 45 to 64 Years	88.81%	★★★
Ages 65+ Years	94.89%	★★★★★
Total	83.63%	★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	30.32%	★★★
Obesity		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	82.24%	★★★★
Counseling for Nutrition—Total	72.51%	★★★
Counseling for Physical Activity—Total	67.15%	★★★
Adult BMI Assessment		
Adult BMI Assessment	94.89%	★★★★★
Pregnancy Care		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	85.40%	★★★

Measure	HEDIS 2018	2018 Performance Level
Postpartum Care	67.15%	★★★
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	88.04%	★★★
*HbA1c Poor Control (>9.0%)**	38.65%	★★★
HbA1c Control (<8.0%)	51.47%	★★★
Eye Exam (Retinal) Performed	69.84%	★★★★★
Medical Attention for Nephropathy	90.64%	★★★
Blood Pressure Control (<140/90 mm Hg)	66.90%	★★★
Medication Management for People With Asthma		
Medication Compliance 50%—Total[2]	72.29%	★★★★
Medication Compliance 75%—Total	51.22%	★★★★★
Asthma Medication Ratio		
Total	60.17%	★★
Controlling High Blood Pressure		
Controlling High Blood Pressure	67.15%	★★★★
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit	81.25%	★★★★
Discussing Cessation Medications	54.90%	★★★
Discussing Cessation Strategies	45.79%	★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	54.45%	★★★
Effective Continuation Phase Treatment	36.08%	★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	85.63%	★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	71.65%	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	76.71%	★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	67.07%	★★★★
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	83.26%	★
Diuretics	83.70%	★

Measure	HEDIS 2018	2018 Performance Level
Total[1]	83.44%	NC
Health Plan Diversity[3]		
Race/Ethnicity Diversity of Membership		
Total—White	61.91%	NC
Total—Black or African American	21.40%	NC
Total—American-Indian and Alaska Native	0.46%	NC
Total—Asian	0.70%	NC
Total—Native Hawaiian and Other Pacific Islander	0.05%	NC
Total—Some Other Race	0.02%	NC
Total—Two or More Races	0.00%	NC
Total—Unknown	6.08%	NC
Total—Declined	9.38%	NC
Total—Hispanic or Latino	5.75%	NC
Language Diversity of Membership		
Spoken Language Preferred for Health Care—English	98.62%	NC
Spoken Language Preferred for Health Care—Non-English	1.35%	NC
Spoken Language Preferred for Health Care—Unknown	0.03%	NC
Spoken Language Preferred for Health Care—Declined	0.00%	NC
Preferred Language for Written Materials—English	98.62%	NC
Preferred Language for Written Materials—Non-English	1.35%	NC
Preferred Language for Written Materials—Unknown	0.03%	NC
Preferred Language for Written Materials—Declined	0.00%	NC
Other Language Needs—English	98.62%	NC
Other Language Needs—Non-English	1.35%	NC
Other Language Needs—Unknown	0.03%	NC
Other Language Needs—Declined	0.00%	NC
Utilization[3]		
Ambulatory Care—Total (Per 1,000 Member Months)		
*ED Visits—Total**	73.23	★
Outpatient Visits—Total	396.18	NC
Inpatient Utilization—General Hospital/Acute Care—Total		
Total Inpatient—Discharges per 1,000 Member Months—Total	7.55	NC
Total Inpatient—Average Length of Stay—Total	3.99	NC
Maternity—Discharges per 1,000 Member Months—Total	3.16	NC
Maternity—Average Length of Stay—Total	2.58	NC
Surgery—Discharges per 1,000 Member Months—Total	1.71	NC
Surgery—Average Length of Stay—Total	6.38	NC

Measure	HEDIS 2018	2018 Performance Level
Medicine—Discharges per 1,000 Member Months—Total	3.57	NC
Medicine—Average Length of Stay—Total	3.74	NC
Use of Opioids From Multiple Providers (Per 1,000 Members)*		
Use of Opioids From Multiple Providers—Multiple Prescribers	214.34	NC
Use of Opioids From Multiple Providers—Multiple Pharmacies	71.53	NC
Use of Opioids From Multiple Providers—Multiple Prescribers and Multiple Pharmacies	44.12	NC
Use of Opioids at High Dosage (Per 1,000 Members)*		
Use of Opioids at High Dosage	26.48	NC

[1] Due to changes in the technical specifications for this measure in HEDIS 2018, comparisons to benchmarks were not performed for this measure.
[2] Performance levels for 2018 were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.
[3] These measure indicator rates and any comparisons to benchmarks for these measures are provided for information only.
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
2018 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table 5-38 shows that **Meridian Health Plan of Michigan** had 17 out of 59 measure rates (28.8 percent) that ranked at or above the national Medicaid 75th percentile, with five rates ranking at or above the national Medicaid 90th percentile. The measure rates that ranked above the national Medicaid 90th percentile include *Well-Child Visits in the First 15 Months of Life—Six or More Visits*, *Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years*, *Adult BMI Assessment*, *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*, and *Medication Management for People With Asthma—Medication Compliance 75%—Total*. Conversely, nine out of 59 measure rates (15.3 percent) fell below the national Medicaid 50th percentile, four of which fell below the national Medicaid 25th percentile including *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*, *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics*, and *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total*. Opportunities for improvement exist for **Meridian Health Plan of Michigan** in the Child & Adolescent Care, Living With Illness, and Utilization domains where some measure rates fell below the national Medicaid 25th percentile.

Validation of Performance Improvement Projects

For the 2017–2018 PIP, **Meridian Health Plan of Michigan** submitted baseline data for the state-mandated topic, *Addressing Disparities in Timeliness of Prenatal Care.* **Meridian Health Plan of Michigan** analyzed historical data and identified a disparity related to timeliness of prenatal care among its women members residing in rural areas (Regions 3 and 5). The goal of the PIP is to improve the

timeliness of prenatal care for women residing in Region 3 and eliminate the identified disparity without a decline in performance for the women residing in Region 5.

Table 5-39 outlines the study indicators for the PIP.

Table 5-39—Study Indicators

PIP Topic	Study Indicators
Addressing Disparities in Timeliness of Prenatal Care	1. The percentage of eligible pregnant women residing in Region 3 who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year. 2. The percentage of eligible pregnant women residing in Region 5 who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.

Table 5-40 displays the validation results for **Meridian Health Plan of Michigan**'s PIP. This table illustrates the MHP's overall application of the PIP process and success in implementing the PIP. 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 5-40 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 5-40—Performance Improvement Project Validation Results for Meridian Health Plan of Michigan

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% (2/2)	0% (0/2)	0% (0/2)
	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% (10/10)**	**0% (0/10)**	**0% (0/10)**

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	100% (4/4)	0% (0/4)	0% (0/4)
Implementation Total			**100% (7/7)**	**0% (0/7)**	**0% (0/7)**
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% (17/17)**		

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

For the baseline measurement period, **Meridian Health Plan of Michigan** reported that 74.7 percent of eligible women residing in Region 3 received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment, and 81.9 percent of eligible women residing in Region 5 received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment. The goal for the PIP is that there will no longer be a statistically significant rate difference between the two subgroups.

Strengths, Weaknesses, and Overall Conclusions

Meridian Health Plan of Michigan demonstrated both strengths and weaknesses based on the results of the 2017–2018 EQR activities. **Meridian Health Plan of Michigan** received a total compliance score of 96 percent across all program areas reviewed during the 2017–2018 compliance review. **Meridian Health Plan of Michigan** scored 93 percent or above for all standards, indicating generally strong performance in all program areas reviewed. While 17 of the 59 HEDIS performance measure rates were ranked at or above the national Medicaid 75th percentile, indicating strengths in these areas, nine HEDIS measure rates fell below the national Medicaid 50th percentile, indicating opportunities for improvement primarily in Child & Adolescent Care, Living With Illness, and Utilization domains.

Meridian Health Plan 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 5-41—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: Received a performance score of 100 percent in the Administrative program area, indicating that the MHP had adequate staffing and oversight mechanisms in place to ensure the delivery of quality services to its members. • Strength: Received a performance score of 100 percent in the Quality program area, indicating that the MHP had the components of an effective QAPIP in place to assess and improve the quality of services provided to members. • Strength: The *Lead Screening in Children* HEDIS performance measure rate was between the national Medicaid 75th and 89th percentiles, indicating many children were tested for lead poisoning by 2 years of age. • Strength: Two of three rates under the *Chlamydia Screening in Women* HEDIS performance measure were between the 75th and 89th percentiles, indicating many women ages 16 to 20 were screened for this sexually transmitted disease which can lead to serious and irreversible complications if left untreated. • Strength: The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* HEDIS performance measure was between the 75th and 89th percentile, and the rate for *Adult BMI Assessment* was at or above the 90th percentile, indicating many child, adolescent, and adult BMIs were assessed by a PCP or OB/GYN to monitor weight problems and identify those who are at risk for obesity. • Strength: One of six rates under the *Comprehensive Diabetes Care* HEDIS performance measures fell at or above the national Medicaid 90th percentile, indicating many members received a retinal eye exam which is essential for proper diabetes management and to reduce risks for complications. • Strength: The two rates under the *Medication Management for People with Asthma* HEDIS performance measures were at or above the national Medicaid 75th percentile, with one of those rates at or above the 90th percentile, indicating many members with persistent asthma were dispensed appropriate asthma controller medications and remained on the medications for most of their treatment period, which could reduce the need for rescue medication. • Strength: The *Controlling High Blood Pressure* HEDIS performance measure rate was between the national Medicaid 75th and 89th percentiles, indicating many members are managing their high blood pressure, which is an important step in preventing heart attacks, stroke, and kidney disease. • Strength: One of three rates under the *Medical Assistance With Smoking and Tobacco Use Cessation* HEDIS performance measure was between the national Medicaid 75th and 89th percentiles, indicating many adults who were tobacco smokers or users received cessation advice to help them quit tobacco and improve overall health.

Performance Area*	Overall Performance Impact
	• Strength: The *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* HEDIS performance measure rate was between the national Medicaid 75th and 89th percentiles, indicating many members were dispensed an antipsychotic medication and remained on the medication for most of their treatment period, which reduces the risk of relapse and hospitalization. • Weakness: While the MHP received a performance score of 95 percent in the Program Integrity standard during the compliance review, findings suggest that additional focus may be needed within the MHP's program integrity processes to ensure program requirements are compliant with federal and State regulations. • Weakness: The *Appropriate Testing for Children With Upper Respiratory Infection* HEDIS performance measure rate fell between the national Medicaid 25th and 49th percentile, indicating many children diagnosed with an upper respiratory infection were prescribed an antibiotic inappropriately which can lead to antibiotic resistant bacteria. • Weakness: The two rates under the *Follow-Up Care for Children Prescribed ADHD Medication* fell at or below the national Medicaid 49th percentile, with one of those rates falling below the 25th percentile, indicating opportunities to improve medication management to control symptoms of hyperactivity, impulsiveness, and inability to sustain concentration. • Weakness: Although the MHP demonstrated strength in its members being dispensed and remaining on asthma controller medications through treatment, the *Asthma Medication Ratio—Total* measure rate fell between the national Medicaid 25th and 49th percentiles, indicating an opportunity to improve the ratio of controller medications to total asthma medications and reducing the prevalence of asthma attacks. • Weakness: One of two rates under the *Antidepressant Medication Management* measure fell between the national Medicaid 25th and 49th percentiles, indicating opportunities for providers to effectively manage the continuation phase of treatment for adults diagnosed with major depression. • Weakness: The HEDIS performance measure rate for *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* fell between the national Medicaid 25th and 49th percentiles, indicating adult members diagnosed with schizophrenia and cardiovascular disease did not receive an LDL-C test, and therefore did not receive appropriate screening and monitoring to detect any decline in health. • Weakness: Two rates under *Annual Monitoring for Patients on Persistent Medications* (*ACE Inhibitors or ARBs* and *Diuretics*) fell below the national Medicaid 25th percentile, indicating many members may be at risk of adverse drug events.

Performance Area*	Overall Performance Impact
Timeliness	• Strength: Received a performance score of 100 percent in the Members program area, indicating that members received member materials, including an ID card, in a timely manner, to have information available to access services as soon as needed. • Strength: 100 percent of the MHP's PIP Design and Implementation stages evaluation elements received a score of *Met*, indicating the MHP is on track to effectively address disparities in timeliness of prenatal care services. • Strength: The rate for one *Childhood Immunization Status* (*Combination 7*) HEDIS performance measure fell between the national Medicaid 75th and 89th percentiles, indicating many children received the DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, and RV vaccinations by 2 years of age to protect them from serious and potentially life-threatening diseases. • Strength: The rates for these HEDIS performance measures were at or above the national Medicaid 75th percentile: *Well-Child Visits in the First 15 Months of Life; Well-Child Visits in the Third, Fourth, Fifth*, and *Sixth Years of Life;* and *Adolescent Well-Care Visits.* The rate for *Well-Child Visits in the First 15 Months of Life* was at or above the 90th percentile, indicating many children and adolescents were seeing their PCPs or OB/GYNs as often as suggested to ensure timely assessment of their physical, emotional, and social development.
Access	• Strength: One of four rates under the *Adults' Access to Preventive/Ambulatory Health Services* HEDIS performance measure was at or above the national Medicaid 90th percentile, indicating many adults 65 years of age and older were accessing ambulatory or preventive care services from their physicians. • Weakness: Although the MHP received a performance score of 93 percent in the Providers program area, the findings suggest that members may experience challenges locating and accessing providers to obtain treatment. • Weakness: The *Ambulatory Care—Total (Per 1,000 Member Months)*, *ED Visits—Total* HEDIS performance measure rate fell below the national Medicaid 25th percentile, indicating potential inadequate access to care resulting in preventable ED visits.

* Performance impacts may be applicable to one or more performance areas; however, for this report they were aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which MHPs addressed the EQR recommendations made from the prior year's technical report. During the 2016–2017 EQR, HSAG made the following recommendations to **Meridian Health Plan of Michigan**, and **Meridian Health Plan of Michigan** addressed these recommendations by taking the following actions:

Compliance Monitoring

For the 2016–2017 review period, HSAG recommended that **Meridian Health Plan of Michigan** initiate QI initiatives to address the opportunities for improvement identified during the annual compliance review. HSAG also recommended that **Meridian Health Plan of Michigan** focus on the Program Integrity standard, the only standard that did not achieve full compliance, with three *Incomplete* findings and a compliance score of 94 percent. Additionally, HSAG recommended that **Meridian Health Plan of Michigan** consider initiating PDSA cycles or PIPs for performance measures that fell below minimum performance standards for consecutive review periods.

The 2016–2017 compliance review identified opportunities for improvement for the Program Integrity standard. **Meridian Health Plan of Michigan**'s 2017–2018 compliance review findings indicate that one of the three deficiencies in the following category was sufficiently addressed: *Data Mining/Algorithm Form*. Two of the three deficiencies during the 2016–2017 review period received similar findings during the 2017–2018 review period and are described below. These findings indicate that **Meridian Health Plan of Michigan** partially addressed the prior year's recommendations.

Table 5-42—Congruent Year-Over-Year Findings

Category	2016–2017 Findings	2017–2018 Findings
Provider Disenrollments Form	**Meridian Health Plan of Michigan** did not properly report the Date of Disenrollment and Effective Date of Disenrollment on the Provider Disenrollments Form.	**Meridian Health Plan of Michigan** received similar findings as the Provider Disenrollments Form continued to contain errors and/or discrepancies for one quarter.

Validation of Performance Measures

The 2016–2017 validation of performance measures for **Meridian Health Plan of Michigan** identified opportunities for improvement in the following performance measures, as these measures fell below the national Medicaid 25th percentile:

Living With Illness

- *Antidepressant Medication Management—Effective Continuation Phase Treatment*
- *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*

Utilization

- *Ambulatory Care—Total (Per 1,000 Member Months)—Emergency Department Visits—Total*

HSAG recommended that **Meridian Health Plan of Michigan** focus on ensuring the completeness and accuracy of data used for calculating all HEDIS measures, and specifically, on improving the rates for measures that fell below the national Medicaid 25th percentile. Based on the results of the 2017–2018 validation, *Antidepressant Medication Management—Effective Continuation Phase Treatment* and *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* improved to rates between the 25th and 49th percentiles; however, the rate for *Ambulatory Care—Total (Per 1,000 Member Months)—Emergency Department Visits—Total* remained below the national Medicaid 25th percentile, indicating **Meridian Health Plan of Michigan** partially addressed the prior recommendations.

Validation of Performance Improvement Projects

For the 2016–2017 validation, **Meridian Health Plan of Michigan** designed a scientifically sound project supported by the use of key research principles, meeting 100 percent of the requirements in the Design stage. The technical design of the PIP was sufficient to measure and monitor PIP outcomes; therefore, there were no required follow-up recommendations.

Recommendations

As a result of the findings related to quality of, timeliness of, and access to care and services provided by **Meridian Health Plan of Michigan** to members, HSAG recommends that **Meridian Health Plan of Michigan** incorporate efforts for improvement of the following performance measures rating below the national Medicaid 25th percentile as part of its QI strategy within the QAPIP:

Child & Adolescent Care

- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*

Living With Illness

- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics*

Utilization

- *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total*

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

1. What were the root causes associated with rates indicating low performance?
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 of Michigan** considering or has already implemented to improve rates and performance for each identified measure?

Based on the information presented, **Meridian Health Plan of Michigan** should include the following within its QI plan:

- Measurable goals and benchmarks for each 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
- QI interventions that address the root cause of the deficiency
- A plan to monitor the QI interventions to detect whether they effect improvement

HSAG also recommends that **Meridian Health Plan of Michigan** adhere to all federal managed care requirements listed under 42 CFR 438 Subpart D and the QAPIP requirements under Subpart E, State of Michigan contract requirements, and specifically, develop meaningful plans of action to bring into compliance each of the following deficient program areas:

- Providers
- MIS
- Program Integrity

Meridian Health Plan of Michigan should include the following in each of its plans of action, and the plans of action should be provided to MDHHS as requested:

- Detailed narrative of the deficiency
- Detailed corrective action steps to resolve each deficiency
- Any resources required to resolve the deficiency
- Due dates for completing each action step
- Assigned party responsible for completing each action step

- Any required deliverables to show that a deficiency has been resolved
- Any dependencies to resolve deficiencies

Finally, **Meridian Health Plan of Michigan** should take proactive steps to ensure a successful PIP. As the PIP progresses, **Meridian Health Plan of Michigan** should ensure the following:

- Follow the approved PIP methodology to calculate and report data accurately in next year's annual submission.
- To impact the Remeasurement 1 study indicator rate, 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 will not have enough time to impact the study indicator rate.
- Document the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.

Molina Healthcare of Michigan

To conduct the 2017–2018 EQR, HSAG reviewed **Molina Healthcare of Michigan**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Molina Healthcare of Michigan**.

EQR Activity Results

Compliance Monitoring

Molina Healthcare of Michigan was evaluated in six program areas referred to as standards. Table 5-43 presents the total number of criteria for each standard as well as the number of criteria for each standard that received a score of *Pass*, *Incomplete*, or *Fail*. Table 5-43 also presents **Molina Healthcare of Michigan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages.

Table 5-43—Compliance Review Results for Molina Healthcare of Michigan (MOL)

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	*Total Applicable*	MOL	Statewide
1	Administrative	5	0	0	5	100%	97%
2	Providers	13	0	2	15	87%	87%
3	Members	7	1	0	8	94%	98%
4	Quality	12	1	0	13	96%	99%
5	MIS	10	0	0	10	100%	99%
6	Program Integrity	21	7	0	28	88%	92%
Overall		**68**	**9**	**2**	**79**	**92%**	**94%**

The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

Molina Healthcare of Michigan demonstrated compliance for 68 of 79 elements, with an overall compliance score of 92 percent, which was below the statewide average. **Molina Healthcare of Michigan** demonstrated strong performance, scoring above 90 percent in four standards, with two standards (Administrative and MIS) achieving full compliance. These program areas of strength include the Administrative, Members, Quality, and MIS standards.

Opportunities for improvement were identified in four of the six standards which included deficiencies related to the following requirements:

- *MHP Provider Directory*—MDHHS conducted a random sample of calls to PCPs to check for accurate provider availability. The findings, as reported by MDHHS, are summarized below:

Table 5-44—Provider Directory Findings

February 2018	August 2018
• 34 percent of providers had the correct information listed in the online directory and confirmed they were accepting new patients • 1 provider was unable to be reached	• 62 percent of providers had the correct information listed in the online directory and confirmed they were accepting new patients • 100 percent of providers matched what was submitted on the 4275 for "accepting new patients" • 100 percent of providers appeared to have matching contact information online and on the 4275 • 3 providers were unable to be reached

- *Written Member Appeal Decisions Rendered*—The requirement to resolve standard appeals and expedited appeals were not always met according to established time frames.
- *PMR Review*—**Molina Healthcare of Michigan** provided acceptable CAPS for all measures except *Provider File Reporting* for the Medicaid Managed Care PMR.
- *Tips and Grievances Form*—Errors and/or discrepancies were noted on the form for one quarter.
- *Data Mining/Algorithm Form*—Errors and/or discrepancies were noted on the form for one quarter.
- *Audits Form*—Errors and/or discrepancies were noted on the form for two quarters.
- *Provider Disenrollments Form*—Errors and/or discrepancies were noted on the form for one quarter.
- *Overpayments Collected Form*—Errors and/or discrepancies were noted on the form for one quarter.
- *EOB Requirements*—Errors and/or discrepancies were noted on the form for one quarter.

Molina Healthcare of Michigan was required to develop and implement a CAP for each requirement in all program areas that received an *Incomplete* or a *Fail* finding.

Validation of Performance Measures

Molina Healthcare of Michigan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the 2018 HEDIS Compliance Audit Report findings, **Molina Healthcare of Michigan** was fully compliant with all IS standards, including:

- IS 1.0: Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry
- IS 2.0: Enrollment Data—Data Capture, Transfer and Entry
- IS 3.0: Practitioner Data—Data Capture, Transfer and Entry
- IS 4.0: Medical Record Review Processes—Training, Sampling, Abstraction and Oversight

- IS 5.0: Supplemental Data—Capture, Transfer and Entry
- IS 7.0: Data Integration—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity

According to the auditors' review, **Molina Healthcare of Michigan**'s submitted measures were prepared according to the NCQA HEDIS 2018 technical specifications. No rates were determined to be materially biased.

Table 5-45 shows each of the measures, the rate for each measure for 2018, and the categorized performance for 2018 relative to national HEDIS 2017 Medicaid results for **Molina Healthcare of Michigan**.

Table 5-45—Scores for Performance Measures for Molina Healthcare of Michigan

Measure	HEDIS 2018	2018 Performance Level
Child & Adolescent Care		
Childhood Immunization Status		
Combination 2	76.60%	★★★
Combination 3	71.68%	★★★
Combination 4	69.78%	★★★
Combination 5	60.29%	★★★
Combination 6	36.61%	★★
Combination 7	59.06%	★★★
Combination 8	36.21%	★★
Combination 9	31.60%	★★
Combination 10	31.31%	★★
Well-Child Visits in the First 15 Months of Life		
Six or More Visits	70.56%	★★★★
Lead Screening in Children		
Lead Screening in Children	78.83%	★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.08%	★★★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	54.39%	★★★
Immunizations for Adolescents		
Combination 1	86.87%	★★★★★
Appropriate Treatment for Children With Upper Respiratory Infection		
Appropriate Treatment for Children With Upper Respiratory Infection	87.40%	★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	75.12%	★★

Measure	HEDIS 2018	2018 Performance Level
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	48.91%	★★★
Continuation and Maintenance Phase	61.82%	★★★
Women—Adult Care		
Breast Cancer Screening[1]		
Breast Cancer Screening	61.50%	NC
Cervical Cancer Screening		
Cervical Cancer Screening	72.34%	★★★★★
Chlamydia Screening in Women		
Ages 16 to 20 Years	65.16%	★★★★
Ages 21 to 24 Years	70.44%	★★★★
Total	67.35%	★★★★
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	95.41%	★★
Ages 25 Months to 6 Years	88.71%	★★★
Ages 7 to 11 Years	91.63%	★★★
Ages 12 to 19 Years	90.83%	★★★
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44 Years	79.17%	★★★
Ages 45 to 64 Years	88.11%	★★★
Ages 65+ Years	92.66%	★★★★
Total	83.04%	★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	33.02%	★★★
Obesity		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	84.64%	★★★★
Counseling for Nutrition—Total	76.82%	★★★★
Counseling for Physical Activity—Total	68.75%	★★★★
Adult BMI Assessment		
Adult BMI Assessment	96.00%	★★★★★
Pregnancy Care		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	77.32%	★
Postpartum Care	73.80%	★★★★★

Measure	HEDIS 2018	2018 Performance Level
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	90.42%	★★★★
*HbA1c Poor Control (>9.0%)**	33.91%	★★★★
HbA1c Control (<8.0%)	54.55%	★★★★
Eye Exam (Retinal) Performed	62.16%	★★★
Medical Attention for Nephropathy	92.87%	★★★★
Blood Pressure Control (<140/90 mm Hg)	51.11%	★
Medication Management for People With Asthma		
Medication Compliance 50%—Total[2]	62.41%	★★★
Medication Compliance 75%—Total	38.56%	★★★
Asthma Medication Ratio		
Total	63.06%	★★★
Controlling High Blood Pressure		
Controlling High Blood Pressure	51.82%	★★
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit	81.08%	★★★★
Discussing Cessation Medications	58.57%	★★★★
Discussing Cessation Strategies	46.01%	★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	54.54%	★★★
Effective Continuation Phase Treatment	37.54%	★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	85.87%	★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	70.70%	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	77.31%	★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	64.74%	★★★
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	88.48%	★★★
Diuretics	88.54%	★★★
Total[1]	88.51%	NC

Measure	HEDIS 2018	2018 Performance Level
Health Plan Diversity[3]		
Race/Ethnicity Diversity of Membership		
Total—White	45.47%	NC
Total—Black or African American	33.92%	NC
Total—American-Indian and Alaska Native	0.26%	NC
Total—Asian	0.32%	NC
Total—Native Hawaiian and Other Pacific Islander	0.00%	NC
Total—Some Other Race	0.00%	NC
Total—Two or More Races	0.00%	NC
Total—Unknown	20.02%	NC
Total—Declined	0.00%	NC
Total—Hispanic or Latino	6.70%	NC
Language Diversity of Membership		
Spoken Language Preferred for Health Care—English	98.66%	NC
Spoken Language Preferred for Health Care—Non-English	1.27%	NC
Spoken Language Preferred for Health Care—Unknown	0.07%	NC
Spoken Language Preferred for Health Care—Declined	0.00%	NC
Preferred Language for Written Materials—English	98.66%	NC
Preferred Language for Written Materials—Non-English	1.27%	NC
Preferred Language for Written Materials—Unknown	0.07%	NC
Preferred Language for Written Materials—Declined	0.00%	NC
Other Language Needs—English	98.66%	NC
Other Language Needs—Non-English	1.27%	NC
Other Language Needs—Unknown	0.07%	NC
Other Language Needs—Declined	0.00%	NC
Utilization[3]		
Ambulatory Care—Total (Per 1,000 Member Months)		
*ED Visits—Total**	70.06	★★
Outpatient Visits—Total	422.90	NC
Inpatient Utilization—General Hospital/Acute Care—Total		
Total Inpatient—Discharges per 1,000 Member Months—Total	7.63	NC
Total Inpatient—Average Length of Stay—Total	4.58	NC
Maternity—Discharges per 1,000 Member Months—Total	2.56	NC
Maternity—Average Length of Stay—Total	2.72	NC
Surgery—Discharges per 1,000 Member Months—Total	1.85	NC
Surgery—Average Length of Stay—Total	7.69	NC

Measure	HEDIS 2018	2018 Performance Level
Medicine—Discharges per 1,000 Member Months—Total	3.93	NC
Medicine—Average Length of Stay—Total	3.98	NC
Use of Opioids From Multiple Providers (Per 1,000 Members)*		
Use of Opioids From Multiple Providers—Multiple Prescribers	224.19	NC
Use of Opioids From Multiple Providers—Multiple Pharmacies	86.93	NC
Use of Opioids From Multiple Providers—Multiple Prescribers and Multiple Pharmacies	59.06	NC
Use of Opioids at High Dosage (Per 1,000 Members)*		
Use of Opioids at High Dosage	21.38	NC

[1] Due to changes in the technical specifications for this measure in HEDIS 2018, comparisons to benchmarks were not performed for this measure.
[2] Performance levels for 2018 were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.
[3] These measure indicator rates and any comparisons to benchmarks for these measures are provided for information only.
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
2018 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table 5-45 shows that **Molina Healthcare of Michigan** had 19 out of 59 measure rates (32.2 percent) that ranked at or above the national Medicaid 75th percentile, four of which ranked at or above the national Medicaid 90th percentile. Measures that ranked at or above the 90th percentile include *Immunizations for Adolescents—Combination 1*, *Cervical Cancer Screening*, *Adult BMI Assessment*, and *Prenatal and Postpartum Care—Postpartum Care*. Conversely, 12 out of 59 measure rates (20.3 percent) fell below the national Medicaid 50th percentile, two of which were below the national Medicaid 25th percentile and were in the Pregnancy Care and Living With Illness domains. These measure rates present opportunities for improvement for **Molina Healthcare of Michigan** in *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*.

Validation of Performance Improvement Projects

For the 2017–2018 PIP, **Molina Healthcare of Michigan** submitted baseline data for the state-mandated topic, *Addressing Disparities in Timeliness of Prenatal Care.* **Molina Healthcare of Michigan** analyzed historical data and identified a disparity related to timeliness of prenatal care among its African-American and Caucasian populations. The goal of the PIP is to improve the timeliness of prenatal care for the African-American population and eliminate the identified disparity without a decline in performance for the Caucasian population.

Table 5-46 outlines the study indicators for the PIP.

Table 5-46—Study Indicators

PIP Topic	Study Indicators
Addressing Disparities in Timeliness of Prenatal Care	1. The percentage of eligible African-American women who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year. 2. The percentage of eligible Caucasian women who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.

Table 5-47 displays the validation results for **Molina Healthcare of Michigan**'s PIP evaluated during 2017–2018. This table illustrates the MHP's overall application of the PIP process and success in implementing the PIP. 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 5-47 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 5-47—Performance Improvement Project Validation Results for Molina Healthcare of Michigan

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% (2/2)	0% (0/2)	0% (0/2)
	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% (9/9)**	**0% (0/9)**	**0% (0/9)**

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	100% (5/5)	0% (0/5)	0% (0/5)
Implementation Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
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% (17/17)**		

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

For the baseline measurement period, **Molina Healthcare of Michigan** reported that 62.5 percent of eligible African-American women received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment, and 71.4 percent of eligible Caucasian women received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment. The goal for the PIP is that there will no longer be a statistically significant rate difference between the two subgroups.

Strengths, Weaknesses, and Overall Conclusions

Molina Healthcare of Michigan demonstrated both strengths and weaknesses based on the results of the 2017–2018 EQR activities. **Molina Healthcare of Michigan** received a total compliance score of 92 percent across all program areas reviewed during the 2017–2018 compliance review. **Molina Healthcare of Michigan** scored 94 percent or above in the Administrative, Members, Quality, and MIS, standards, indicating generally strong performance in these program areas, but did not perform as well in the Providers and Program Integrity standards, as demonstrated by moderate performance scores (87 percent and 88 percent, respectively), reflecting that additional focus is needed in these areas. While 19 of the 59 HEDIS performance measure rates were ranked at or above the national Medicaid 75th percentile, indicating strengths in these areas, 12 HEDIS measure rates fell below the national Medicaid 50th percentile indicating opportunities for improvement primarily in Child & Adolescent Care, Access to Care, Pregnancy Care, and Living With Illness domains.

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 5-48—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: Received a performance score of 100 percent in the Administrative program area, indicating that the MHP had adequate staffing and oversight mechanisms in place to ensure the delivery of quality services to its members. • Strength: Received a performance score of 100 percent in the MIS program area, indicating that the MHP maintained a health information system that is capable of collecting, analyzing, integrating, and reporting data to meet the obligations under its contract with MDHHS and, therefore, the ability to appropriately monitor the quality of services being provided to members. • Strength: The rate for the *Cervical Cancer Screening* HEDIS performance measure was at or above the national Medicaid 90th percentile, indicating many women were screened for this type of cancer which is highly treatable if detected early. • Strength: All three rates under the *Chlamydia Screening in Women* HEDIS measure were between the national Medicaid 75th and 89th percentiles, indicating many women were being screened for this sexually transmitted disease. • Strength: All three rates for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* were between the 75th and 89th percentiles, and the rate for *Adult BMI Assessment* was at or above the national Medicaid 90th percentile, indicating child, adolescent, and adult BMIs were assessed by a PCP or OB/GYN during a medical appointment, and children received counseling for nutrition and physical activity which are important to identify at-risk members and provide suggestions and services to assist them in obtaining and maintaining a healthier weight. • Strength: Four of six rates under the *Comprehensive Diabetes Care* HEDIS performance measure fell between the 75th and 89th percentiles, indicating many adults with diabetes received HbA1c testing and medical attention for nephropathy which are essential to control blood glucose and reduce risks for complications. • Strength: Two of three rates under the *Medical Assistance With Smoking and Tobacco Use Cessation* HEDIS performance measure were between the national Medicaid 75th and 89th percentiles, indicating many adults who were tobacco smokers or users received cessation advice and discussed cessation medications and strategies to help quit tobacco and improve overall health. • Strength: The rate for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* HEDIS performance measure was between the 75th and 89th percentiles, indicating many adults diagnosed with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication had a diabetes screening. • Weakness: Received a performance score of 88 percent in the Program Integrity standard during the compliance review, suggesting that additional focus may be

Performance Area*	Overall Performance Impact
	needed within the MHP's program integrity processes to ensure program requirements are compliant with federal and State regulations. • Weakness: The *Appropriate Testing for Children with Upper Respiratory Infection* HEDIS performance measure rate fell between the national Medicaid 25th and 49th percentiles, indicating many children diagnosed with an upper respiratory infection were prescribed an antibiotic inappropriately which can lead to antibiotic resistant bacteria. • Weakness: The *Appropriate Testing for Children With Pharyngitis* HEDIS performance measure rate fell between the national Medicaid 25th and 49th percentiles, indicating many children diagnosed with pharyngitis and dispensed an antibiotic did not receive the appropriate testing which reduces the unnecessary use of antibiotics. • Weakness: One of six rates under the *Comprehensive Diabetes Care* HEDIS performance measure was below the national Medicaid 25th percentile, indicating opportunities for improvement to control blood pressure in adults with diabetes which is essential to reduce risks for complications. • Weakness: The HEDIS performance measure rate for *Controlling High Blood Pressure* fell between the national Medicaid 25th and 49th percentiles, indicating opportunities for controlling high blood pressure, which is an important step in preventing heart attacks, stroke, and kidney disease. • Weakness: The HEDIS performance measure rate for *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* fell between the national Medicaid 25th and 49th percentiles, indicating adult members diagnosed with schizophrenia and cardiovascular disease did not receive an LDL-C test, and therefore did not receive appropriate screening and monitoring to detect any decline in health.
Timeliness	• Strength: 100 percent of the MHP's PIP Design and Implementation stages evaluation elements received a score of *Met*, indicating the MHP is on track to effectively address disparities in timeliness of prenatal care services. • Strength: The rate for the *Well-Child Visits in the First 15 Months of Life* HEDIS performance measure fell between the national Medicaid 75th and 89th percentiles, indicating many children in the first 15 months of life were seeing their PCPs as often as suggested to ensure timely assessment of their physical, emotional, and social development. • Strength: The *Immunizations for Adolescents* HEDIS performance measure rate met or exceeded the national Medicaid 90th percentile, indicating adolescents 13 years of age were receiving recommended vaccinations to prevent diseases, including meningococcal meningitis, tetanus, diphtheria, pertussis, and human papillomavirus. • Strength: One of two HEDIS performance measure rates under the *Prenatal and Postpartum Care* HEDIS performance measure, *Postpartum Care,* met or exceeded the national Medicaid 90th percentile, indicating many women were accessing timely postpartum care which could positively impact the health of the member and her baby and future pregnancies.

Performance Area*	Overall Performance Impact
	• Weakness: Although the MHP received a compliance score of 94 percent in the Members standard, it failed to always resolve standard and expedited appeals in a timely manner, indicating members may not have received services as promptly as needed when services were determined to be medically necessary. • Weakness: Four of nine total HEDIS *Childhood Immunization Status* performance measure rates fell between the national Medicaid 25th and 49th percentiles, indicating children were not always receiving vaccines in a timely manner to protect them from serious and potentially life-threatening illnesses. • Weakness: One of two HEDIS performance measure rates for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* fell below the national Medicaid 25th percentile, indicating many women were not accessing timely prenatal care which could impact the health of the member and her baby during pregnancy and after delivery.
Access	• Strength: One of four rates under the *Adults' Access to Preventive/Ambulatory Health Services* HEDIS performance measure was between the national Medicaid 75th and 89th percentiles, indicating many adults 65 years of age and older were accessing ambulatory or preventive care services from their physicians. • Weakness: Received a performance score of 87 percent in the Providers program area, indicating members may experience challenges locating and accessing providers to obtain treatment. • Weakness: One of four rates under the *Children and Adolescents' Access to Primary Care Practitioners* HEDIS performance measure fell between the national Medicaid 25th and 49th percentiles, indicating children ages 12 to 24 months were not always accessing primary care services for appropriate screenings, treatment, and preventive services. • Weakness: The *Ambulatory Care—Total (Per 1,000 Member Months)*, *ED Visits—Total* HEDIS performance measure rate fell between the national Medicaid 25th and 49th percentiles, indicating potential inadequate access to care resulting in preventable ED visits.

* Performance impacts may be applicable to one or more performance areas; however, for this report they were aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which MHPs addressed the EQR recommendations made from the prior year's technical report. During the 2016–2017 EQR, HSAG made the following recommendations to **Molina Healthcare of Michigan**, and **Molina Healthcare of Michigan** addressed these recommendations by taking the following actions:

Compliance Monitoring

For the 2016–2017 review period, HSAG recommended that **Molina Healthcare of Michigan** initiate QI initiatives to address the opportunities for improvement identified during the annual compliance review. HSAG also recommended that **Molina Healthcare of Michigan** focus on the Providers standard, its lowest-scoring standard, with one *Incomplete* finding, two *Fail* findings, and a compliance score of 83 percent.

The 2016–2017 compliance review identified opportunities for improvement for the Providers, Members, and Program Integrity standards. **Molina Healthcare of Michigan**'s 2017–2018 compliance review findings indicate that three of the six deficiencies in the following category was sufficiently addressed: *Provider Subcontractor: Health Benefit, Administrative and/or Transportation*, *Member Handbook*, and *OIG Program Integrity—Compliance Plan*. Three of the six deficiencies during the 2016–2017 review period received similar findings during the 2017–2018 review period and are described below. These findings indicate that **Molina Healthcare of Michigan** partially addressed the prior year's recommendations.

Table 5-49—Congruent Year-Over-Year Findings

Category	2016–2017 Findings	2017–2018 Findings
MHP Provider Directory	**Molina Healthcare of Michigan**'s online provider directory and/or provider availability was not current based on the information obtained from calls made to primary care providers in February and August 2017 to check for accurate provider availability.	**Molina Healthcare of Michigan** received similar findings, as the provider directory and/or provider availability was not current based on a random sample of calls made to PCPs in February and August 2018 to check for accurate provider availability.
Written Member Appeal Decisions Rendered	**Molina Healthcare of Michigan** did not meet the 30-day time frame for all non-expedited appeal decisions.	**Molina Healthcare of Michigan** received similar findings as standard and expedited appeal time frames were not always met.

Validation of Performance Measures

The 2016–2017 validation of performance measures for **Molina Healthcare of Michigan** identified opportunities for improvement in the following performance measures, as these measures fell below the national Medicaid 25th percentile:

Living With Illness

- *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*

HSAG recommended that **Molina Healthcare of Michigan** focus on ensuring the completeness and accuracy of data used for calculating all HEDIS measures, and specifically, on improving the rates for measures that fell below the national Medicaid 25th percentile. Based on the results of the 2017–2018

validation, *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* improved to rates between the 50th and 74th percentiles, indicating **Molina Healthcare of Michigan** addressed the prior recommendations.

Validation of Performance Improvement Projects

For the 2016–2017 validation, **Molina Healthcare of Michigan** designed a scientifically sound project supported by the use of key research principles, meeting 100 percent of the requirements in the Design stage. The technical design of the PIP was sufficient to measure and monitor PIP outcomes; therefore, there were no required follow-up recommendations.

Recommendations

As a result of the findings related to 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 of the following performance measures rating below the national Medicaid 25th percentile as part of its QI strategy within the QAPIP:

Pregnancy of Care

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Living With Illness

- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*

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

1. What were the root causes associated with rates indicating low performance?
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 measure?

Based on the information presented, **Molina Healthcare of Michigan** should include the following within its QI plan:

- Measurable goals and benchmarks for each 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
- QI interventions that address the root cause of the deficiency
- A plan to monitor the QI interventions to detect whether they effect improvement

HSAG also recommends that **Molina Healthcare of Michigan** adhere to all federal managed care requirements listed under 42 CFR 438 Subpart D and the QAPIP requirements under Subpart E, State of Michigan contract requirements, and specifically, develop meaningful plans of action to bring into compliance each of the following deficient program areas:

- Providers
- Members
- Quality
- Program Integrity

Molina Healthcare of Michigan should include the following in each of its plans of action, and the plans of action should be provided to MDHHS as requested:

- Detailed narrative of the deficiency
- Detailed corrective action steps to resolve each deficiency
- Any resources required to resolve the deficiency
- Due dates for completing each action step
- Assigned party responsible for completing each action step
- Any required deliverables to show that a deficiency has been resolved
- Any dependencies to resolve deficiencies

Finally, **Molina Healthcare of Michigan** should take proactive steps to ensure a successful PIP. As the PIP progresses, **Molina Healthcare of Michigan** should ensure the following:

- Follow the approved PIP methodology to calculate and report data accurately in next year's annual submission.
- To impact the Remeasurement 1 study indicator rate, 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 will not have enough time to impact the study indicator rate.
- Document the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.

Priority Health Choice, Inc.

To conduct the 2017–2018 EQR, HSAG reviewed **Priority Health Choice, Inc.**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Priority Health Choice, Inc**.

EQR Activity Results

Compliance Monitoring

Priority Health Choice, Inc. was evaluated in six program areas referred to as standards. Table 5-50 presents the total number of criteria for each standard as well as the number of criteria for each standard that received a score of *Pass*, *Incomplete*, or *Fail*. Table 5-50 also presents **Priority Health Choice, Inc.**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages.

Table 5-50—Compliance Review Results for Priority Health Choice, Inc. (PRI)

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	*Total Applicable*	PRI	Statewide
1	Administrative	5	0	0	5	100%	97%
2	Providers	13	0	2	15	87%	87%
3	Members	8	0	0	8	100%	98%
4	Quality	13	0	0	13	100%	99%
5	MIS	10	0	0	10	100%	99%
6	Program Integrity	27	1	0	28	98%	92%
Overall		**76**	**1**	**2**	**79**	**97%**	**94%**

The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

Priority Health Choice, Inc. demonstrated compliance for 76 of 79 elements, with an overall compliance score of 97 percent, which was above the statewide average. **Priority Health Choice, Inc.** demonstrated strong performance, scoring above 90 percent in five standards, with four standards (Administrative, Members, Quality, and MIS) achieving full compliance. These program areas of strength include the Administrative, Members, Quality, MIS, and Program Integrity standards.

Opportunities for improvement were identified in two of the six standards which included deficiencies related to the following requirements:

- *MHP Provider Directory*—MDHHS conducted a random sample of calls to PCPs to check for accurate provider availability. The findings, as reported by MDHHS, are summarized below:

Table 5-51—Provider Directory Findings

February 2018	August 2018
• 63 percent of providers had the correct information listed in the online directory and confirmed they were accepting new patients • 1 provider was unable to be reached	• 39 percent of providers had the correct information listed in the online directory and confirmed they were accepting new patients • 80 percent of providers matched what was submitted on the 4275 for "accepting new patients" • 95 percent of providers appeared to have matching contact information online and on the 4275

- *Tips and Grievances Form*—Errors and/or discrepancies were noted on the form for one quarter.

Priority Health Choice, Inc. was required to develop and implement a CAP for each requirement in all program areas that received an *Incomplete* or a *Fail* finding.

Validation of Performance Measures

Priority Health Choice, Inc. was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the 2018 HEDIS Compliance Audit Report findings, **Priority Health Choice, Inc.** was fully compliant with all IS standards, including:

- IS 1.0: Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry
- IS 2.0: Enrollment Data—Data Capture, Transfer and Entry
- IS 3.0: Practitioner Data—Data Capture, Transfer and Entry
- IS 4.0: Medical Record Review Processes—Training, Sampling, Abstraction and Oversight
- IS 5.0: Supplemental Data—Capture, Transfer and Entry
- IS 7.0: Data Integration—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity

According to the auditors' review, **Priority Health Choice, Inc.**'s submitted measures were prepared according to the NCQA HEDIS 2018 technical specifications. No rates were determined to be materially biased.

Table 5-52 shows each of the measures, the rate for each measure for 2018, and the categorized performance for 2018 relative to national HEDIS 2017 Medicaid results for **Priority Health Choice, Inc.**

Table 5-52—Scores for Performance Measures for Priority Health Choice, Inc.

Measure	HEDIS 2018	2018 Performance Level
Child & Adolescent Care		
Childhood Immunization Status		
Combination 2	82.97%	★★★★★
Combination 3	81.02%	★★★★★
Combination 4	79.56%	★★★★★
Combination 5	73.48%	★★★★★
Combination 6	56.20%	★★★★★
Combination 7	72.02%	★★★★★
Combination 8	55.47%	★★★★★
Combination 9	51.82%	★★★★★
Combination 10	51.09%	★★★★★
Well-Child Visits in the First 15 Months of Life		
Six or More Visits	77.30%	★★★★★
Lead Screening in Children		
Lead Screening in Children	84.54%	★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.41%	★★★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	61.67%	★★★★
Immunizations for Adolescents		
Combination 1	87.59%	★★★★★
Appropriate Treatment for Children With Upper Respiratory Infection		
Appropriate Treatment for Children With Upper Respiratory Infection	93.94%	★★★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	86.44%	★★★★
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	36.13%	★
Continuation and Maintenance Phase	40.38%	★
Women—Adult Care		
Breast Cancer Screening[1]		
Breast Cancer Screening	63.99%	NC
Cervical Cancer Screening		
Cervical Cancer Screening	68.85%	★★★★

Measure	HEDIS 2018	2018 Performance Level
Chlamydia Screening in Women		
Ages 16 to 20 Years	65.53%	★★★★
Ages 21 to 24 Years	68.61%	★★★
Total	66.82%	★★★★
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	96.18%	★★★
Ages 25 Months to 6 Years	86.67%	★★
Ages 7 to 11 Years	90.54%	★★
Ages 12 to 19 Years	91.09%	★★★
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44 Years	80.88%	★★★
Ages 45 to 64 Years	89.42%	★★★★
Ages 65+ Years	93.56%	★★★★★
Total	84.49%	★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	42.29%	★★★★★
Obesity		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	95.32%	★★★★★
Counseling for Nutrition—Total	81.87%	★★★★
Counseling for Physical Activity—Total	79.53%	★★★★★
Adult BMI Assessment		
Adult BMI Assessment	97.00%	★★★★★
Pregnancy Care		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	83.45%	★★
Postpartum Care	71.53%	★★★★
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	94.07%	★★★★★
*HbA1c Poor Control (>9.0%)**	22.68%	★★★★★
HbA1c Control (<8.0%)	67.01%	★★★★★
Eye Exam (Retinal) Performed	73.71%	★★★★★
Medical Attention for Nephropathy	94.85%	★★★★★
Blood Pressure Control (<140/90 mm Hg)	76.80%	★★★★★

Measure	HEDIS 2018	2018 Performance Level
Medication Management for People With Asthma		
Medication Compliance 50%—Total[2]	65.82%	★★★★
Medication Compliance 75%—Total	45.07%	★★★★
Asthma Medication Ratio		
Total	73.04%	★★★★★
Controlling High Blood Pressure		
Controlling High Blood Pressure	65.57%	★★★★
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit	83.65%	★★★★★
Discussing Cessation Medications	60.90%	★★★★★
Discussing Cessation Strategies	48.08%	★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	71.28%	★★★★★
Effective Continuation Phase Treatment	51.06%	★★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	84.56%	★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	56.99%	★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NC
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	64.26%	★★★
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	88.29%	★★★
Diuretics	87.81%	★★
Total[1]	88.09%	NC
Health Plan Diversity[3]		
Race/Ethnicity Diversity of Membership		
Total—White	62.18%	NC
Total—Black or African American	14.10%	NC
Total—American-Indian and Alaska Native	0.55%	NC
Total—Asian	0.83%	NC
Total—Native Hawaiian and Other Pacific Islander	0.07%	NC
Total—Some Other Race	0.01%	NC

Measure	HEDIS 2018	2018 Performance Level
Total—Two or More Races	0.00%	NC
Total—Unknown	22.27%	NC
Total—Declined	0.00%	NC
Total—Hispanic or Latino	10.59%	NC
Language Diversity of Membership		
Spoken Language Preferred for Health Care—English	0.00%	NC
Spoken Language Preferred for Health Care—Non-English	0.00%	NC
Spoken Language Preferred for Health Care—Unknown	100.00%	NC
Spoken Language Preferred for Health Care—Declined	0.00%	NC
Preferred Language for Written Materials—English	0.00%	NC
Preferred Language for Written Materials—Non-English	0.00%	NC
Preferred Language for Written Materials—Unknown	100.00%	NC
Preferred Language for Written Materials—Declined	0.00%	NC
Other Language Needs—English	0.00%	NC
Other Language Needs—Non-English	0.00%	NC
Other Language Needs—Unknown	100.00%	NC
Other Language Needs—Declined	0.00%	NC
Utilization[3]		
Ambulatory Care—Total (Per 1,000 Member Months)		
*ED Visits—Total**	71.90	★★
Outpatient Visits—Total	381.02	NC
Inpatient Utilization—General Hospital/Acute Care—Total		
Total Inpatient—Discharges per 1,000 Member Months—Total	6.80	NC
Total Inpatient—Average Length of Stay—Total	3.62	NC
Maternity—Discharges per 1,000 Member Months—Total	2.95	NC
Maternity—Average Length of Stay—Total	2.65	NC
Surgery—Discharges per 1,000 Member Months—Total	1.57	NC
Surgery—Average Length of Stay—Total	4.48	NC
Medicine—Discharges per 1,000 Member Months—Total	3.17	NC
Medicine—Average Length of Stay—Total	3.85	NC
Use of Opioids From Multiple Providers (Per 1,000 Members)*		
Use of Opioids From Multiple Providers—Multiple Prescribers	294.43	NC
Use of Opioids From Multiple Providers—Multiple Pharmacies	91.29	NC
Use of Opioids From Multiple Providers—Multiple Prescribers and Multiple Pharmacies	55.72	NC

Measure	HEDIS 2018	2018 Performance Level
Use of Opioids at High Dosage (Per 1,000 Members)*		
Use of Opioids at High Dosage	39.28	NC

[1] Due to changes in the technical specifications for this measure in HEDIS 2018, comparisons to benchmarks were not performed for this measure.
[2] Performance levels for 2018 were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.
[3] These measure indicator rates and any comparisons to benchmarks for these measures are provided for information only.
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table 5-52 shows **Priority Health Choice, Inc.** had 41 out of 58 measure rates (70.7 percent) that ranked at or above the national Medicaid 75th percentile, 27 of which ranked at or above the national Medicaid 90th percentile. Measure rates that ranked at or above the 90th percentile spanned across Child & Adolescent Care, Access to Care, Obesity, and Living With Illness domains. Conversely, eight out of 58 measure rates (13.8 percent) fell below the national Medicaid 50th percentile, three of which fell below the national Medicaid 25th percentile including both *Follow-Up Care for Children Prescribed ADHD Medication* indicators and *Diabetes Monitoring for People With Diabetes and Schizophrenia*. Although only three rates fell below the national Medicaid 25th percentile, opportunities for improvement for **Priority Health Choice, Inc.** exist for those measure rates that fell below the national Medicaid 50th percentile, such as *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years* and *Ages 7 to 11 Years*, *Prenatal and Postpartum Care—Timeliness of Prenatal Care,* and *Annual Monitoring for Patients on Persistent Medications—Diuretics*.

Validation of Performance Improvement Projects

For the 2017–2018 PIP, **Priority Health Choice, Inc.** submitted baseline data for the state-mandated topic, *Addressing Disparities in Timeliness of Prenatal Care.* **Priority Health Choice, Inc.** analyzed historical data to identify potential disparity within its population related to timeliness of prenatal care. However, a disparity among **Priority Health Choice, Inc.** 's populations did not exist. It was determined, and MDHHS approved, that **Priority Health Choice, Inc.** would focus on improving the timeliness of prenatal care for African-American women as this subpopulation's compliance rate demonstrated an opportunity for improvement.

Table 5-53 outlines the study indicator for the PIP.

Table 5-53—Study Indicator

PIP Topic	Study Indicator
Improving the Timeliness of Prenatal Care for African-American Women	The percentage of eligible, pregnant African-American women who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.

Table 5-54 displays the validation results for **Priority Health Choice, Inc.**'s PIP. This table illustrates the MHP's overall application of the PIP process and success in implementing the PIP. 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 5-54 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 5-54—Performance Improvement Project Validation Results for Priority Health Choice, Inc.

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% (2/2)	0% (0/2)	0% (0/2)
	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% (9/9)**	**0% (0/9)**	**0% (0/9)**

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	100% (4/4)	0% (0/4)	0% (0/4)
Implementation Total			**100% (7/7)**	**0% (0/7)**	**0% (0/7)**
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% (16/16)**		

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

For the baseline measurement period, **Priority Health Choice, Inc.** reported that 46.8 percent of eligible African-American women received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment. The Remeasurement 1 goal was set at 53.7 percent.

Strengths, Weaknesses, and Overall Conclusions

Priority Health Choice, Inc. demonstrated both strengths and weaknesses based on the results of the 2017–2018 EQR activities. **Priority Health Choice, Inc.** received a total compliance score of 97 percent across all program areas reviewed during the 2017–2018 compliance review. **Priority Health Choice, Inc.** scored 98 percent or above in the Administrative, Members, Quality, MIS, and Program Integrity standards, indicating strong performance in these program areas, but did not perform as well in the Providers standard, as demonstrated by a moderate performance score (87 percent), reflecting that additional focus is needed in this area. While 41 of the 58 HEDIS performance measure rates were ranked at or above the national Medicaid 75th percentile, indicating strengths in these areas, eight HEDIS measure rates fell below the national Medicaid 50th percentile, indicating opportunities for improvement primarily in Child & Adolescent Care, Access to Care, Pregnancy Care, and Living With Illness domains.

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

Table 5-55—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: Received a performance score of 100 percent in the Administrative program area, indicating that the MHP had adequate staffing and oversight mechanisms in place to ensure the delivery of quality services to its members. • Strength: Received a performance score of 100 percent in the Quality program area, indicating that the MHP had the components of an effective QAPIP in place to assess and improve the quality of services provided to members. • Strength: Received a performance score of 100 percent in the MIS program area, indicating that the MHP maintained a health information system that is capable of collecting, analyzing, integrating, and reporting data to meet the obligations under its contract with MDHHS and, therefore, the ability to appropriately monitor the quality of services being provided to members. • Strength: Received a performance score of 98 percent in the Program Integrity standard during the compliance review, indicating most of the MHP's program integrity processes are compliant with federal and State regulations, and contracted providers have been appropriately screened and meet the MHP's expectations for a quality provider. • Strength: The *Lead Screening in Children* HEDIS performance measure rate was between the national Medicaid 75th and 89th percentiles, indicating many children were tested for lead poisoning by 2 years of age. • Strength: The *Appropriate Treatment for Children With Upper Respiratory Infection* and *Appropriate Testing for Children with Pharyngitis* HEDIS performances measure rates were between the national Medicaid 75th and 89th percentiles, indicating many children diagnosed with upper respiratory infections were not being prescribed antibiotics inappropriately, and many children diagnosed with pharyngitis received appropriate testing and treatment. • Strength: The rate for the *Cervical Cancer Screening* HEDIS performance measure was between the national Medicaid 75th and 89th percentiles, indicating many women were screened for this type of cancer which is highly treatable if detected early. • Strength: Two of three rates under the *Chlamydia Screening in Women* (*Ages 16 to 20 Years* and *Total*) HEDIS performance measure were between the national Medicaid 75th and 89th percentiles, indicating many women ages 16 to 20 years were being screened for this sexually transmitted disease. • Strength: The *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* HEDIS performance measure rate met or exceeded the 90th percentile, indicating many adults diagnosed with acute bronchitis were not dispensed an antibiotic which helps avoid side-effects and possible resistance to antibiotics. • Strength: All three rates under the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* HEDIS performance measure were at or above the 75th percentile, with two of those rates and the rate for *Adult BMI Assessment*

Performance Area*	Overall Performance Impact
	at or above the national Medicaid 90th percentile, indicating many child, adolescent, and adult BMIs were assessed by a PCP or OB/GYN during a medical appointment, and many children received counseling for nutrition and physical activity which are important to identify at-risk members and provide suggestions and services to assist them in obtaining and maintaining a healthier weight. • Strength: The six HEDIS performance measure rates under *Comprehensive Diabetes Care* met or exceeded the 90th percentile, indicating many adults received proper diabetes management which is essential to control blood glucose and reduce risks for complications. • Strength: The two HEDIS performance measure rates under *Medication Management for People With Asthma* were between the national Medicaid 75th and 89th percentiles, and the rate for *Asthma Medication Ratio* met or exceeded the 90th percentile, indicating members received appropriate medication management which could reduce the need for rescue medication as well as the costs associated with ED visits, inpatient admissions, and missed days of work or school. • Strength: The rate for the *Controlling High Blood Pressure* HEDIS performance measure was between the national Medicaid 75th and 89th percentiles, indicating many adults had adequately controlled blood pressure, which is an important step in preventing heart attacks, strokes, and kidney disease. • Strength: Two of three rates under the *Medical Assistance With Smoking and Tobacco Use Cessation* HEDIS performance measure met or exceeded the 90th percentile, indicating many adults who are tobacco smokers or users received cessation advice and discussed cessation medications to help quit tobacco and improve overall health. • Strength: The two rates under the *Antidepressant Medication Management* HEDIS performance measure met or exceeded the 90th percentile, indicating adult members diagnosed with major depression received effective medication management which can improve a person's daily functioning and wellbeing, and reduce the risk of suicide. • Strength: The rate for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* HEDIS performance measure was between the national Medicaid 75th and 89th percentiles, indicating many adults diagnosed with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication had a diabetes screening. • Weakness: The two rates under the *Follow-Up Care for Children Prescribed ADHD Medication* HEDIS performance measure fell below the national Medicaid 25th percentile, indicating additional opportunities for prescribed ADHD medications to be more closely monitored by a pediatrician. • Weakness: The rate for the *Diabetes Monitoring for People With Diabetes and Schizophrenia* HEDIS performance measure fell below the national Medicaid 25th percentile, indicating many adult members diagnosed with schizophrenia and diabetes did not always receive a LDL-C and HbA1c test during the year, and therefore may have an increased risk for declining health.

Performance Area*	Overall Performance Impact
	• Weakness: One rate under *Annual Monitoring for Patients on Persistent Medications—Diuretics* fell between the national Medicaid 25th and 49th percentiles, indicating many adult members may be at risk of adverse drug events.
Timeliness	• Strength: Received a performance score of 100 percent in the Members program area, indicating members received member materials, including an ID card, in a timely manner, to have information available to access services as needed. • Strength: 100 percent of the MHP's PIP Design and Implementation stages evaluation elements received a score of *Met*, indicating the MHP is on track to effectively address disparities in timeliness of prenatal care services. • Strength: Nine of nine rates under the *Childhood Immunization Status* and the *Immunizations for Adolescents* HEDIS performance measures met or exceeded the national Medicaid 90th percentile, indicating many children and adolescents received vaccines in a timely manner to protect them from serious and potentially life-threatening illnesses. • Strength: The rate for the *Well-Child Visits in the First 15 Months of Life* HEDIS performance measure met or exceeded the national Medicaid 90th percentile, and the rate for *Adolescent Well-Care Visits* was between the national Medicaid 75th and 89th percentiles, indicating many children in the first 15 months of life and adolescents were seeing their PCPs as often as suggested to ensure timely assessment of their physical, emotional, and social development. • Strength: One of two HEDIS performance measure rates under *Prenatal and Postpartum Care* was between the national Medicaid 75th and 89th, indicating many women were accessing timely postpartum care which could impact the health of the member and her baby after pregnancy. • Weakness: One of two HEDIS performance measure rates under *Prenatal and Postpartum Care* fell between the national Medicaid 25th and 49th percentiles, indicating many pregnant women were not always accessing timely prenatal care which could impact the health of the member and her baby before, during, and after pregnancy.
Access	• Strength: Two of four rates under the *Adults' Access to Preventive/Ambulatory Health Services* HEDIS performance measure were at or above the 75th percentile, with one of those rates at or above the 90th percentile, indicating many adults 45 years of age and older were accessing ambulatory or preventive care services from their physicians. • Weakness: Received a performance score of 87 percent in the Providers program area, indicating members may experience challenges locating and accessing providers to obtain treatment. • Weakness: Two of four rates under the *Children and Adolescents' Access to Primary Care Practitioners* HEDIS performance measure fell between the national Medicaid 25th and 49th percentiles, indicating children ages 25 months to 11 years were not always accessing primary care services for appropriate screenings, treatment, and preventive services.

Performance Area*	Overall Performance Impact
	• Weakness: The *Ambulatory Care—Total (Per 1,000 Member Months)*, *ED Visits—Total* HEDIS performance measure rate fell between the national Medicaid 25th and 49th percentiles, indicating potential inadequate access to care resulting in preventable ED visits.

* Performance impacts may be applicable to one or more performance areas; however, for this report they were aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which MHPs addressed the EQR recommendations made from the prior year's technical report. During the 2016–2017 EQR, HSAG made the following recommendations to **Priority Health Choice, Inc.**, and **Priority Health Choice, Inc.** addressed these recommendations by taking the following actions:

Compliance Monitoring

For the 2016–2017 review period, HSAG recommended that **Priority Health Choice, Inc.** initiate QI initiatives to address the opportunities for improvement identified during the annual compliance review. HSAG also recommended that **Priority Health Choice, Inc.** focus on the Providers standard, its lowest-scoring standard, with two *Fail* findings and a compliance score of 87 percent. Additionally, HSAG recommended that **Priority Health Choice, Inc.** consider initiating PDSA cycles or PIPs for performance measures that fell below standards for consecutive review periods.

The 2016–2017 compliance review identified opportunities for improvement for the Providers and Program Integrity standards. **Priority Health Choice, Inc.**'s 2017–2018 compliance review findings indicate that one of the three deficiencies in the following category was sufficiently addressed: *Overpayments Collected Form*. Two of the three deficiencies during the 2016–2017 review period received similar findings during the 2017–2018 review period and are described below. These findings indicate that **Priority Health Choice, Inc.** partially addressed the prior year's recommendations.

Table 5-56—Congruent Year-Over-Year Findings

Category	2016–2017 Findings	2017–2018 Findings
MHP Provider Directory	**Priority Health Choice, Inc.**'s online provider directory and/or provider availability was not current based on the information obtained from calls made to primary care providers in February and August 2017 to check for accurate provider availability.	**Priority Health Choice, Inc.** received similar findings, as the provider directory and/or provider availability was not current based on a random sample of calls made to PCPs in February and August 2018 to check for accurate provider availability.

Validation of Performance Measures

The 2016–2017 validation of performance measures for **Priority Health Choice, Inc.** identified opportunities for improvement in the following performance measures, as these measures fell below the national Medicaid 25th percentile:

Child & Adolescent Care

- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*

Living With Illness

- *Diabetes Monitoring for People With Diabetes and Schizophrenia*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*

Utilization

- *Ambulatory Care—Total (Per 1,000 Member Months)—Emergency Department Visits—Total*

HSAG recommended that **Priority Health Choice, Inc.** focus on ensuring the completeness and accuracy of data used for calculating all HEDIS measures, and specifically, on improving the rates for measures that fell below the national Medicaid 25th percentile. Based on the results of the 2017–2018 validation, *Ambulatory Care—Total (Per 1,000 Member Months)—Emergency Department Visits—Total* improved to rates between the 25th and 49th percentiles; however, the remaining performance measure rates with an appropriate comparison and benchmark remained below the national Medicaid 25th percentile, indicating **Priority Health Choice, Inc.** partially addressed the prior recommendations.

Validation of Performance Improvement Projects

For the 2016–2017 validation, **Priority Health Choice, Inc.** designed a scientifically sound project supported by the use of key research principles, meeting 100 percent of the requirements in the Design stage. The technical design of the PIP was sufficient to measure and monitor PIP outcomes; therefore, there were no required follow-up recommendations.

Recommendations

As a result of the findings related to quality of, timeliness of, and access to care and services provided by **Priority Health Choice, Inc.** to members, HSAG recommends that **Priority Health Choice, Inc.** incorporate efforts for improvement of the following performance measures rating below the national Medicaid 25th percentile as part of its QI strategy within the QAPIP:

Child & Adolescent Care

- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*

Living With Illness

- *Diabetes Monitoring for People With Diabetes and Schizophrenia*

Priority Health Choice, Inc. should include within its next annual QAPIP review the results of analyses for the performance measures listed above that answer the following questions:

1. What were the root causes associated with rates indicating low performance?
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 **Priority Health Choice, Inc.** considering or has already implemented to improve rates and performance for each identified measure?

Based on the information presented, **Priority Health Choice, Inc.** should include the following within its QI plan:

- Measurable goals and benchmarks for each 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
- QI interventions that address the root cause of the deficiency
- A plan to monitor the QI interventions to detect whether they effect improvement

HSAG also recommends that **Priority Health Choice, Inc.** adhere to all federal managed care requirements listed under 42 CFR 438 Subpart D and the QAPIP requirements under Subpart E, State of Michigan contract requirements, and specifically, develop meaningful plans of action to bring into compliance each of the following deficient program areas:

- Providers
- Program Integrity

Priority Health Choice, Inc. should include the following in each of its plans of action, and the plans of action should be provided to MDHHS as requested:

- Detailed narrative of the deficiency
- Detailed corrective action steps to resolve each deficiency
- Any resources required to resolve the deficiency
- Due dates for completing each action step
- Assigned party responsible for completing each action step
- Any required deliverables to show that a deficiency has been resolved
- Any dependencies to resolve deficiencies

Finally, **Priority Health Choice, Inc.** should take proactive steps to ensure a successful PIP. As the PIP progresses, **Priority Health Choice, Inc.** should ensure the following:

- Follow the approved PIP methodology to calculate and report data accurately in next year's annual submission.
- To impact the Remeasurement 1 study indicator rate, 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 will not have enough time to impact the study indicator rate.
- Document the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.

Total Health Care, Inc.

To conduct the 2017–2018 EQR, HSAG reviewed **Total Health Care, Inc.**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Total Health Care, Inc**.

EQR Activity Results

Compliance Monitoring

Total Health Care, Inc. was evaluated in six program areas referred to as standards. Table 5-57 presents the total number of criteria for each standard as well as the number of criteria for each standard that received a score of *Pass*, *Incomplete*, or *Fail*. Table 5-57 also presents **Total Health Care, Inc.**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages.

Table 5-57—Compliance Review Results for Total Health Care, Inc. (THC)

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	*Total Applicable*	THC	Statewide
1	Administrative	5	0	0	5	100%	97%
2	Providers	13	0	2	15	87%	87%
3	Members	8	0	0	8	100%	98%
4	Quality	13	0	0	13	100%	99%
5	MIS	10	0	0	10	100%	99%
6	Program Integrity	23	5	0	28	91%	92%
Overall		**72**	**5**	**2**	**79**	**94%**	**94%**

The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

Total Health Care, Inc. demonstrated compliance for 72 of 79 elements, with an overall compliance score of 94 percent, which was equal to the statewide average. **Total Health Care, Inc.** demonstrated strong performance, scoring above 90 percent in five standards, with four of those standards (Administrative, Members, Quality, and MIS) achieving full compliance. These program areas of strength include the Administrative, Members, Quality, MIS, and Program Integrity standards.

Opportunities for improvement were identified in two of the six standards which included deficiencies related to the following requirements:

- *MHP Provider Directory*—MDHHS conducted a random sample of calls to PCPs to check for accurate provider availability. The findings, as reported by MDHHS, are summarized below:

Table 5-58—Provider Directory Findings

February 2018	August 2018
• 72 percent of providers had the correct information listed in the online directory and confirmed they were accepting new patients • 2 providers were unable to be reached	• 62 percent of providers had the correct information listed in the online directory and confirmed they were accepting new patients • 94 percent of providers matched what was submitted on the 4275 for "accepting new patients" • 78 percent of providers appeared to have matching contact information online and on the 4275 • 1 provider was unable to be reached

- *Tips and Grievances Form*—Errors and/or discrepancies were noted on the form for one quarter.
- *Data Mining/Algorithm Form*—Errors and/or discrepancies were noted on the form for two quarters.
- *Audits Form*—Errors and/or discrepancies were noted on the form for one quarter.
- *Overpayments Collected Form*—Errors and/or discrepancies were noted on the form for one quarter.

Total Health Care, Inc. was required to develop and implement a CAP for each requirement in all program areas that received an *Incomplete* or a *Fail* finding.

Validation of Performance Measures

Total Health Care, Inc. was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the 2018 HEDIS Compliance Audit Report findings, **Total Health Care, Inc.** was fully compliant with all IS standards, including:

- IS 1.0: Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry
- IS 2.0: Enrollment Data—Data Capture, Transfer and Entry
- IS 3.0: Practitioner Data—Data Capture, Transfer and Entry
- IS 4.0: Medical Record Review Processes—Training, Sampling, Abstraction and Oversight
- IS 5.0: Supplemental Data—Capture, Transfer and Entry
- IS 7.0: Data Integration—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity

According to the auditors' review, **Total Health Care, Inc.**'s submitted measures were prepared according to the NCQA HEDIS 2018 technical specifications. No rates were determined to be materially biased.

Table 5-59 shows each of the measures, the rate for each measure for 2018, and the categorized performance for 2018 relative to national HEDIS 2017 Medicaid results for **Total Health Care, Inc.**

Table 5-59—Scores for Performance Measures for Total Health Care, Inc.

Measure	HEDIS 2018	2018 Performance Level
Child & Adolescent Care		
Childhood Immunization Status		
Combination 2	71.29%	★★
Combination 3	65.45%	★★
Combination 4	64.48%	★★
Combination 5	53.77%	★
Combination 6	32.12%	★★
Combination 7	53.04%	★★
Combination 8	31.63%	★★
Combination 9	27.25%	★★
Combination 10	27.01%	★★
Well-Child Visits in the First 15 Months of Life		
Six or More Visits	70.32%	★★★★
Lead Screening in Children		
Lead Screening in Children	70.80%	★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.45%	★★★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	55.96%	★★★
Immunizations for Adolescents		
Combination 1	85.16%	★★★★
Appropriate Treatment for Children With Upper Respiratory Infection		
Appropriate Treatment for Children With Upper Respiratory Infection	92.09%	★★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	69.62%	★★
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	53.79%	★★★★
Continuation and Maintenance Phase	66.67%	★★★★

Measure	HEDIS 2018	2018 Performance Level
Women—Adult Care		
Breast Cancer Screening[1]		
Breast Cancer Screening	50.82%	NC
Cervical Cancer Screening		
Cervical Cancer Screening	60.10%	★★★
Chlamydia Screening in Women		
Ages 16 to 20 Years	68.07%	★★★★
Ages 21 to 24 Years	70.00%	★★★★
Total	68.79%	★★★★
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	92.76%	★
Ages 25 Months to 6 Years	83.03%	★
Ages 7 to 11 Years	87.90%	★★
Ages 12 to 19 Years	86.71%	★★
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44 Years	74.92%	★★
Ages 45 to 64 Years	84.31%	★★
Ages 65+ Years	79.64%	★
Total	78.87%	★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	30.80%	★★★
Obesity		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	78.59%	★★★
Counseling for Nutrition—Total	73.72%	★★★
Counseling for Physical Activity—Total	57.91%	★★
Adult BMI Assessment		
Adult BMI Assessment	84.67%	★★
Pregnancy Care		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	63.99%	★
Postpartum Care	48.18%	★
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	82.00%	★
*HbA1c Poor Control (>9.0%)**	52.07%	★

Measure	HEDIS 2018	2018 Performance Level
HbA1c Control (<8.0%)	38.93%	★
Eye Exam (Retinal) Performed	50.61%	★★
Medical Attention for Nephropathy	90.02%	★★
Blood Pressure Control (<140/90 mm Hg)	41.85%	★
Medication Management for People With Asthma		
Medication Compliance 50%—Total[2]	87.36%	★★★★★
Medication Compliance 75%—Total	72.51%	★★★★★
Asthma Medication Ratio		
Total	52.33%	★
Controlling High Blood Pressure		
Controlling High Blood Pressure	29.68%	★
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit	78.67%	★★★
Discussing Cessation Medications	57.96%	★★★★
Discussing Cessation Strategies	45.73%	★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	68.20%	★★★★★
Effective Continuation Phase Treatment	55.35%	★★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.73%	★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	59.79%	★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NC
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	48.95%	★
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	87.17%	★★
Diuretics	86.04%	★★
Total[1]	86.66%	NC
Health Plan Diversity[3]		
Race/Ethnicity Diversity of Membership		
Total—White	30.89%	NC
Total—Black or African American	54.27%	NC

Measure	HEDIS 2018	2018 Performance Level
Total—American-Indian and Alaska Native	0.28%	NC
Total—Asian	1.15%	NC
Total—Native Hawaiian and Other Pacific Islander	0.06%	NC
Total—Some Other Race	2.63%	NC
Total—Two or More Races	0.00%	NC
Total—Unknown	10.72%	NC
Total—Declined	0.00%	NC
Total—Hispanic or Latino	2.63%	NC
Language Diversity of Membership		
Spoken Language Preferred for Health Care—English	99.13%	NC
Spoken Language Preferred for Health Care—Non-English	0.87%	NC
Spoken Language Preferred for Health Care—Unknown	0.00%	NC
Spoken Language Preferred for Health Care—Declined	0.00%	NC
Preferred Language for Written Materials—English	99.13%	NC
Preferred Language for Written Materials—Non-English	0.87%	NC
Preferred Language for Written Materials—Unknown	0.00%	NC
Preferred Language for Written Materials—Declined	0.00%	NC
Other Language Needs—English	99.13%	NC
Other Language Needs—Non-English	0.87%	NC
Other Language Needs—Unknown	0.00%	NC
Other Language Needs—Declined	0.00%	NC
Utilization[3]		
Ambulatory Care—Total (Per 1,000 Member Months)		
*ED Visits—Total**	70.05	★★
Outpatient Visits—Total	336.34	NC
Inpatient Utilization—General Hospital/Acute Care—Total		
Total Inpatient—Discharges per 1,000 Member Months—Total	10.34	NC
Total Inpatient—Average Length of Stay—Total	4.58	NC
Maternity—Discharges per 1,000 Member Months—Total	2.40	NC
Maternity—Average Length of Stay—Total	2.69	NC
Surgery—Discharges per 1,000 Member Months—Total	2.08	NC
Surgery—Average Length of Stay—Total	7.05	NC
Medicine—Discharges per 1,000 Member Months—Total	6.44	NC
Medicine—Average Length of Stay—Total	4.32	NC
Use of Opioids From Multiple Providers (Per 1,000 Members)*		
Use of Opioids From Multiple Providers—Multiple Prescribers	199.52	NC
Use of Opioids From Multiple Providers—Multiple Pharmacies	84.30	NC

Measure	HEDIS 2018	2018 Performance Level
Use of Opioids From Multiple Providers—Multiple Prescribers and Multiple Pharmacies	52.59	NC
Use of Opioids at High Dosage (Per 1,000 Members)*		
Use of Opioids at High Dosage	80.72	NC

[1] Due to changes in the technical specifications for this measure in HEDIS 2018, comparisons to benchmarks were not performed for this measure.
[2] Performance levels for 2018 were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.
[3] These measure indicator rates and any comparisons to benchmarks for these measures are provided for information only.
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table 5-59 shows **Total Health Care, Inc.** had 12 out of 58 measure rates (20.7 percent) that ranked at or above the national Medicaid 75th percentile, four of which ranked at or above the national Medicaid 90th percentile. The measure rates that ranked at or above the 90th percentile include both *Medication Management for People With Asthma* indicators and both *Antidepressant Medication Management* indicators. Conversely, 36 out of 58 measure rates (62.1 percent) fell below the national Medicaid 50th percentile, 14 of which were below the national Medicaid 25th percentile. Measure rates that fell below the national Medicaid 25th percentile spanned multiple domains including Child & Adolescent Care, Access to Care, Pregnancy Care, and Living With Illness. Opportunities for improvement exist for **Total Health Care, Inc.**, especially in the Access to Care and Pregnancy Care domains where most of the measures in each domain fell below the national Medicaid 50th percentile.

Validation of Performance Improvement Projects

For the 2017–2018 PIP, **Total Health Care, Inc.** submitted baseline data for the state-mandated topic, *Addressing Disparities in Timeliness of Prenatal Care.* **Total Health Care, Inc.** analyzed historical data to identify potential disparity within its population related to timeliness of prenatal care. However, after conducting a thorough analysis of its data, **Total Health Care, Inc.** identified no disparities and determined that the focus of the PIP should be to improve timeliness of prenatal care for women ages 23 to 28. MDHHS approved the MHP's selected topic.

Table 5-60 outlines the study indicator for the PIP.

Table 5-60—Study Indicator

PIP Topic	Study Indicator
Improving Timeliness of Prenatal Care for Women Ages 23 to 28	The percentage of eligible women ages 23 to 28 who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.

Table 5-61 displays the validation results for **Total Health Care, Inc.**'s PIP. This table illustrates the MHP's overall application of the PIP process and success in implementing the PIP. 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 5-61 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 5-61—Performance Improvement Project Validation Results for Total Health Care, Inc.

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% (2/2)	0% (0/2)	0% (0/2)
	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% (10/10)**	**0% (0/10)**	**0% (0/10)**

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	75% (3/4)	25% (1/4)	0% (0/4)
Implementation Total			**86% (6/7)**	**14% (1/7)**	**0% (0/7)**
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**94% (16/17)**		

Overall, 94 percent of all applicable evaluation elements received a score of *Met* for the Design and Implementation stages of the PIP. The MHP has opportunities for improvement related to documentation completeness and addressing HSAG's validation feedback in the Implementation stage.

For the baseline measurement period, **Total Health Care, Inc.** reported that 35.4 percent of eligible women 23 to 28 years of age received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment. The Remeasurement 1 goal was set at 42 percent.

Strengths, Weaknesses, and Overall Conclusions

Total Health Care, Inc. demonstrated both strengths and weaknesses based on the results of the 2017–2018 EQR activities. **Total Health Care, Inc.** received a total compliance score of 94 percent across all program areas reviewed during the 2017–2018 compliance review. **Total Health Care, Inc.** scored 91 percent or above in the Administrative, Members, Quality, MIS, and Program Integrity standards, indicating generally strong performance in these program areas, but did not perform as well in the Providers standard, as demonstrated by a moderate performance score (87 percent), reflecting that additional focus is needed in this area. While 12 of the 58 HEDIS performance measure rates were ranked at or above the national Medicaid 75th percentile, indicating strengths in these areas, 36 HEDIS measure rates fell below the national Medicaid 50th percentile, indicating opportunities for improvement primarily in the Child & Adolescent Care, Access to Care, Pregnancy Care, and Living With Illness domains.

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

Table 5-62—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: Received a performance score of 100 percent in the Administrative program area, indicating that the MHP had adequate staffing and oversight mechanisms in place to ensure the delivery of quality services to its members. • Strength: Received a performance score of 100 percent in the Quality program area, indicating that the MHP had the components of an effective QAPIP in place to assess and improve the quality of services provided to members. • Strength: Received a performance score of 100 percent in the MIS program area, indicating that the MHP maintained a health information system that is capable of collecting, analyzing, integrating, and reporting data to meet the obligations under its contract with MDHHS and, therefore, the ability to appropriately monitor the quality of services being provided to members. • Strength: The two HEDIS performance rates under *Follow-Up Care for Children Prescribed ADHD Medication* were between the national Medicaid 75th and 89th percentiles, indicating prescribed ADHD medications were closely monitored by a pediatrician. • Strength: All three rates under the *Chlamydia Screening in Women* HEDIS performance measure were between the national Medicaid 75th and 89th percentiles, indicating many women ages 16 to 24 years were being screened for this sexually transmitted disease. • Strength: The two rates under the *Medication Management for People With Asthma* HEDIS performance measure ranked at or above the national Medicaid 90th percentile, indicating adult and child members diagnosed with persistent asthma were dispensed appropriate asthma controller medications and remained on the medications for most of their treatment period. • Strength: One of three rates under the *Medical Assistance With Smoking and Tobacco Use Cessation* HEDIS performance measure was between the national Medicaid 75th and 89th percentiles, indicating many adults who are tobacco smokers or users discussed cessation medications to help quit tobacco and improve overall health. • Strength: The two rates under the *Antidepressant Medication Management* HEDIS performance measure ranked at or exceeded the 90th percentile, indicating adults diagnosed with major depression received effective medication management which can improve a person's daily functioning and wellbeing, and reduce the risk of suicide. • Weakness: The *Lead Screening in Children* HEDIS performance measure rate was between the national Medicaid 25th and 49th percentiles, indicating many children were not tested for lead poisoning which can lead to irrevocable effects on a child's physical and mental health. • Weakness: The *Appropriate Testing for Children With Pharyngitis* HEDIS performance measure rate fell between the national Medicaid 25th and 49th

Performance Area*	Overall Performance Impact
	percentiles, indicating many children diagnosed with pharyngitis and dispensed an antibiotic did not receive the appropriate testing which reduces the unnecessary use of antibiotics. • Weakness: One of three HEDIS performance measure rates under *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* and the rate for *Adult BMI Assessment* fell between the national Medicaid 25th and 49th percentiles, indicating children and adolescents did not receive counseling on physical activity and adult BMIs were not assessed by a PCP or OB/GYN during a medical appointment. These actions are important to identify at-risk members and provide suggestions and services to assist them in obtaining and maintaining a healthier weight. • Weakness: Two of six rates under the *Comprehensive Diabetes Care* HEDIS performance measure fell between the national Medicaid 25th and 49th percentiles, and four rates fell below the 25th percentile, indicating opportunities for improvement to control blood pressure which is essential to reduce risks for complications. • Weakness: Although the MHP demonstrated strength in its members being dispensed and remaining on asthma controller medications through treatment, the *Asthma Medication Ratio—Total* measure rate fell below the national Medicaid 25th percentile, indicating an opportunity to improve the ratio of controller medications to total asthma medications and reducing the prevalence of asthma attacks. • Weakness: The HEDIS performance measure rate for *Controlling High Blood Pressure* fell below the national Medicaid 25th percentile, indicating opportunities for controlling high blood pressure, which is an important step in preventing heart attacks, strokes, and kidney disease. • Weakness: The rate for the *Diabetes Monitoring for People With Diabetes and Schizophrenia* HEDIS performance measure fell below the national Medicaid 25th percentile, indicating many adult members diagnosed with schizophrenia and diabetes did not always receive a LDL-C and HbA1c test during the year, and therefore may have an increased risk for declining health. • Weakness: The *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* HEDIS performance measure rate fell below the national Medicaid 25th percentile, indicating many adults with schizophrenia were dispensed but did not remain on an antipsychotic for most of their treatment period, therefore increasing the risk of relapse and complications. • Weakness: The two HEDIS performance rates under *Annual Monitoring for Patients on Persistent Medications* (*ACE Inhibitors or ARBs* and *Diuretics*) fell between the national Medicaid 25th and 49th percentiles, indicating many adult members may be at risk of adverse drug events.

Performance Area*	Overall Performance Impact
Timeliness	• Strength: Received a performance score of 100 percent in the Members program area, indicating members received member materials, including an ID card, in a timely manner, to have information available to access services as soon as needed. • Strength: Although the MHP had opportunities to improve documentation completeness for its PIP, 94 percent of all applicable evaluation elements received a score of *Met* for the Design and Implementation stages, indicating the MHP is on track to effectively address disparities in timeliness of prenatal care services. • Strength: The rate for the *Well-Child Visits in the First 15 Months of Life* HEDIS performance measure was between the national Medicaid 75th and 89th percentiles, indicating many children in the first 15 months of life were seeing their PCPs as often as suggested to ensure timely assessment of their physical, emotional, and social development. • Strength: The *Immunizations for Adolescents* HEDIS performance measure rate was between the national Medicaid 75th and 89th percentiles, indicating many adolescents received vaccines in a timely manner to protect them from serious and potentially life-threatening illnesses. • Weakness: Nine of nine *Childhood Immunization Status* HEDIS performance measure rates fell at or below the national Medicaid 49th percentile, with one of those rates falling below the 25th percentile, indicating children were not always receiving vaccines in a timely manner to protect them from serious and potentially life-threatening illnesses. • Weakness: The two HEDIS performance measure rates under *Prenatal and Postpartum Care* fell below the national Medicaid 25th percentile, indicating pregnant women are not always accessing timely prenatal care and/or having a timely postpartum visit after delivery, which could impact the health of the member and her baby before, during, and after pregnancy.
Access	• Weakness: Received a performance score of 87 percent in the Providers program area, indicating members may experience challenges locating and accessing providers to obtain treatment. • Weakness: All four rates under the *Children and Adolescents' Access to Primary Care Practitioners* HEDIS performance measure fell at or below the national Medicaid 49th percentiles, with two of those rates falling below the 25th percentile, indicating children of all ages were not always accessing primary care services for appropriate screenings, treatment, and preventive services. • Weakness: Three of four rates under the *Adults' Access to Preventive/Ambulatory Health Services* HEDIS performance measure were between the national Medicaid 25th and 49th percentiles, with one rate falling below the 25th percentile, indicating many adults of all ages were not accessing ambulatory or preventive care services from their physicians. • Weakness: The *Ambulatory Care—Total (Per 1,000 Member Months)*, *ED Visits—Total* HEDIS performance measure rate fell between the national Medicaid 25th and 49th percentiles, indicating potential inadequate access to care resulting in preventable ED visits.

* Performance impacts may be applicable to one or more performance areas; however, for this report they were aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which MHPs addressed the EQR recommendations made from the prior year's technical report. During the 2016–2017 EQR, HSAG made the following recommendations to **Total Health Care, Inc.**, and **Total Health Care, Inc.** addressed these recommendations by taking the following actions:

Compliance Monitoring

For the 2016–2017 review period, HSAG recommended that **Total Health Care, Inc.** initiate QI initiatives to address the opportunity for improvement identified during the annual compliance review for the Providers standard, with one *Fail* finding and a compliance score of 93 percent.

The 2016–2017 compliance review identified opportunities for improvement for the Providers standard. **Total Health Care, Inc.**'s 2017–2018 compliance review findings indicate that the one deficiency during the 2016–2017 review period received similar findings during the 2017–2018 review period and is described below. These findings indicate that **Total Health Care, Inc.** did not fully address the prior year's recommendation.

Table 5-63—Congruent Year-Over-Year Findings

Category	2016–2017 Findings	2017–2018 Findings
MHP Provider Directory	**Total Health Care, Inc.**'s online provider directory and/or provider availability was not current based on the information obtained from calls made to primary care providers in February 2017 to check for accurate provider availability.	**Total Health Care, Inc.** received similar findings, as the provider directory and/or provider availability was not current based on a random sample of calls made to PCPs in February and August 2018 to check for accurate provider availability.

Validation of Performance Measures

The 2016–2017 validation of performance measures for **Total Health Care, Inc.** identified opportunities for improvement in the following performance measures, as these measures fell below the national Medicaid 25th percentile:

Child & Adolescent Care

- *Childhood Immunization Status—Combination 6*, *8*, *9,* and *10*
- *Appropriate Testing for Children With Pharyngitis*

Access to Care

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years*

Pregnancy Care

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits*

Living With Illness

- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* and *Blood Pressure Control (<140/90 mm Hg)*
- *Asthma Medication Ratio—Total*
- *Controlling High Blood Pressure*
- *Diabetes Monitoring for People With Diabetes and Schizophrenia*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*

Utilization

- *Ambulatory Care—Total (Per 1,000 Member Months)—Emergency Department Visits—Total*

HSAG recommended that **Total Health Care, Inc.** focus on ensuring the completeness and accuracy of data used for calculating all HEDIS measures, and specifically, on improving the rates for measures that fell below the national Medicaid 25th percentile. Based on the results of the 2017–2018 validation, several indicators (*Childhood Immunization Status—Combination 6, 8, 9, and 10; Appropriate Testing for Children With Pharyngitis; Children and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years*; and *Ambulatory Care—Total [Per 1,000 Member Months]—Emergency Department Visits—Total*) improved to rates between the 25th and 49th percentiles; however, the remaining performance measure rates remained below the national Medicaid 25th percentile, indicating **Total Health Care, Inc.** partially addressed the prior recommendations. The *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits* and *Annual Monitoring for Patients on Persistent Medications—Digoxin* rates were not included in the 2017–2018 PMV.

Validation of Performance Improvement Projects

For the 2016–2017 validation, **Total Health Care, Inc.** designed a scientifically sound project supported by the use of key research principles, meeting 100 percent of the requirements in the Design stage. The technical design of the PIP was sufficient to measure and monitor PIP outcomes; therefore, there were no required follow-up recommendations.

Recommendations

As a result of the findings related to quality of, timeliness of, and access to care and services provided by **Total Health Care, Inc.** to members, HSAG recommends that **Total Health Care, Inc.** incorporate efforts for improvement of the following performance measures rating below the national Medicaid 25th percentile as part of its QI strategy within the QAPIP:

Child & Adolescent Care

- *Childhood Immunization Status—Combination 5*

Access to Care

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months* and *Ages 25 Months to 6 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years*

Pregnancy Care

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

Living With Illness

- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%),* and *Blood Pressure Control (<140/90 mm Hg)*
- *Asthma Medication Ratio—Total*
- *Controlling High Blood Pressure*
- *Diabetes Monitoring for People With Diabetes and Schizophrenia*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*

Total Health Care, Inc. should include within its next annual QAPIP review the results of analyses for the performance measures listed above that answer the following questions:

1. What were the root causes associated with rates indicating low performance?
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 **Total Health Care, Inc.** considering or has already implemented to improve rates and performance for each identified measure?

Based on the information presented, **Total Health Care, Inc.** should include the following within its QI plan:

- Measurable goals and benchmarks for each 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
- QI interventions that address the root cause of the deficiency
- A plan to monitor the QI interventions to detect whether they effect improvement

HSAG also recommends that **Total Health Care, Inc.** adhere to all federal managed care requirements listed under 42 CFR 438 Subpart D and the QAPIP requirements under Subpart E, State of Michigan contract requirements, and specifically, develop meaningful plans of action to bring into compliance each of the following deficient program areas:

- Providers
- Program Integrity

Total Health Care, Inc. should include the following in each of its plans of action, and the plans of action should be provided to MDHHS as requested:

- Detailed narrative of the deficiency
- Detailed corrective action steps to resolve each deficiency
- Any resources required to resolve the deficiency
- Due dates for completing each action step
- Assigned party responsible for completing each action step
- Any required deliverables to show that a deficiency has been resolved
- Any dependencies to resolve deficiencies

Finally, **Total Health Care, Inc.** should take proactive steps to ensure a successful PIP. As the PIP progresses, **Total Health Care, Inc.** should ensure the following:

- Address all validation feedback and make necessary corrections prior to the next annual submission.
- Follow the approved PIP methodology to calculate and report data accurately in next year's annual submission.
- To impact the Remeasurement 1 study indicator rate, 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 will not have enough time to impact the study indicator rate.

- Document the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.

UnitedHealthcare Community Plan

To conduct the 2017–2018 EQR, HSAG reviewed **UnitedHealthcare Community Plan**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **UnitedHealthcare Community Plan**.

EQR Activity Results

Compliance Monitoring

UnitedHealthcare Community Plan was evaluated in six program areas referred to as standards. Table 5-64 presents the total number of criteria for each standard as well as the number of criteria for each standard that received a score of *Pass*, *Incomplete*, or *Fail*. Table 5-64 presents **UnitedHealthcare Community Plan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages.

Table 5-64—Compliance Review Results for UnitedHealthcare Community Plan (UNI)

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	*Total Applicable*	UNI	Statewide
1	Administrative	5	0	0	5	100%	97%
2	Providers	13	0	2	15	87%	87%
3	Members	8	0	0	8	100%	98%
4	Quality	13	0	0	13	100%	99%
5	MIS	10	0	0	10	100%	99%
6	Program Integrity	27	1	0	28	98%	92%
Overall		**76**	**1**	**2**	**79**	**97%**	**94%**

The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

UnitedHealthcare Community Plan demonstrated compliance for 76 of 79 elements, with an overall compliance score of 97 percent, which was above the statewide average. **UnitedHealthcare Community Plan** demonstrated strong performance, scoring above 90 percent in five standards, with four standards (Administrative, Members, Quality, and MIS) achieving full compliance. These program areas of strength include the Administrative, Members, Quality, MIS, and Program Integrity standards.

Opportunities for improvement were identified in two of the six standards which included deficiencies related to the following requirements:

- *MHP Provider Directory*—MDHHS conducted a random sample of calls to PCPs to check for accurate provider availability. The findings, as reported by MDHHS, are summarized below:

Table 5-65—Provider Directory Findings

February 2018	August 2018
• 60 percent of providers had the correct information listed in the online directory and confirmed they were accepting new patients • 3 providers were unable to be reached	• 64 percent of providers had the correct information listed in the online directory and confirmed they were accepting new patients • 90 percent of providers matched what was submitted on the 4275 for "accepting new patients" • 89 percent of providers appeared to have matching contact information online and on the 4275 • 3 providers were unable to be reached

- *Tips and Grievances Form*—Errors and/or discrepancies were noted on the form for one quarter.

UnitedHealthcare Community Plan was required to develop and implement a corrective action plan for each requirement in all program areas that received an *Incomplete* or a *Fail* finding.

Validation of Performance Measures

UnitedHealthcare Community Plan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the 2018 HEDIS Compliance Audit Report findings, **UnitedHealthcare Community Plan** was fully compliant with all IS standards, including:

- IS 1.0: Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry
- IS 2.0: Enrollment Data—Data Capture, Transfer and Entry
- IS 3.0: Practitioner Data—Data Capture, Transfer and Entry
- IS 4.0: Medical Record Review Processes—Training, Sampling, Abstraction and Oversight
- IS 5.0: Supplemental Data—Capture, Transfer and Entry
- IS 7.0: Data Integration—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity

According to the auditors' review, **UnitedHealthcare Community Plan**'s submitted measures were prepared according to the NCQA HEDIS 2018 technical specifications. No rates were determined to be materially biased.

Table 5-66 shows each of the measures, the rate for each measure for 2018, and the categorized performance for 2018 relative to national HEDIS 2017 Medicaid results for **UnitedHealthcare Community Plan**.

Table 5-66—Scores for Performance Measures for UnitedHealthcare Community Plan

Measure	HEDIS 2018	2018 Performance Level
Child & Adolescent Care		
Childhood Immunization Status		
Combination 2	75.91%	★★★
Combination 3	71.53%	★★
Combination 4	71.29%	★★★
Combination 5	61.56%	★★★
Combination 6	37.71%	★★
Combination 7	61.56%	★★★
Combination 8	37.71%	★★
Combination 9	34.31%	★★★
Combination 10	34.31%	★★★
Well-Child Visits in the First 15 Months of Life		
Six or More Visits	68.61%	★★★
Lead Screening in Children		
Lead Screening in Children	81.51%	★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.37%	★★★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	63.26%	★★★★
Immunizations for Adolescents		
Combination 1	84.91%	★★★★
Appropriate Treatment for Children With Upper Respiratory Infection		
Appropriate Treatment for Children With Upper Respiratory Infection	90.42%	★★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	76.71%	★★★
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	44.49%	★★
Continuation and Maintenance Phase	58.02%	★★★
Women—Adult Care		
Breast Cancer Screening[1]		
Breast Cancer Screening	62.65%	NC
Cervical Cancer Screening		
Cervical Cancer Screening	67.88%	★★★★

Measure	HEDIS 2018	2018 Performance Level
Chlamydia Screening in Women		
Ages 16 to 20 Years	67.29%	★★★★
Ages 21 to 24 Years	70.87%	★★★★
Total	68.73%	★★★★
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	95.11%	★★
Ages 25 Months to 6 Years	88.96%	★★★
Ages 7 to 11 Years	91.73%	★★★
Ages 12 to 19 Years	91.91%	★★★
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44 Years	78.88%	★★
Ages 45 to 64 Years	88.66%	★★★
Ages 65+ Years	95.99%	★★★★★
Total	82.74%	★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	33.20%	★★★
Obesity		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	85.89%	★★★★
Counseling for Nutrition—Total	77.86%	★★★★
Counseling for Physical Activity—Total	70.32%	★★★★
Adult BMI Assessment		
Adult BMI Assessment	94.65%	★★★★★
Pregnancy Care		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	78.83%	★★
Postpartum Care	67.15%	★★★
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	89.29%	★★★
*HbA1c Poor Control (>9.0%)**	31.29%	★★★★
HbA1c Control (<8.0%)	57.29%	★★★★
Eye Exam (Retinal) Performed	64.43%	★★★★
Medical Attention for Nephropathy	94.43%	★★★★★
Blood Pressure Control (<140/90 mm Hg)	66.29%	★★★

Measure	HEDIS 2018	2018 Performance Level
Medication Management for People With Asthma		
Medication Compliance 50%—Total[2]	75.52%	★★★★★
Medication Compliance 75%—Total	57.49%	★★★★★
Asthma Medication Ratio		
Total	62.26%	★★★
Controlling High Blood Pressure		
Controlling High Blood Pressure	64.48%	★★★
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit	83.54%	★★★★★
Discussing Cessation Medications	61.27%	★★★★★
Discussing Cessation Strategies	52.87%	★★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	61.66%	★★★★
Effective Continuation Phase Treatment	46.89%	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	85.33%	★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	71.10%	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	75.38%	★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	55.04%	★★
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	88.88%	★★★
Diuretics	88.73%	★★★
Total[1]	88.82%	NC
Health Plan Diversity[3]		
Race/Ethnicity Diversity of Membership		
Total—White	51.27%	NC
Total—Black or African American	30.28%	NC
Total—American-Indian and Alaska Native	0.25%	NC
Total—Asian	2.05%	NC
Total—Native Hawaiian and Other Pacific Islander	0.01%	NC

Measure	HEDIS 2018	2018 Performance Level
Total—Some Other Race	0.00%	NC
Total—Two or More Races	0.00%	NC
Total—Unknown	16.15%	NC
Total—Declined	0.00%	NC
Total—Hispanic or Latino	5.60%	NC
Language Diversity of Membership		
Spoken Language Preferred for Health Care—English	95.63%	NC
Spoken Language Preferred for Health Care—Non-English	4.37%	NC
Spoken Language Preferred for Health Care—Unknown	0.00%	NC
Spoken Language Preferred for Health Care—Declined	0.00%	NC
Preferred Language for Written Materials—English	95.63%	NC
Preferred Language for Written Materials—Non-English	4.37%	NC
Preferred Language for Written Materials—Unknown	0.00%	NC
Preferred Language for Written Materials—Declined	0.00%	NC
Other Language Needs—English	0.00%	NC
Other Language Needs—Non-English	0.00%	NC
Other Language Needs—Unknown	100.00%	NC
Other Language Needs—Declined	0.00%	NC
Utilization[3]		
Ambulatory Care—Total (Per 1,000 Member Months)		
*ED Visits—Total**	69.56	★★
Outpatient Visits—Total	380.46	NC
Inpatient Utilization—General Hospital/Acute Care—Total		
Total Inpatient—Discharges per 1,000 Member Months—Total	6.33	NC
Total Inpatient—Average Length of Stay—Total	4.18	NC
Maternity—Discharges per 1,000 Member Months—Total	2.56	NC
Maternity—Average Length of Stay—Total	2.56	NC
Surgery—Discharges per 1,000 Member Months—Total	1.49	NC
Surgery—Average Length of Stay—Total	6.74	NC
Medicine—Discharges per 1,000 Member Months—Total	3.00	NC
Medicine—Average Length of Stay—Total	3.91	NC
Use of Opioids From Multiple Providers (Per 1,000 Members)*		
Use of Opioids From Multiple Providers—Multiple Prescribers	184.59	NC
Use of Opioids From Multiple Providers—Multiple Pharmacies	1.36	NC
Use of Opioids From Multiple Providers—Multiple Prescribers and Multiple Pharmacies	0.83	NC

Measure	HEDIS 2018	2018 Performance Level
Use of Opioids at High Dosage (Per 1,000 Members)*		
Use of Opioids at High Dosage	35.33	NC

[1] Due to changes in the technical specifications for this measure in HEDIS 2018, comparisons to benchmarks are not performed for this measure.
[2] Performance levels for 2018 were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.
[3] These measure indicator rates and any comparisons to benchmarks for these measures are provided for information only.
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
2018 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table 5-66 shows **UnitedHealthcare Community Plan** had 24 out of 59 measure rates (40.7 percent) that ranked at or above the national Medicaid 75th percentile, seven of which ranked at or above the national Medicaid 90th percentile. Measures that ranked at or above the 90th percentile were in the Access to Care, Obesity, and Living With Illness domains. Conversely, 10 out of 59 measure rates (16.9 percent) fell below the national Medicaid 50th percentile. Although no measure rates fell below the national Medicaid 25th percentile, opportunities for improvement for **UnitedHealthcare Community Plan** could be extended to include those measures that fell below the national Medicaid 50th percentile, such as measures within the Access to Care and Pregnancy Care domains.

Validation of Performance Improvement Projects

For the 2017–2018 PIP, **UnitedHealthcare Community Plan** submitted baseline data for the state-mandated topic, *Addressing Disparities in Timeliness of Prenatal Care.* **UnitedHealthcare Community Plan** analyzed historical data and identified a disparity related to timeliness of prenatal care among its African-American/Black and White populations. The goal of the PIP is to improve the timeliness of prenatal care for the African-American/Black population and eliminate the identified disparity without a decline in performance for the White population.

Table 5-67 outlines the study indicators for the PIP.

Table 5-67—Study Indicators

PIP Topic	Study Indicators
Addressing Disparities in Timeliness of Prenatal Care	1. The percentage of eligible African-American or Black women who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year. 2. The percentage of eligible White women who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.

Table 5-68 displays the validation results for **UnitedHealthcare Community Plan**'s PIP. This table illustrates the MHP's overall application of the PIP process and success in implementing the PIP. 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 5-68 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 5-68—Performance Improvement Project Validation Results for UnitedHealthcare Community Plan

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% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	67% (2/3)	33% (1/3)	0% (0/3)
Design Total			**89% (8/9)**	**11% (1/9)**	**0% (0/9)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	67% (2/3)	33% (1/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (5/5)	0% (0/5)	0% (0/5)
Implementation Total			**88% (7/8)**	**13% (1/8)**	**0% (0/8)**
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**88% (15/17)**		

*Percentage totals may not equal 100 due to rounding.

Overall, 88 percent of all applicable evaluation elements received a score of *Met* for both the Design and Implementation stages of the PIP. The technical design of the PIP was sufficient to measure and monitor PIP outcomes; however, opportunities for improvement exist related to the MHP's documentation and omission of requirements in Step VI, Accurate/Complete Data Collection and Step VII, Sufficient Data Analysis and Interpretation of Results.

For the baseline measurement period, **UnitedHealthcare Community Plan** reported that 55.9 percent of eligible Black/African-American women received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment, and 61.3 percent of eligible White women received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment. The goal for the PIP is that there will no longer be a statistically significant rate difference between the two subgroups.

Strengths, Weaknesses, and Overall Conclusions

UnitedHealthcare Community Plan demonstrated both strengths and weaknesses based on the results of the 2017–2018 EQR activities. **UnitedHealthcare Community Plan** received a total compliance score of 97 percent across all program areas reviewed during the 2017–2018 compliance review. **UnitedHealthcare Community Plan** scored 98 percent or above in the Administrative, Members, Quality, MIS, and Program Integrity standards, indicating strong performance in these program areas, but did not perform as well in the Providers standard, as demonstrated by a moderate performance score (87 percent), reflecting that additional focus is needed in this area. While 24 of the 59 HEDIS performance measure rates were ranked at or above the national Medicaid 75th percentile, indicating strengths in these areas, 10 HEDIS measure rates fell below the national Medicaid 50th percentile, indicating opportunities for improvement primarily in the Access to Care and Pregnancy Care domains.

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

Table 5-69—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: Received a performance score of 100 percent in the Administrative program area, indicating that the MHP had adequate staffing and oversight mechanisms in place to ensure the delivery of quality services to its members. • Strength: Received a performance score of 100 percent in the Quality program area, indicating that the MHP had the components of an effective QAPIP in place to assess and improve the quality of services provided to members. • Strength: Received a performance score of 100 percent in the MIS program area, indicating that the MHP maintained a health information system that is capable of collecting, analyzing, integrating, and reporting data to meet the obligations under its contract with MDHHS and, therefore, the ability to appropriately monitor the quality of services being provided to members.

Performance Area*	Overall Performance Impact
	• Strength: Received a performance score of 98 percent in the Program Integrity standard during the compliance review, indicating the MHP's program integrity processes are compliant with federal and State regulations, and contracted providers have been appropriately screened and meet the MHP's expectations for a quality provider. • Strength: The *Lead Screening in Children* HEDIS performance measure rate was between the national Medicaid 75th and 89th percentiles, indicating many children were tested for lead poisoning by 2 years of age. • Strength: The rate for the *Cervical Cancer Screening* HEDIS performance measure was between the national Medicaid 75th and 89th percentiles, indicating many women were screened for this type of cancer which is highly treatable if detected early. • Strength: All three rates under the *Chlamydia Screening in Women* HEDIS performance measure were between the national Medicaid 75th and 89th percentiles, indicating many women ages 16 to 24 years were being screened for this sexually transmitted disease. • Strength: The three rates under the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* HEDIS performance measure were between the national Medicaid 75th and 89th percentiles, and the *Adult BMI Assessment* rate ranked at or above the 90th percentile, indicating child, adolescent, and adult BMIs were assessed and children and adolescents received counseling for nutrition and physical activity by a PCP or OB/GYN during a medical appointment which can help providers identify at-risk members and provide suggestions and services to assist them in obtaining and maintaining a healthier weight. • Strength: Three of six HEDIS performance measure rates under *Comprehensive Diabetes Care* (i.e., *HbA1c Poor Control [>9.0%]*, *HbA1c Control [<8.0%]*, and *Eye Exam [Retinal] Performed*) were between the national Medicaid 74th and 89th percentiles, and one rate (*Medical Attention for Nephropathy*) met or exceeded the 90th percentile, indicating many adults received proper diabetes management which is essential to control blood glucose and reduce risks for complications. • Strength: The two rates under the *Medication Management for People With Asthma* HEDIS performance measure met or exceeded the national Medicaid 90th percentile, indicating adult and child members diagnosed with persistent asthma were dispensed appropriate asthma controller medications and remained on the medications for most of their treatment period. • Strength: The three rates under the *Medical Assistance With Smoking and Tobacco Use Cessation* HEDIS performance measure were at or above the national Medicaid 75th percentile, with two of those rates at or above the 90th percentile, indicating many adults who are tobacco smokers or users received cessation advice and discussed cessation medications and strategies to help quit tobacco and improve overall health. • Strength: The two rates under the *Antidepressant Medication Management* HEDIS performance measure were between the national Medicaid 75th and 90th percentiles, indicating adults diagnosed with major depression received effective medication

Performance Area*	Overall Performance Impact
	management which can improve a person's daily functioning and wellbeing, and reduce the risk of suicide. • Strength: The rate for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* HEDIS performance measure was between the national Medicaid 75th and 89th percentiles, indicating many adults diagnosed with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication had a diabetes screening. • Weakness: One of two rates under the *Follow-Up Care for Children Prescribed ADHD Medication* HEDIS performance measure (*Initiation Phase*) fell between the national Medicaid 25th and 49th percentiles, indicating additional opportunities for prescribed ADHD medications to be more closely monitored by a pediatrician. • Weakness: The HEDIS performance measure rate for *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* fell between the national Medicaid 25th and 49th percentiles, indicating many adult members diagnosed with schizophrenia and cardiovascular disease did not receive an LDL-C test, and therefore did not receive appropriate screening and monitoring to detect any decline in health. • Weakness: The *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* HEDIS performance measure rate fell between the national Medicaid 25th and 49th percentiles, indicating adults may be at risk for relapse or even hospitalization due to medication nonadherence.
Timeliness	• Strength: Received a performance score of 100 percent in the Members program area, indicating members received member materials, including an ID card, in a timely manner, to have information available to access services as needed. • Strength: The rate for the *Adolescent Well-Care Visits* HEDIS performance measure was between the national Medicaid 75th and 89th percentiles, indicating many adolescents were seeing their PCPs as often as suggested to ensure timely assessment of their physical, emotional, and social development. • Strength: The *Immunizations for Adolescents* HEDIS performance measure rate was between the national Medicaid 75th and 89th percentiles, indicating many adolescents received vaccines in a timely manner to protect them from serious and potentially life-threatening illnesses. • Weakness: Although the technical design of the MHP's PIP was sufficient to measure and monitor PIP outcomes, 88 percent of the applicable evaluation elements received a score of *Met,* indicating the MHP still had opportunities to improve its documentation, collection of data, data analysis, and interpretation of results to improve processes and interventions that may positively impact the timeless of prenatal care for its members. • Weakness: Three of nine *Childhood Immunization Status* HEDIS performance measure rates fell between the 25th and 49th percentiles, indicating children were not always receiving vaccines in a timely manner to protect them from serious and potentially life-threatening illnesses.

Performance Area*	Overall Performance Impact
	• Weakness: One of two HEDIS performance measure rates under *Prenatal and Postpartum Care* fell between the national Medicaid 25th and 49th percentiles, indicating pregnant women are not always accessing timely prenatal care which could impact the health of the member and her baby before, during, and after pregnancy.
Access	• Strength: One of four rates under the *Adults' Access to Preventive/Ambulatory Health Services* HEDIS performance measure ranked at or above the 90th percentile, indicating many adults 65 years of age and older were accessing ambulatory or preventive care services from their physicians. • Weakness: Received a performance score of 87 percent in the Providers program area, indicating members may experience challenges locating and accessing providers to obtain treatment. • Weakness: One of four rates under the *Children and Adolescents' Access to Primary Care Practitioners* HEDIS performance measure was between the 25th and 49th percentiles, indicating many children between the ages of 12 and 24 months were not always accessing primary care services for appropriate screenings, treatment, and preventive services. • Weakness: One of four rates under the *Adults' Access to Preventive/Ambulatory Health Services* HEDIS performance measure was between the 25th and 49th percentiles, indicating many adults ages 20 to 44 years were not accessing ambulatory or preventive care services from their physicians. • Weakness: The *Ambulatory Care—Total (Per 1,000 Member Months)*, *ED Visits—Total* HEDIS performance measure rate fell between the national Medicaid 25th and 49th percentiles, indicating potential inadequate access to care resulting in preventable ED visits.

* Performance impacts may be applicable to one or more performance areas; however, for this report they were aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which MHPs addressed the EQR recommendations made from the prior year's technical report. During the 2016–2017 EQR, HSAG made the following recommendations to **UnitedHealthcare Community Plan**, and **UnitedHealthcare Community Plan** addressed these recommendations by taking the following actions:

Compliance Monitoring

For the 2016–2017 review period, HSAG recommended that **UnitedHealthcare Community Plan** initiate QI initiatives to address the opportunities for improvement identified during the annual compliance review. HSAG also recommended that **UnitedHealthcare Community Plan** focus on the Providers standard, its lowest-scoring standard, with one *Fail* finding and a compliance score of 93 percent. Additionally, HSAG recommended that **UnitedHealthcare Community Plan** consider

initiating PDSA cycles or PIPs for performance measures that fell below standards for consecutive review periods.

The 2016–2017 compliance review identified opportunities for improvement for the Providers and Program Integrity standards. **UnitedHealthcare Community Plan**'s 2017–2018 compliance review findings indicate that two of the three deficiencies in the following categories were sufficiently addressed: *Audits Form*, and *Provider Disenrollments Form*. One of the three deficiencies during the 2016–2017 review period received similar findings during the 2017–2018 review period, which are described below. These findings indicate that **UnitedHealthcare Community Plan** partially addressed the prior year's recommendations.

Table 5-70—Congruent Year-Over-Year Findings

Category	2016–2017 Findings	2017–2018 Findings
MHP Provider Directory	**UnitedHealthcare Community Plan**'s online provider directory and/or provider availability was not current based on the information obtained from calls made to primary care providers in February 2017 to check for accurate provider availability.	**UnitedHealthcare Community Plan** received similar findings, as the provider directory and/or provider availability was not current based on a random sample of calls made to PCPs in February and August 2018 to check for accurate provider availability.

Validation of Performance Measures

The 2016–2017 validation of performance measures for **UnitedHealthcare Community Plan** identified opportunities for improvement in the following performance measures, as these measures fell below the national Medicaid 25th percentile:

Living With Illness

- *Annual Monitoring for Patients on Persistent Medications—Digoxin*

HSAG recommended that **UnitedHealthcare Community Plan** focus on ensuring the completeness and accuracy of data used for calculating all HEDIS measures, and specifically, on improving the rates for measures that fell below the national Medicaid 25th percentile. *Annual Monitoring for Patients on Persistent Medications—Digoxin* rates were not included in the 2017–2018 PMV; therefore, HSAG was unable to determine if **UnitedHealthcare Community Plan** effectively addressed the prior recommendation.

Validation of Performance Improvement Projects

For the 2016–2017 validation, **UnitedHealthcare Community Plan** designed a scientifically sound project supported by the use of key research principles, meeting 100 percent of the requirements in the Design stage. The technical design of the PIP was sufficient to measure and monitor PIP outcomes; therefore, there were no required follow-up recommendations.

Recommendations

As a result of the findings related to quality of, timeliness of, and access to care and services provided by **UnitedHealthcare Community Plan** to members, HSAG determined that **UnitedHealthcare Community Plan** had no measure rates that were below the national Medicaid 25th percentile. HSAG recommends that **UnitedHealthcare Community Plan** prioritize its efforts for improvement on those measure rates below the national Medicaid 50th percentile and focus particularly on those measure rates within the Access to Care and Pregnancy Care domains. **UnitedHealthcare Community** Plan should incorporate these efforts as part of its QI strategy within the QAPIP and consider answering the following questions:

1. What were the root causes associated with rates indicating lower performance?
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 **UnitedHealthcare Community Plan** considering or has already implemented to improve rates and performance for each identified measure?

Based on the information presented, **UnitedHealthcare Community Plan** should include the following within its QI plan:

- Measurable goals and benchmarks for each 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
- QI interventions that address the root cause of the deficiency
- A plan to monitor the QI interventions to detect whether they effect improvement

HSAG also recommends that **UnitedHealthcare Community Plan** adhere to all federal managed care requirements listed under 42 CFR 438 Subpart D and the QAPIP requirements under Subpart E, State of Michigan contract requirements, and specifically, develop meaningful plans of action to bring into compliance each of the following deficient program areas:

- Providers
- Program Integrity

UnitedHealthcare Community Plan should include the following in each of its plans of action, and the plans of action should be provided to MDHHS as requested:

- Detailed narrative of the deficiency
- Detailed corrective action steps to resolve each deficiency
- Any resources required to resolve the deficiency
- Due dates for completing each action step
- Assigned party responsible for completing each action step
- Any required deliverables to show that a deficiency has been resolved
- Any dependencies to resolve deficiencies

Finally, **UnitedHealthcare Community Plan** should take proactive steps to ensure a successful PIP. As the PIP progresses, **UnitedHealthcare Community Plan** should ensure the following:

- Address all validation feedback and make necessary corrections prior to the next annual submission, including those recommendations for improvement related to documentation and omission of requirements in Step VI, Reliably Collect Data and Step VII, Sufficient Data Analysis and Interpretation of Results.
- Develop and implement additional interventions targeted to the two subgroups for the PIP.
- Follow the approved PIP methodology to calculate and report data accurately in next year's annual submission.
- To impact the Remeasurement 1 study indicator rate, 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 will not have enough time to impact the study indicator rate.
- Document the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.
- Seek technical assistance throughout the PIP process to address any questions or concerns.

Upper Peninsula Health Plan

To conduct the 2017–2018 EQR, HSAG reviewed **Upper Peninsula Health Plan**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Upper Peninsula Health Plan**.

EQR Activity Results

Compliance Monitoring

Upper Peninsula Health Plan was evaluated in six program areas referred to as standards. Table 5-71 presents the total number of criteria for each standard as well as the number of criteria for each standard that received a score of *Pass*, *Incomplete*, or *Fail*. Table 5-71 also presents **Upper Peninsula Health Plan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages.

Table 5-71—Compliance Review Results for Upper Peninsula Health Plan (UPP)

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	*Total Applicable*	UPP	Statewide
1	Administrative	5	0	0	5	100%	97%
2	Providers	14	1	0	15	97%	87%
3	Members	8	0	0	8	100%	98%
4	Quality	13	0	0	13	100%	99%
5	MIS	10	0	0	10	100%	99%
6	Program Integrity	25	3	0	28	95%	92%
Overall		**75**	**4**	**0**	**79**	**97%**	**94%**

The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

Upper Peninsula Health Plan demonstrated compliance for 75 out 79 elements, with an overall compliance score of 97 percent, which was above the statewide average. **Upper Peninsula Health Plan** demonstrated strong performance, scoring above 90 percent in all six standards, with four standards (Administrative, Members, Quality, and MIS) achieving full compliance. These program areas of strength include the Administrative, Providers, Members, Quality, MIS, and Program Integrity standards.

Opportunities for improvement were identified in two of the six standards which included deficiencies related to the following requirements:

- *MHP Provider Directory*—MDHHS conducted a random sample of calls to PCPs to check for accurate provider availability. The findings, as reported by MDHHS, are summarized below:

Table 5-72—Provider Directory Findings

February 2018[5-2]
• 72 percent of providers had the correct information listed in the online directory and confirmed they were accepting new patients

- *Tips and Grievances Form*—Errors and/or discrepancies were noted on the form for two quarters.
- *Data Mining/Algorithm Form*—Errors and/or discrepancies were noted on the form for one quarter.

Upper Peninsula Health Plan was required to develop and implement a CAP for each requirement in all program areas that received an *Incomplete* or a *Fail* finding.

Validation of Performance Measures

Upper Peninsula Health Plan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the 2018 HEDIS Compliance Audit Report findings, **Upper Peninsula Health Plan** was fully compliant with all IS standards, including:

- IS 1.0: Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry
- IS 2.0: Enrollment Data—Data Capture, Transfer and Entry
- IS 3.0: Practitioner Data—Data Capture, Transfer and Entry
- IS 4.0: Medical Record Review Processes—Training, Sampling, Abstraction and Oversight
- IS 5.0: Supplemental Data—Capture, Transfer and Entry
- IS 7.0: Data Integration—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity

According to the auditors' review, **Upper Peninsula Health Plan** followed the NCQA HEDIS 2018 technical specifications. No rates were determined to be materially biased.

[5-2] Upper Peninsula Health Plan received a *Pass* finding in August 2018; therefore, those results are not displayed in Table 5-72.

Table 5-73 shows each of the measures, the rate for each measure for 2018, and the categorized performance for 2018 relative to national HEDIS 2017 Medicaid results for **Upper Peninsula Health Plan**.

Table 5-73—Scores for Performance Measures for Upper Peninsula Health Plan

Measure	HEDIS 2018	2018 Performance Level
Child & Adolescent Care		
Childhood Immunization Status		
Combination 2	73.97%	★★
Combination 3	70.56%	★★
Combination 4	67.40%	★★
Combination 5	56.93%	★★
Combination 6	48.18%	★★★★
Combination 7	55.23%	★★
Combination 8	47.20%	★★★★
Combination 9	41.85%	★★★★
Combination 10	41.61%	★★★★
Well-Child Visits in the First 15 Months of Life		
Six or More Visits	72.75%	★★★★★
Lead Screening in Children		
Lead Screening in Children	82.73%	★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.18%	★★★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	47.93%	★★
Immunizations for Adolescents		
Combination 1	80.78%	★★★
Appropriate Treatment for Children With Upper Respiratory Infection		
Appropriate Treatment for Children With Upper Respiratory Infection	93.59%	★★★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	80.16%	★★★
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	48.24%	★★★
Continuation and Maintenance Phase	52.43%	★★
Women—Adult Care		
Breast Cancer Screening[1]		
Breast Cancer Screening	64.08%	NC

Measure	HEDIS 2018	2018 Performance Level
Cervical Cancer Screening		
Cervical Cancer Screening	63.02%	★★★
Chlamydia Screening in Women		
Ages 16 to 20 Years	46.17%	★
Ages 21 to 24 Years	60.71%	★★
Total	52.28%	★★
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	97.15%	★★★★
Ages 25 Months to 6 Years	89.84%	★★★
Ages 7 to 11 Years	92.15%	★★★
Ages 12 to 19 Years	92.03%	★★★
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44 Years	82.87%	★★★
Ages 45 to 64 Years	87.40%	★★★
Ages 65+ Years	NA	NC
Total	84.66%	★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	25.24%	★★
Obesity		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	89.78%	★★★★★
Counseling for Nutrition—Total	72.26%	★★★
Counseling for Physical Activity—Total	70.80%	★★★★
Adult BMI Assessment		
Adult BMI Assessment	96.84%	★★★★★
Pregnancy Care		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	92.94%	★★★★★
Postpartum Care	73.72%	★★★★★
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	92.32%	★★★★
*HbA1c Poor Control (>9.0%)**	30.00%	★★★★
HbA1c Control (<8.0%)	60.00%	★★★★★
Eye Exam (Retinal) Performed	71.25%	★★★★★
Medical Attention for Nephropathy	91.07%	★★★

Measure	HEDIS 2018	2018 Performance Level
Blood Pressure Control (<140/90 mm Hg)	77.50%	★★★★★
Medication Management for People With Asthma		
Medication Compliance 50%—Total[2]	71.01%	★★★★
Medication Compliance 75%—Total	46.56%	★★★★
Asthma Medication Ratio		
Total	59.92%	★★
Controlling High Blood Pressure		
Controlling High Blood Pressure	72.75%	★★★★★
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit	77.95%	★★★
Discussing Cessation Medications	56.82%	★★★★
Discussing Cessation Strategies	46.65%	★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	59.84%	★★★★
Effective Continuation Phase Treatment	41.41%	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	87.97%	★★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	NA	NC
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NC
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	82.24%	★★★★★
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	87.50%	★★
Diuretics	87.53%	★★
Total[1]	87.51%	NC
Health Plan Diversity[3]		
Race/Ethnicity Diversity of Membership		
Total—White	87.26%	NC
Total—Black or African American	1.54%	NC
Total—American-Indian and Alaska Native	2.30%	NC
Total—Asian	0.24%	NC
Total—Native Hawaiian and Other Pacific Islander	0.05%	NC

Measure	HEDIS 2018	2018 Performance Level
Total—Some Other Race	1.64%	NC
Total—Two or More Races	0.00%	NC
Total—Unknown	0.00%	NC
Total—Declined	6.96%	NC
Total—Hispanic or Latino	1.64%	NC
Language Diversity of Membership		
Spoken Language Preferred for Health Care—English	99.95%	NC
Spoken Language Preferred for Health Care—Non-English	0.03%	NC
Spoken Language Preferred for Health Care—Unknown	0.02%	NC
Spoken Language Preferred for Health Care—Declined	0.00%	NC
Preferred Language for Written Materials—English	99.95%	NC
Preferred Language for Written Materials—Non-English	0.03%	NC
Preferred Language for Written Materials—Unknown	0.02%	NC
Preferred Language for Written Materials—Declined	0.00%	NC
Other Language Needs—English	0.00%	NC
Other Language Needs—Non-English	0.00%	NC
Other Language Needs—Unknown	100.00%	NC
Other Language Needs—Declined	0.00%	NC
Utilization[3]		
Ambulatory Care—Total (Per 1,000 Member Months)		
*ED Visits—Total**	61.07	★★★
Outpatient Visits—Total	339.03	NC
Inpatient Utilization—General Hospital/Acute Care—Total		
Total Inpatient—Discharges per 1,000 Member Months—Total	6.26	NC
Total Inpatient—Average Length of Stay—Total	3.98	NC
Maternity—Discharges per 1,000 Member Months—Total	2.42	NC
Maternity—Average Length of Stay—Total	2.77	NC
Surgery—Discharges per 1,000 Member Months—Total	1.81	NC
Surgery—Average Length of Stay—Total	5.67	NC
Medicine—Discharges per 1,000 Member Months—Total	2.65	NC
Medicine—Average Length of Stay—Total	3.66	NC
Use of Opioids From Multiple Providers (Per 1,000 Members)*		
Use of Opioids From Multiple Providers—Multiple Prescribers	237.61	NC
Use of Opioids From Multiple Providers—Multiple Pharmacies	92.79	NC
Use of Opioids From Multiple Providers—Multiple Prescribers and Multiple Pharmacies	65.73	NC

Measure	HEDIS 2018	2018 Performance Level
Use of Opioids at High Dosage (Per 1,000 Members)*		
Use of Opioids at High Dosage	30.99	NC

[1] Due to changes in the technical specifications for this measure in HEDIS 2018, comparisons to benchmarks were not performed for this measure.
[2] Performance levels for 2018 were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.
[3] These measure indicator rates and any comparisons to benchmarks for these measures are provided for information only.
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table 5-73 shows **Upper Peninsula Health Plan** had 26 out of 56 measure rates (46.4 percent) that ranked at or above the national Medicaid 75th percentile, 11 of which ranked at or above the national Medicaid 90th percentile. Measures that ranked above the national Medicaid 90th percentile were in the Child & Adolescent Care, Obesity, Pregnancy Care, and Living With Illness domains. Conversely, 14 out of 56 measure rates (25.0 percent) fell below the national Medicaid 50th percentile, with only one measure rate (*Chlamydia Screening in Women—Ages 16 to 20 Years*) falling below the national Medicaid 25th percentile. Although only one measure rate fell below the national Medicaid 25th percentile, opportunities for improvement for **Upper Peninsula Health Plan** could be extended to include those measures that fell below the national Medicaid 50th percentile, such as *Childhood Immunization Status*, *Chlamydia Screening in Women*, and *Annual Monitoring for Patients on Persistent Medications*.

Validation of Performance Improvement Projects

For the 2017–2018 PIP, **Upper Peninsula Health Plan** submitted baseline data for the state-mandated topic, *Addressing Disparities in Timeliness of Prenatal Care.* **Upper Peninsula Health Plan** analyzed historical data and identified a disparity related to timeliness of prenatal care among its counties. The goal of the PIP is to improve the timeliness of prenatal care for women residing in Marquette County and eliminate the identified disparity without a decline in performance for women residing in all other counties served by UPP.

Table 5-74 outlines the study indicators for the PIP.

Table 5-74—Study Indicators

PIP Topic	Study Indicators
Addressing Disparities in Timeliness of Prenatal Care	1. The percentage of eligible pregnant women residing in Marquette County who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year. 2. The percentage of eligible pregnant women residing in all other counties served by **Upper Peninsula Health Plan** who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.

Table 5-75 displays the validation results for **Upper Peninsula Health Plan**'s **PIP**. This table illustrates the MHP's overall application of the PIP process and success in implementing the PIP. 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 5-75 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 5-75—Performance Improvement Project Validation Results for Upper Peninsula Health Plan

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% (2/2)	0% (0/2)	0% (0/2)
	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% (9/9)**	**0% (0/9)**	**0% (0/9)**

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	100% (5/5)	0% (0/5)	0% (0/5)
Implementation Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
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% (17/17)**		

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

For the baseline measurement period, **Upper Peninsula Health Plan** reported that 39.6 percent of eligible women residing in Marquette County received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment, and 52.3 percent of eligible women residing in all other counties served by **Upper Peninsula Health Plan** received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment. The goal for the PIP is that there will no longer be a statistically significant rate difference between the two subgroups.

Strengths, Weaknesses, and Overall Conclusions

Upper Peninsula Health Plan demonstrated both strengths and weaknesses based on the results of the 2017–2018 EQR activities. **Upper Peninsula Health Plan** received a total compliance score of 97 percent across all program areas reviewed during the 2017–2018 compliance review. **Upper Peninsula Health Plan** scored 95 percent or above in the Administrative, Providers, Members, Quality, MIS, and Program Integrity standards, indicating strong performance in all program areas. While 26 of the 56 HEDIS performance measure rates were ranked at or above the national Medicaid 75th percentile, indicating strengths in these areas, 14 HEDIS measure rates fell below the national Medicaid 50th percentile, indicating opportunities for improvement primarily in the Child & Adolescent Care, Women—Adult Care, Access to Care, and Living With Illness domains.

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 5-76—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: Received a performance score of 100 percent in the Administrative program area, indicating that the MHP had adequate staffing and oversight mechanisms in place to ensure the delivery of quality services to its members. • Strength: Received a performance score of 100 percent in the Quality program area, indicating that the MHP had the components of an effective QAPIP in place to assess and improve the quality of services provided to members. • Strength: Received a performance score of 100 percent in the MIS program area, indicating that the MHP maintained a health information system that is capable of collecting, analyzing, integrating, and reporting data to meet the obligations under its contract with MDHHS and, therefore, the ability to appropriately monitor the quality of services being provided to members. • Strength: The *Lead Screening in Children* HEDIS performance measure rate was between the national Medicaid 75th and 89th percentiles, indicating many children were tested for lead poisoning by 2 years of age. • Strength: The *Appropriate Treatment for Children With Upper Respiratory Infection* HEDIS performances measure rate fell between the national Medicaid 75th and 89th percentiles, indicating many children diagnosed with upper respiratory infections were not being prescribed antibiotics inappropriately. • Strength: Two of three rates under the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* HEDIS performance measure were at or above the national Medicaid 75th percentile, with one of those rates and the *Adult BMI Assessment* rate at or above the 90th percentile, indicating child, adolescent, and adult BMIs were assessed and children and adolescents received counseling for physical activity by a PCP or OB/GYN during a medical appointment, which can help providers identify at-risk members and provide suggestions and services to assist them in obtaining and maintaining a healthier weight. • Strength: Two of six HEDIS performance measure rates under *Comprehensive Diabetes Care* (*Hemoglobin A1c [HbA1c] Testing* and *HbA1c Poor Control [>9.0%])* were between the national Medicaid 74th and 89th percentiles, and three rates (*HbA1c Control [<8.0%]*, *Eye Exam [Retinal] Performed,* and *Blood Pressure Control [<140/90 mm Hg]*) met or exceeded the 90th percentile, indicating many adults received proper diabetes management which is essential to control blood glucose and reduce risks for complications. • Strength: The two rates under the *Medication Management for People With Asthma* HEDIS performance measure ranked between the national Medicaid 75th and 89th percentiles, indicating adult and child members diagnosed with persistent asthma

Performance Area*	Overall Performance Impact
	were dispensed appropriate asthma controller medications and remained on the medications for most of their treatment period. • Strength: The rate for the *Controlling High Blood Pressure* HEDIS performance measure ranked at or above the national Medicaid 90th percentile, indicating many adults had adequately controlled blood pressure, which is an important step in preventing heart attacks, strokes, and kidney disease. • Strength: One or three rates under the *Medical Assistance With Smoking and Tobacco Use Cessation* HEDIS performance measure was between the national Medicaid 75th and 89th percentiles, indicating many adults who are tobacco smokers discussed cessation medications to help quit tobacco and improve overall health. • Strength: The two rates under the *Antidepressant Medication Management* HEDIS performance measure were between the national Medicaid 75th and 89th percentiles, indicating adults diagnosed with major depression received effective medication management which can improve a person's daily functioning and wellbeing, and reduce the risk of suicide. • Strength: The rate for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* HEDIS performance measure ranked at or above the 90th percentile, indicating many adults diagnosed with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication had a diabetes screening. • Weakness: While the MHP received a performance score of 95 percent in the Program Integrity standard during the compliance review, findings suggest that additional focus may be needed within the MHP's program integrity processes to ensure program requirements are compliant with federal and State regulations. • Weakness: One of two rates under the *Follow-Up Care for Children Prescribed ADHD Medication* (*Continuation and Maintenance Phase*) HEDIS performance measure fell between the national Medicaid 25th and 49th percentiles, indicating additional opportunities for prescribed ADHD medications to be more closely monitored by a pediatrician. • Weakness: The three rates under *Chlamydia Screening in Women* HEDIS performance measures were at or below the national Medicaid 49th percentile, with one of those rates falling below the 25th percentile, indicating many women were not being screened for this sexually transmitted disease which can lead to serious and irreversible complications if left untreated. • Weakness: The *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* HEDIS performance measure rate fell between the national Medicaid 25th and 49th percentiles, indicating many adults diagnosed with bronchitis were dispensed an antibiotic which can lead to side-effects and possible resistance to antibiotics. • Although the MHP demonstrated strength in its members being dispensed and remaining on asthma controller medications through treatment, the *Asthma Medication Ratio—Total* measure rate fell between the national Medicaid 25th and 49th percentiles, indicating an opportunity to improve the ratio of controller

Performance Area*	Overall Performance Impact
	medications to total asthma medications and reducing the prevalence of asthma attacks. • Weakness: The two HEDIS performance rates under *Annual Monitoring for Patients on Persistent Medications* (*ACE Inhibitors or ARBs* and *Diuretics*) fell between the national Medicaid 25th and 49th percentiles, indicating many adult members may be at risk of adverse drug events.
Timeliness	• Strength: Received a performance score of 100 percent in the Members program area, indicating members received member materials, including an ID card, in a timely manner, to have information available to access services as soon as needed. • Strength: Four of nine *Childhood Immunization Status* HEDIS performance measure rates (*Combination 6, 8, 9, and 10)* were between the national Medicaid 75th and 89th percentiles, indicating many children were receiving these vaccines in a timely manner to protect them from serious and potentially life-threatening illnesses. • Strength: The rate for the *Well-Child Visits in the First 15 Months of Life* HEDIS performance measure ranked at or above the national Medicaid 90th percentile, indicating many children in the first 15 months of life were seeing their PCPs as often as suggested to ensure timely assessment of their physical, emotional and social development. • Strength: The two HEDIS performance measure rates under *Prenatal and Postpartum Care* met or exceeded the national Medicaid 90th percentile, indicating many women were accessing timely prenatal and/or postpartum care which could positively impact the health of the member and her baby before, during, and after pregnancy. • Weakness: Five of nine *Childhood Immunization Status* HEDIS performance measure rates (*Combination 2*, *3*, *4*, *5*, and *7)* were between the national Medicaid 25th and 49th percentiles, indicating many children are not always receiving these vaccines in a timely manner to protect them from serious and potentially life-threatening illnesses. • Weakness: The rate for the *Adolescent Well-Care Visits* HEDIS performance measure fell between the national Medicaid 25th and 49th percentiles, indicating many adolescents were not seeing their PCP or OB/GYN as often as suggested to ensure timely assessment of their physical, emotional, and social development.
Access	• Strength: One of four rates under the *Children and Adolescents' Access to Primary Care Practitioners* HEDIS performance measure was between the national Medicaid 75th and 89th percentiles, indicating many children between the ages of 12 to 24 months were accessing primary care services for appropriate screenings, treatment, and preventive services. • Weakness: Although the MHP received a performance score of 97 percent in the Providers program area, the findings suggest that members may still experience potential challenges locating and accessing providers to obtain treatment.

* Performance impacts may be applicable to one or more performance areas; however, for this report they were aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which MHPs addressed the EQR recommendations made from the prior year's technical report. During the 2016–2017 EQR, HSAG made the following recommendations to **Upper Peninsula Health Plan**, and **Upper Peninsula Health Plan** addressed these recommendations by taking the following actions:

Compliance Monitoring

For the 2016–2017 review period, HSAG recommended that **Upper Peninsula Health Plan** initiate QI initiatives to address the opportunities for improvement identified during the annual compliance review. HSAG also recommended that **Upper Peninsula Health Plan** focus on the Administrative standard, its lowest-scoring standard, with one *Incomplete* finding and a compliance score of 90 percent. Additionally, HSAG recommended that **Upper Peninsula Health Plan** consider initiating PDSA cycles or PIPs for those performance measures which fell below standards for consecutive review periods.

The 2016–2017 compliance review identified opportunities for improvement for the Administrative, Providers, Members, and Program Integrity standards. **Upper Peninsula Health Plan**'s 2017–2018 compliance review findings indicate that four of the five deficiencies in the following categories were sufficiently addressed: *Mandatory Administrative Meetings, Provider Subcontracts: Health Benefit, Administrative and/or Transportation, Member Material—ID Card and Member Handbook*, and *OIG Program Integrity—Compliance Plan*. One of the five deficiencies during the 2016–2017 review period received similar findings during the 2017–2018 review period and is described below. These findings indicate that **Upper Peninsula Health Plan** partially addressed the prior year's recommendations.

Table 5-77—Congruent Year-Over-Year Findings

Category	2016–2017 Findings	2017–2018 Findings
Tips and Grievances Form	The Activity Report tab of the report showed three completed reviews that were related to members; however, the Tips and Grievances tab showed four completed reviews that were related to members.	**Upper Peninsula Health Plan** received similar findings as the Tips and Grievances Form continued to contain errors and/or discrepancies for one quarter.

Validation of Performance Measures

The 2016–2017 validation of performance measures for **Upper Peninsula Health Plan** identified opportunities for improvement in the following performance measures, as these measures fell below the national Medicaid 25th percentile:

Child & Adolescent Care

- *Appropriate Testing for Children With Pharyngitis*

HSAG recommended that **Upper Peninsula Health Plan** focus on ensuring the completeness and accuracy of data used for calculating all HEDIS measures, and specifically, on improving the rates for measures that fell below the national Medicaid 25th percentile. Based on the results of the 2017–2018 validation, *Appropriate Testing for Children With Pharyngitis* improved to a rate between the 50th and 74th percentiles, indicating **Upper Peninsula Health Plan** addressed the prior recommendation.

Validation of Performance Improvement Projects

For the 2016–2017 validation, **Upper Peninsula Health Plan** designed a scientifically sound project supported by the use of key research principles, meeting 100 percent of the requirements in the Design stage. The technical design of the PIP was sufficient to measure and monitor PIP outcomes; therefore, there were no required follow-up recommendations.

Recommendations

As a result of the findings related to 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 of the following performance measures rating below the national Medicaid 25th percentile as part of its QI strategy within the QAPIP:

Women—Adult Care

- *Chlamydia Screening in Women—Ages 16 to 20 Years*

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

1. What were the root causes associated with the rate indicating low performance?
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 the rate and performance for the identified measure?

Based on the information presented, **Upper Peninsula Health Plan** should include the following within its QI plan:

- Measurable goals and benchmarks for each 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
- QI interventions that address the root cause of the deficiency
- A plan to monitor the QI interventions to detect whether they effect improvement

HSAG also recommends that **Upper Peninsula Health Plan** adhere to all federal managed care requirements listed under 42 CFR 438 Subpart D and the QAPIP requirements under Subpart E, State of Michigan contract requirements, and specifically, develop meaningful plans of action to bring into compliance each of the following deficient program areas:

- Providers
- Program Integrity

Upper Peninsula Health Plan should include the following in each of its plans of action, and the plans of action should be provided to MDHHS as requested:

- Detailed narrative of the deficiency
- Detailed corrective action steps to resolve each deficiency
- Any resources required to resolve the deficiency
- Due dates for completing each action step
- Assigned party responsible for completing each action step
- Any required deliverables to show that a deficiency has been resolved
- Any dependencies to resolve deficiencies

Finally, **Upper Peninsula Health Plan** should take proactive steps to ensure a successful PIP. As the PIP progresses, **Upper Peninsula Health Plan** should ensure the following:

- Address feedback provided in *Points of Clarification* associated with *Met* validation scores.
- Follow the approved PIP methodology to calculate and report data accurately in next year's annual submission.
- To impact the Remeasurement 1 study indicator rate, 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 will not have enough time to impact the study indicator rate.
- Document the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.

6. MHP Comparative Information With Recommendations for Michigan Department of Health and Human Services

In addition to performing a comprehensive assessment of the performance of each MHP, HSAG compared the findings and conclusions established for each MHP to assess the Michigan Medicaid managed care program. The overall findings of the 11 MHPs were used to identify the overall strengths and weaknesses of the Michigan Medicaid managed care program and to identify areas in which MDHHS could leverage or modify Michigan's Quality Strategy to promote improvement.

EQR Activity Results

This section provides the summarized results for the mandatory EQR activities across the 11 MHPs.

Compliance Monitoring

Table 6-1 presents a summary of performance results for the Medicaid programs of the MHPs, as well as statewide aggregated performance. The percentage of requirements that were met for each of the six compliance standards reviewed during the 2017–2018 Compliance Monitoring Review are provided.

Table 6-1—Compliance Monitoring Comparative Results

Standard		AET	BCC	HAR	MCL	MER	MID	MOL	PRI	THC	UNI	UPP	Statewide
1	Administrative	100%	100%	90%	90%	100%	90%	100%	100%	100%	100%	100%	97%
2	Providers	87%	87%	73%	87%	93%	83%	87%	87%	87%	87%	97%	87%
3	Members	94%	100%	94%	100%	100%	100%	94%	100%	100%	100%	100%	98%
4	Quality	100%	100%	100%	100%	100%	96%	96%	100%	100%	100%	100%	99%
5	MIS	100%	100%	95%	100%	95%	95%	100%	100%	100%	100%	100%	99%
6	Program Integrity	88%	100%	89%	98%	95%	75%	88%	98%	91%	98%	95%	92%
Overall Totals/Score		**92%**	**97%**	**89%**	**96%**	**96%**	**86%**	**92%**	**97%**	**94%**	**97%**	**97%**	**94%**

Blue Cross Complete of Michigan, **Priority Health Choice, Inc.**, **UnitedHealthcare Community Plan**, and **Upper Peninsula Health Plan** were the highest-performing MHPs, each with an overall compliance score of 97 percent. **Blue Cross Complete of Michigan** achieved full compliance in five of the six standards, while **Priority Health Choice, Inc.**, **UnitedHealthcare Community Plan**, and **Upper Peninsula Health Plan** achieved full compliance in four of the six standards. **McLaren Health Plan**, **Meridian Health Plan of Michigan**, and **Total Health Care, Inc.** also demonstrated strong performance, each with an overall compliance score at or above the statewide average.

Aetna Better Health of Michigan and **Molina Healthcare of Michigan** demonstrated moderately strong performance, with overall compliance scores above 90 percent but below the statewide average. **Harbor Health Plan** and **HAP Midwest Health Plan** demonstrated moderate performance, with overall compliance scores below 90 percent—89 percent and 86 percent, respectively.

The highest-scoring program areas statewide, scoring between 97 percent and 99 percent, were the Administrative, Members, Quality, and MIS standards. The lowest-scoring program areas statewide were the Providers and Program Integrity standards (87 percent and 92 percent, respectively).

Providers was the lowest-scoring standard for nine of 11 MHPs. Consistent with last year's compliance review, MDHHS conducted a random sample of calls to PCPs to check for accuracy in provider availability. Specifically, these calls were to confirm whether the provider was accepting new patients and to verify whether this information along with the provider's contact information matched the MHP's provider directory and the 4275 Provider Network File. All 11 MHPs received one or more *Incomplete* or *Fail* findings in the *MHP Provider Directory* category within the Providers standard, indicating a statewide opportunity for improvement remains in this program area.

Table 6-2 presents—for each standard and overall across all standards—the statewide compliance scores for the 2016–2017 and 2017–2018 compliance reviews.

Table 6-2—Comparison of Results From the Compliance Reviews: Previous Results for 2016–2017 and Current Results for 2017–2018

Standard		Statewide Compliance Score	
		2016–2017	2017–2018
1	Administrative	95%	97%
2	Providers	88%	87%
3	Members	97%	98%
4	Quality	96%	99%
5	MIS	99%	99%
6	Program Integrity	97%	92%
Overall Score/Total		**95%**	**94%**

The current year's overall statewide compliance score across all standards and all MHPs was 94 percent, which was comparable to the previous year's statewide score of 95 percent. The Administrative, Providers, Members, Quality, and MIS standards remained relatively stable. The Program Integrity standard demonstrated the greatest variance in score by falling 5 percentage points compared to the prior year, indicating MHPs should focus on the areas identified through the compliance monitoring review as deficient.

Performance Measures

Table 6-3 displays the Michigan Medicaid 2017 and 2018 HEDIS weighted averages, comparison of performance between 2017 and 2018, and the performance level for 2018. Weighted averages were calculated and compared from HEDIS 2017 to HEDIS 2018, and comparisons were based on a Chi-square test of statistical significance, with a *p* value of <0.01 considered statistically significant due to large denominators. Of note, 2017 to 2018 comparison values are based on comparisons of the exact HEDIS 2017 and HEDIS 2018 statewide weighted averages rather than on rounded values.

For most measures, the performance levels compare the 2018 Michigan Medicaid weighted average and the NCQA Quality Compass national Medicaid HMO percentiles for HEDIS 2017, as displayed in Table 6-3: [6-1]

Table 6-3—HEDIS 2018 Performance Levels

Performance Levels	Percentile
★★★★★	90th percentile and above
★★★★	75th to 89th percentile
★★★	50th to 74th percentile
★★	25th to 49th percentile
★	Below 25th percentile

For certain measures such as *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total*, where lower rates indicate better performance, the national Medicaid 10th percentile (rather than the national Medicaid 90th percentile) represents excellent performance, and the national Medicaid 75th percentile (rather than the national Medicaid 25th percentile) represents below-average performance.

Of note, measures in the Health Plan Diversity and Utilization domains are provided within this section for information only as they assess the MHPs' use of services and/or describe health plan characteristics and are not related to performance. Therefore, most of these rates were not evaluated in comparison to national benchmarks and were not analyzed for statistical significance.

[6-1] 2018 performance levels were based on comparisons to national Medicaid HMO Quality Compass HEDIS 2017 benchmarks, with the exception of the *Medication Management for People With Asthma—Medication Compliance 50%—Total* indicator, which was compared to national Medicaid HMO NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.

Table 6-4—Overall Statewide Averages for HEDIS 2017 and HEDIS 2018 Performance Measures

Measure	HEDIS 2017	HEDIS 2018	2017–2018 Comparison[1]	Performance Level for 2018[2]
Child & Adolescent Care				
Childhood Immunization Status				
Combination 2	76.95%	76.35%	-0.60	★★★
Combination 3	72.84%	72.28%	-0.56	★★★
Combination 4	70.43%	70.75%	+0.32	★★★
Combination 5	61.73%	62.63%	+0.90	★★★
Combination 6	39.84%	39.93%	+0.09	★★★
Combination 7	60.05%	61.53%	**+1.48+**	★★★
Combination 8	39.20%	39.56%	+0.36	★★★
Combination 9	34.47%	35.85%	**+1.38+**	★★★
Combination 10	33.98%	35.55%	**+1.57+**	★★★
Well-Child Visits in the First 15 Months of Life				
Six or More Visits	69.79%	71.89%	**+2.10+**	★★★★
Lead Screening in Children				
Lead Screening in Children	80.98%	80.55%	-0.43	★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.09%	75.19%	**-0.90++**	★★★
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	55.69%	56.75%	**+1.06+**	★★★
Immunizations for Adolescents				
Combination 1	86.73%	85.14%	**-1.59++**	★★★★
Appropriate Treatment for Children With Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection	88.94%	88.83%	-0.11	★★
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	70.91%	79.20%	**+8.29+**	★★★
Follow-Up Care for Children Prescribed ADHD Medication[3]				
Initiation Phase	42.54%	43.86%	+1.32	★★
Continuation and Maintenance Phase	55.03%	53.56%	-1.47	★★
Women—Adult Care				
Breast Cancer Screening[4]				
Breast Cancer Screening	—	62.13%	—	NC
Cervical Cancer Screening				
Cervical Cancer Screening	64.84%	66.19%	**+1.35+**	★★★★

Measure	HEDIS 2017	HEDIS 2018	2017–2018 Comparison[1]	Performance Level for 2018[2]
Chlamydia Screening in Women				
Ages 16 to 20 Years	62.27%	63.28%	**+1.01**$^{+}$	★★★★
Ages 21 to 24 Years	68.89%	68.65%	-0.24	★★★
Total	65.23%	65.65%	+0.42	★★★★
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	96.06%	95.16%	**-0.90**$^{++}$	★★
Ages 25 Months to 6 Years	89.08%	87.89%	**-1.19**$^{++}$	★★★
Ages 7 to 11 Years	91.39%	91.13%	-0.26	★★★
Ages 12 to 19 Years	90.79%	90.42%	**-0.37**$^{++}$	★★★
Adults' Access to Preventive/Ambulatory Health Services				
Ages 20 to 44 Years	81.68%	78.64%	**-3.04**$^{++}$	★★
Ages 45 to 64 Years	89.21%	87.57%	**-1.64**$^{++}$	★★★
Ages 65+ Years	90.26%	91.79%	**+1.53**$^{+}$	★★★★
Total	84.73%	82.25%	**-2.48**$^{++}$	★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis				
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	29.23%	32.20%	**+2.97**$^{+}$	★★★
Obesity				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	82.10%	84.40%	**+2.30**$^{+}$	★★★★
Counseling for Nutrition—Total	72.21%	74.50%	**+2.29**$^{+}$	★★★
Counseling for Physical Activity—Total	61.24%	67.49%	**+6.25**$^{+}$	★★★
Adult BMI Assessment				
Adult BMI Assessment	92.86%	94.47%	**+1.61**$^{+}$	★★★★★
Pregnancy Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	81.57%	80.23%	**-1.34**$^{++}$	★★
Postpartum Care	68.96%	67.27%	**-1.69**$^{++}$	★★★
Living with Illness				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	87.79%	88.81%	**+1.02**$^{+}$	★★★
*HbA1c Poor Control (>9.0%)**	36.07%	36.88%	**+0.81**$^{++}$	★★★
HbA1c Control (<8.0%)	53.16%	52.73%	-0.43	★★★
Eye Exam (Retinal) Performed	62.85%	64.18%	**+1.33**$^{+}$	★★★★
Medical Attention for Nephropathy	91.14%	91.94%	**+0.80**$^{+}$	★★★★
Blood Pressure Control (<140/90 mm Hg)	61.73%	62.23%	+0.50	★★★

Measure	HEDIS 2017	HEDIS 2018	2017–2018 Comparison[1]	Performance Level for 2018[2]
Medication Management for People With Asthma				
Medication Compliance 50%—Total[2]	71.33%	70.74%	-0.59	★★★★
Medication Compliance 75%—Total	49.96%	49.83%	-0.13	★★★★
Asthma Medication Ratio				
Total	62.63%	62.06%	-0.57	★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	56.75%	58.21%	**+1.46**+	★★★
Medical Assistance With Smoking and Tobacco Use Cessation[5]				
Advising Smokers and Tobacco Users to Quit	80.15%	80.59%	**+0.44**+	★★★★
Discussing Cessation Medications	55.95%	57.14%	**+1.19**+	★★★★
Discussing Cessation Strategies	45.89%	47.32%	**+1.43**+	★★★
Antidepressant Medication Management[3]				
Effective Acute Phase Treatment	52.72%	58.27%	**+5.55**+	★★★★
Effective Continuation Phase Treatment	36.03%	41.25%	**+5.22**+	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.09%	84.31%	**+1.22**+	★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia				
Diabetes Monitoring for People With Diabetes and Schizophrenia	69.01%	69.97%	+0.96	★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia				
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	69.64%	76.86%	+7.22	★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	61.16%	63.18%	**+2.02**+	★★★
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	87.00%	86.60%	-0.40	★★
Diuretics	87.08%	86.64%	-0.44	★★
Total[4]	—	86.62%	—	NC
Utilization[6]				
Ambulatory Care—Total (Per 1,000 Member Months)				
*ED Visits—Total**	74.37	70.86	-3.51	★★
Outpatient Visits—Total	389.30	386.18	-3.12	NC
Inpatient Utilization—General Hospital/Acute Care—Total				
Total Inpatient—Discharges per 1,000 Member Months—Total	8.68	8.10	-0.58	NC
Total Inpatient—Average Length of Stay—Total	4.02	4.38	+0.36	NC

Measure	HEDIS 2017	HEDIS 2018	2017–2018 Comparison[1]	Performance Level for 2018[2]
Maternity—Discharges per 1,000 Member Months—Total	2.36	2.38	+0.02	NC
Maternity—Average Length of Stay—Total	2.61	2.62	+0.01	NC
Surgery—Discharges per 1,000 Member Months—Total	2.30	1.91	-0.39	NC
Surgery—Average Length of Stay—Total	5.91	6.44	+0.53	NC
Medicine—Discharges per 1,000 Member Months—Total	4.48	4.40	-0.08	NC
Medicine—Average Length of Stay—Total	3.67	4.17	+0.50	NC
Use of Opioids From Multiple Providers (Per 1,000 Members)*				
Multiple Prescribers	—	209.04	—	NC
Multiple Pharmacies	—	80.47	—	NC
Multiple Pharmacies and Multiple Prescribers	—	47.15	—	NC
Use of Opioids at High Dosage (Per 1,000 Members)*				
Use of Opioids at High Dosage	—	33.20	—	NC

[1] Weighted averages were calculated and compared from HEDIS 2017 to HEDIS 2018, and comparisons were based on a Chi-square test of statistical significance, with a p value of <0.01 due to large denominators. Rates shaded green with one cross (+) indicate statistically significant improvement from the previous year. Rates shaded red with two crosses (++) indicate statistically significantly decline in performance from the previous year. Of note, 2017–2018 comparison values are based on comparisons of the exact HEDIS 2017 and HEDIS 2018 statewide weighted averages, not rounded values.

[2] Performance levels for 2018 were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.

[3] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2018 and prior years.

[4] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks could not be made for this measure.

[5] The weighted averages for this measure were based on the eligible population for the survey, rather than only the number of people who responded to the survey as being a smoker.

[6] Significance testing was not performed for Utilization-based measure indicator rates, and any performance levels for 2018 or 2017–2018 comparisons provided for these measures are for information only.

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

— indicates that the rate is not presented in this report as the measure is a first-year measure; therefore, no trending information is available. This symbol may also indicate that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

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

Performance levels for 2018 represent the following percentile comparisons:

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

Of the 59 measure rates with national benchmarks available and appropriate for comparison, 35 statewide rates (59.3 percent) demonstrated improvement from HEDIS 2017 to HEDIS 2018. Furthermore, 25 measure rates from HEDIS 2017 to HEDIS 2018 indicated a statistically significant improvement.

Statewide performance that demonstrated a statistically significant increase spanned multiple domains including:

- **Child & Adolescent Care** (*Childhood Immunization Status—Combination 7*, *9*, and *10*; *Well-Child Visits in the First 15 Months of Life—Six or More Visits*; *Adolescent Well-Care Visits*; and *Appropriate Testing for Children With Pharyngitis*).
- **Women—Adult Care** (*Cervical Cancer Screening* and *Chlamydia Screening in Women—Ages 16 to 20 Years*).
- **Access to Care** (*Adults' Access to Preventive/Ambulatory Health Services—Ages 65 and Older* and *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*).
- **Obesity** (*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*; and *Adult BMI Assessment*).
- **Living With Illness** (*Comprehensive Diabetes Care—HbA1c Testing*, *Eye Exam [Retinal] Performed*, and *Medical Attention for Nephropathy*; *Controlling High Blood Pressure*; *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*; *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*; *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*; and *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*).

Conversely, 24 statewide rates (40.7 percent) demonstrated a decline in performance from HEDIS 2017 to HEDIS 2018. Of note, 11 measure rates showed a statistically significant decline in performance from HEDIS 2017 to HEDIS 2018. Rates in the Access to Care (*Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months* and *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years*) and Pregnancy Care (*Prenatal and Postpartum Care—Timeliness of Prenatal Care*) domains ranked below the national Medicaid 50th percentile and showed a statistically significant decline in performance, indicating opportunities for improvement at the statewide level.

Table 6-5 presents, by measure, the number of MHPs that performed at each performance level. The counts include only measures with a valid, reportable rate that could be compared to national Medicaid benchmarks. Therefore, not all row totals will equal 11 MHPs.

Table 6-5—Count of MHPs by Performance Level

Measure	Number of Stars				
	★	★★	★★★	★★★★	★★★★★
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	2	4	3	0	1
Combination 3	2	4	3	0	1
Combination 4	2	3	4	0	1
Combination 5	3	1	5	0	1
Combination 6	2	4	2	1	1
Combination 7	2	2	4	1	1
Combination 8	2	4	2	1	1
Combination 9	2	3	3	1	1
Combination 10	2	3	3	1	1
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	2	0	2	3	3
Lead Screening in Children					
Lead Screening in Children	0	1	4	5	0
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	2	3	5	1	0
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	2	2	4	3	0
Immunizations for Adolescents					
Combination 1	0	1	3	3	3
Appropriate Treatment for Children With Upper Respiratory Infection					
Appropriate Treatment for Children With Upper Respiratory Infection	2	3	3	3	0
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	0	4	4	2	0
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	2	2	4	1	0
Continuation and Maintenance Phase	3	1	4	1	0

Measure	Number of Stars				
	★	★★	★★★	★★★★	★★★★★
Women—Adult Care					
Cervical Cancer Screening					
Cervical Cancer Screening	1	1	6	2	1
Chlamydia Screening in Women					
Ages 16 to 20 Years	1	0	1	6	2
Ages 21 to 24 Years	1	2	3	3	2
Total	0	1	2	6	2
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	5	3	2	1	0
Ages 25 Months to 6 Years	6	1	4	0	0
Ages 7 to 11 Years	3	4	4	0	0
Ages 12 to 19 Years	3	3	5	0	0
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	3	4	4	0	0
Ages 45 to 64 Years	2	2	5	2	0
Ages 65+ Years	1	3	1	1	3
Total	2	2	7	0	0
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	0	1	7	2	1
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	0	1	2	5	3
Counseling for Nutrition—Total	0	3	5	3	0
Counseling for Physical Activity—Total	1	3	3	3	1
Adult BMI Assessment					
Adult BMI Assessment	1	1	0	3	6
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	6	3	1	0	1
Postpartum Care	4	1	3	1	2
Living With Illness					
Comprehensive Diabetes Care					
Hemoglobin A1c (HbA1c) Testing	3	2	2	3	1
*HbA1c Poor Control (>9.0%)**	2	3	2	3	1

Measure	Number of Stars				
	★	★★	★★★	★★★★	★★★★★
HbA1c Control (<8.0%)	2	3	2	2	2
Eye Exam (Retinal) Performed	1	2	3	2	3
Medical Attention for Nephropathy	1	2	4	2	2
Blood Pressure Control (<140/90 mm Hg)	4	1	3	1	2
Medication Management for People With Asthma					
Medication Compliance 50%—Total	0	1	1	5	4
Medication Compliance 75%—Total	0	1	2	3	5
Asthma Medication Ratio					
Total	2	5	3	0	1
Controlling High Blood Pressure					
Controlling High Blood Pressure	3	3	2	2	1
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	0	1	3	4	3
Discussing Cessation Medications	0	0	3	3	5
Discussing Cessation Strategies	0	0	8	2	1
Antidepressant Medication Management					
Effective Acute Phase Treatment	1	0	3	4	3
Effective Continuation Phase Treatment	0	3	2	3	3
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	1	0	4	4	2
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	4	0	4	1	0
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	0	4	0	0	0
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	2	2	2	2	2
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	4	4	3	0	0
Diuretics	2	7	2	0	0

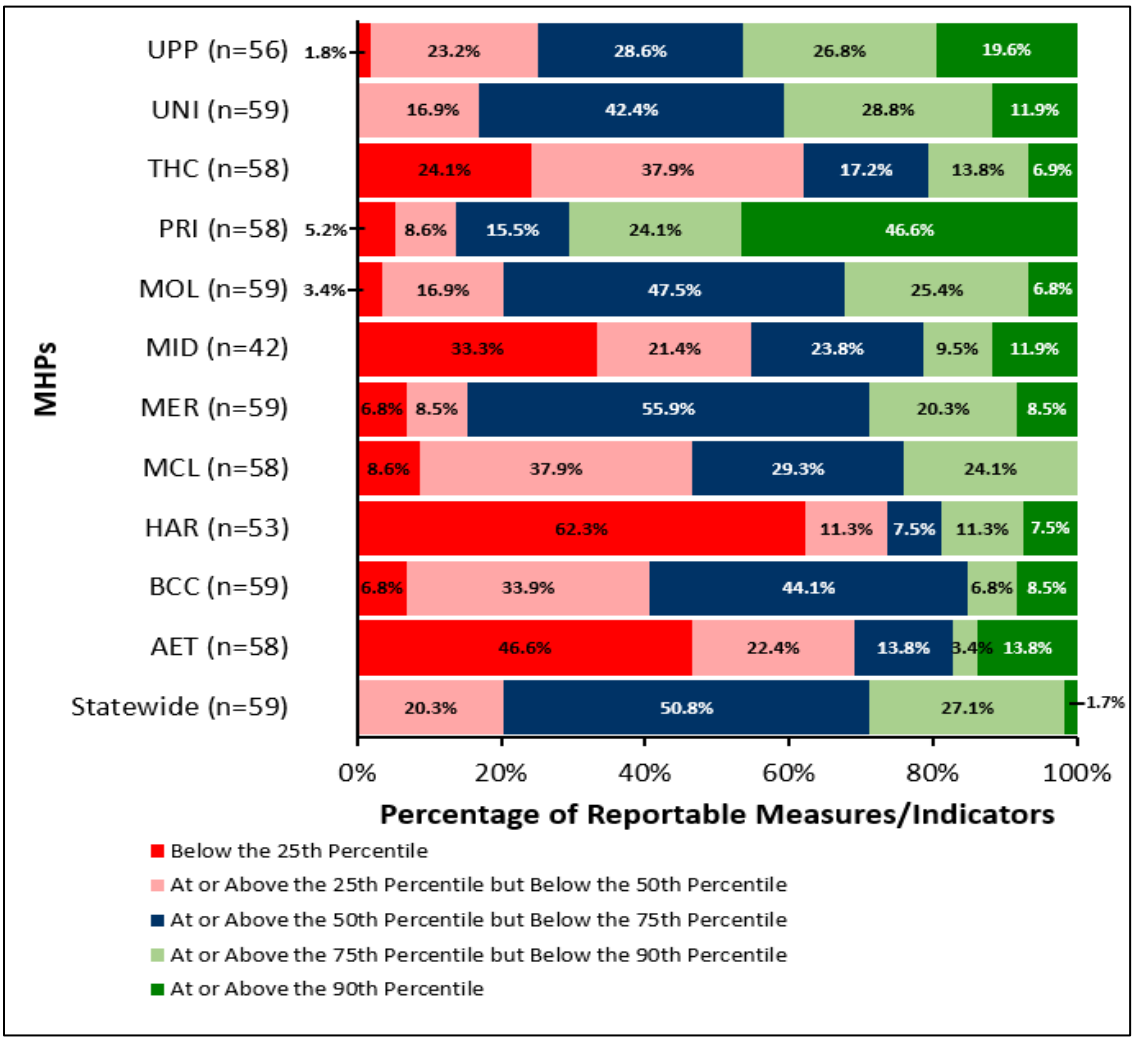
Measure	Number of Stars				
	★	★★	★★★	★★★★	★★★★★
Utilization					
Ambulatory Care—Total (Per 1,000 Member Months)					
Emergency Department Visits—Total‡,*	3	7	1	0	0
Total	**107**	**135**	**186**	**111**	**80**

‡ Utilization-based measure rates and any performance levels for 2018 comparisons provided for these measures are for information only.
* For this indicator, a lower rate indicates better performance.
Performance levels for 2018 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Table 6-5 shows that 186 out of 619 of performance measure rates (30.0 percent) reported by the MHPs fell into the average (★★★) range relative to national Medicaid results. When compared to national Medicaid benchmarks, at least half of the plans ranked at or above the national Medicaid 90th percentile for *Adult BMI Assessment*. Conversely, at least half of the plans scored below the national Medicaid 25th percentile for *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*.

Figure 6-1 displays the percentage of MHP-specific and statewide rates by percentile ranking for the performance measure rates displayed in this report, except for health plan diversity and utilization measure rates (with the exception of the *Ambulatory Care—Total [Per 1,000 Member Months]—ED Visits—Total*) as these types of measures in isolation may not be indicative of quality of services received. Since statewide averages were weighted according to each MHP's eligible population for each measure, the number of statewide averages under each star ranking category is not the sum of all the MHPs for that category.

Figure 6-1—Percentage of Reportable Measures/Indicators*



** Rates that had a small denominator (NA) as a result of the MHP's HEDIS audit are not included in this analysis. "N" Indicates the number of rates that were included in this analysis by MHP.*

Performance Improvement Project

For the 2017–2018 validation, the MHPs provided baseline data and completed Steps I through VIII for their ongoing state-mandated PIP topic: *Addressing Disparities in Timeliness of Prenatal Care*. Figure 6-2 provides a comparison of the validation scores, by MHP. Table 6-6 provides a comparison of the overall validation status, by MHP.

Figure 6-2—Comparison of Validation Scores by MHP

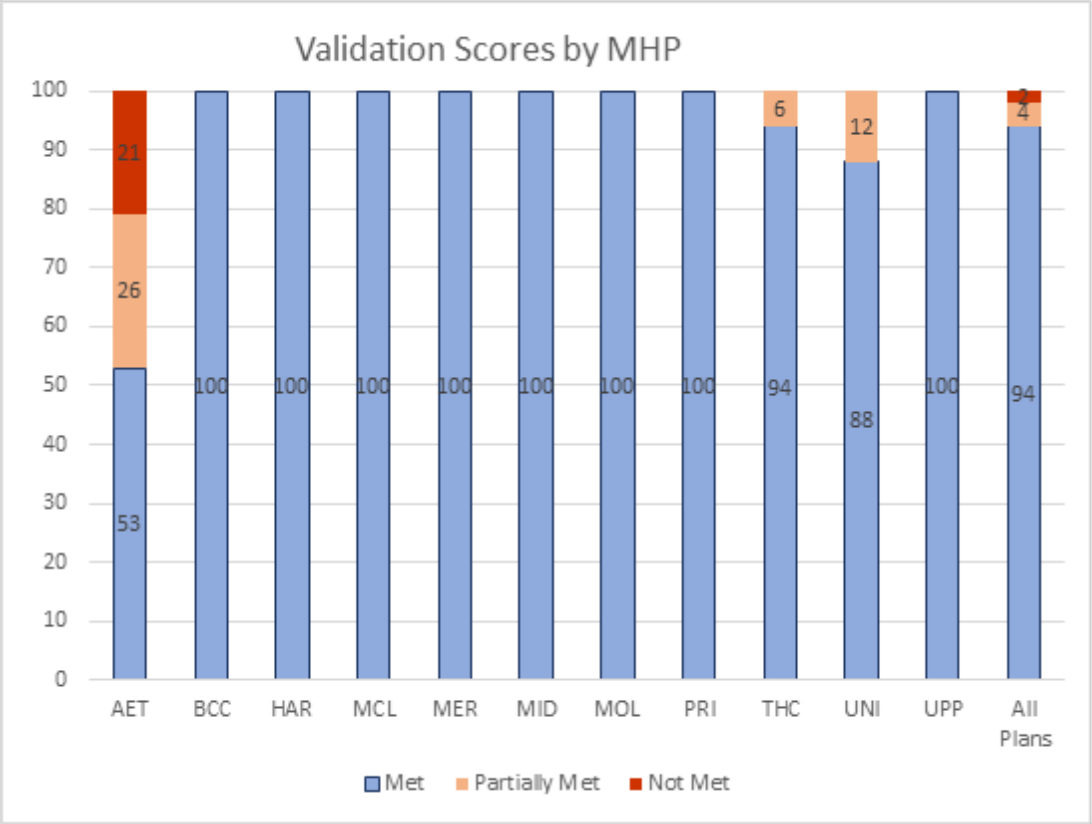


Table 6-6—Comparison of Overall Validation Status by MHP

Overall PIP Validation Status, by MHP	
AET	*Not Met*
BCC	*Met*
MID	*Met*
HAR	*Met*
MCL	*Met*
MER	*Met*
MOL	*Met*
PRI	*Met*
THC	*Partially Met*
UNI	*Met*
UPP	*Met*

The results from the 2017–2018 validation reflected strong performance for most of the MHPs, as demonstrated through an overall *Met* validation status. Two MHPs, **Aetna Better Health of Michigan** and **Total Health Care, Inc.**, did not achieve an overall *Met* validation status. The validation statuses for both MHPs are related to one or more critical evaluation elements not receiving a *Met* score, which impacted the overall validation status. **Aetna Better Health of Michigan** had the lowest validation scores for the Design and Implementation stages (Steps I through VIII). Both MHPs can improve these validation scores by ensuring all documentation requirements and HSAG's feedback are addressed in the next annual submission.

Summary, Conclusions, and Recommendations

HSAG performed a comprehensive assessment of the performance of each MHP and of the overall strengths and weaknesses of the Michigan Medicaid managed care 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 Michigan Medicaid managed care program.

Strengths and Associated Conclusions

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

Compliance Monitoring

Through the 2017–2018 Compliance Monitoring Review, overall, the Michigan Medicaid managed care program demonstrated areas of strength in managing and adhering to expectations established for the Medicaid program through State and federal requirements. Most of these requirements relate to or impact the quality of, timeliness of, and access to care and services provided by each MHP to its members. Statewide average scores in each of the following standards were at 92 percent or above, demonstrating strong performance:

- **Administrative**—The MHPs had adequate staffing and oversight mechanisms in place to support its obligations under its contract with MDHHS, which include ensuring members have adequate access to all covered services.
- **Members**—The MHPs provided members with information to help them understand the full array of their Medicaid benefits and had effective systems in place for members to express dissatisfaction related to services or other areas of the program and/or challenge the denial of requested services.
- **Quality**—The MHPs had an effective QAPIP in place that included QI and utilization management policies and procedures to ensure consistency in processes, clinical practice guidelines to support decisions related to medical necessity, QI evaluations and workplans to evaluate and track QI initiatives and progress, PIPs to target improvement in clinical and/or nonclinical performance areas, initiatives for addressing health disparities, and reporting to monitor performance with MDHHS-established performance measures and minimum standards.
- **MIS**—The MHPs maintained sufficient health information systems that collect, analyze, integrate, and report data, ensuring expectations and obligations under their contracts with MDHHS can be met.
- **Program Integrity**—The MHPs had effective compliance plans in place which include mechanisms to detect and prevent fraud, waste, and abuse, and monitoring processes to ensure that network providers were not excluded from providing services under federal programs and met the MHPs' established expectations.

Performance Measures

The individual MHPs were evaluated against national benchmarks for measures related to quality of, access to, and timeliness of services. When the individual MHP scores were aggregated, 59.3 percent of the 59 measure rates with national benchmarks available and appropriate for comparison demonstrated an improvement over the prior year's performance. Additionally, multiple domains included statewide rates that performed at or above the national Medicaid 75th percentile, indicating many members were receiving these recommended services, which can positively impact their overall health and wellbeing.

Child & Adolescent Care—Well-child visits provide an opportunity for providers to positively impact the health and development of child members, while vaccines can protect adolescents against potentially deadly diseases, such as meningococcal meningitis, tetanus, diphtheria, pertussis, and human papillomavirus.

- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*
- *Immunizations for Adolescents—Combination 1*

Women—Adult Care—Cervical cancer can be prevented through effective screenings, while screenings and subsequent treatment of chlamydia can reduce the potential for serious and irreversible complications such as pelvic inflammatory disease and infertility.

- *Cervical Cancer Screening*
- *Chlamydia Screening in Women—Ages 16 to 20 Years* and *Total*

Access to Care—Doctor visits provide an opportunity for members to receive preventive services and counseling, and can help members detect and treat health conditions sooner.

- *Adults' Access to Preventive/Ambulatory Health Services*—Ages 65+ Years

Obesity—Weight assessments are an important tool for providers to identify at-risk members and provide counseling and services to assist them in obtaining and maintaining a healthier weight, which can mitigate risks for developing weight-related diseases.

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, BMI Percentile—Total*
- *Adult BMI Assessment*

Living With Illness—Appropriate diabetes management is important to reduce risks for complications in members with diabetes. Additionally, proper medication management and quitting tobacco can lead to better health outcomes for members.

- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* and *Medical Attention for Nephropathy*
- *Medication Management for People With Asthma, Medication Compliance 50%—Total* and *Medication Compliance 75%—Total*
- *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Medications*
- *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

Performance Improvement Project

Through their participation in the PIP, the MHPs are focusing their efforts on reducing disparities related to timely receipt of prenatal care. Through implementation of this PIP, the MHPs are developing initiatives and interventions to support improvement in the health of pregnant women and their infants before, during, and after pregnancy.

Weaknesses and Associated Conclusions

HSAG's comprehensive assessment of the MHPs and the Michigan Medicaid managed care program also identified two areas of focus that represent significant opportunities for improvement within the program. These primary areas of focus, identified primarily through the compliance monitoring review findings and PMV, are access to care and pregnancy care.

Access to Care

Accessibility to quality healthcare is important for promoting and maintaining health, preventing and managing diseases, and achieving health equity for all populations. Members' accessibility to care is a priority for MDHHS, as evident from the initiatives included as part of Michigan Medicaid's Quality Strategy; however, conclusions drawn from HSAG's comprehensive assessment of the MHPs and the Michigan Medicaid managed care program indicate significant opportunities remain for improving members' accessibility to care.

Low statewide performance compared to national benchmarks on two HEDIS performance measures within the Access to Care domain indicated that access to care and services should be addressed to ensure Medicaid members are visiting their PCPs regularly and getting check-ups at least annually. Specifically, the statewide averages for these HEDIS performance measure rates were below the national Medicaid 50th percentiles: *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months* and *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years.* Additionally, six out of the eight rates within these two measures declined significantly from the prior year's performance, and seven out of the eight rates were below the national Medicaid 75th percentile. Ten out of the 11 MHPs also scored below the national Medicaid 50th percentile for the *Ambulatory Care—Total (Per 1,000 Member Months), Emergency Department Visits—Total* measure within the Utilization domain, indicating a large percentage of members may be going to the ED for preventable or treatable conditions due to potential network deficiencies or other barriers to receiving timely access to services.

As demonstrated through the compliance monitoring review, the Providers standard was the lowest-scoring area statewide. MDHHS identified data inconsistencies in all 11 MHPs' provider directories during PCP telephone surveys, potentially indicating members' access to care is being impeded by inaccurate provider information. Because data in the Provider Network File (4275) are a reflection of the data maintained by the MHPs and used by members to select providers, inconsistencies may limit members' ability to choose providers that are easily accessible and meet the healthcare needs of

members and their families. Additionally, since MDHHS uses the 4275 to monitor network adequacy, the data may not be an accurate reflection of the providers available to see members.

Pregnancy Care

Appropriate and timely prenatal services and education can have a significant impact on the health and wellness of women and their infants. The postnatal period is also a critical phase in the lives of mothers and newborn babies, as most maternal and infant deaths occur during this time.[6-2] MDHHS has placed significant emphasis on pregnancy care through several quality initiatives, including implementation of the *Addressing Disparities in Timeliness of Prenatal Care* PIP and the Low Birth Weight Project. However, as demonstrated through statewide performance related to HEDIS measures within the Pregnancy Care domain, pregnancy care remains an area of opportunity for the Michigan Medicaid managed care program.

The two rates under the *Prenatal and Postpartum Care* HEDIS performance measure experienced statistically significant declines in performance from the 2016–2017 review period. Additionally, the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure rate was below the national Medicaid 50th percentile. Nine out of 11 MHPs performed below the national Medicaid 50th percentile for the percentage of deliveries that received a timely prenatal care visit, with six MHPs performing below the national Medicaid 25th percentile. Eight MHPs performed below the national Medicaid 75th percentile in the *Prenatal and Postpartum Care—Postpartum Care* HEDIS performance measure, with four MHPs' performance rating below the national Medicaid 25th, indicating a large percentage of members were also not receiving timely postpartum visits after delivery.

Quality Strategy Recommendations for Michigan

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

- Access to Care
- Pregnancy Care

Michigan's quality strategy is designed to improve the health outcomes of its Medicaid members, by measuring access, efficiency, and outcomes through standardized performance measures; initiating PIPs 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

[6-2] World Health Organization. WHO recommendations on postnatal care of the mother and newborn. Available at: https://www.who.int/maternal_child_adolescent/documents/postnatal-care-recommendations/en/. Accessed on: Feb 11, 2019.

goals of the quality strategy and the comparative review of findings for all activities, HSAG recommends the following QI initiatives, which target the identified specific areas of opportunity.

Access to Care

Complete, accurate healthcare provider information is necessary to provide members with adequate information to help them choose a provider, allow for timely access to providers when needed, and increase satisfaction with their provider and the Michigan Medicaid managed care program. Inaccuracies in provider information maintained and published by the MHPs could potentially contribute to access issues being experienced by members. Resolving these inaccuracies could improve member satisfaction and address some of the factors contributing to uncontrolled chronic conditions and impeding children's and adults' access to PCPs for preventive care visits, which in turn, should result in improved HEDIS rates and reduce the number of avoidable ED visits. To improve the accuracy of provider data, HSAG recommends MDHHS expand the scope of existing provider data validation activities within the compliance monitoring review by conducting an evaluation of each MHP's provider data systems. This review could include:

- A focused review and assessment of each MHP's collection, maintenance, and publication of provider data.
- An evaluation of provider data accuracy on a sample of in-network providers enrolled with multiple MHPs to allow controlled comparisons of key data elements.
- A comparison of results by key subpopulations to identify trends by geographic location or provider groups.
- Implementation of a time-limited workgroup to:
  - Identify best practices for collecting, maintaining, and producing accurate provider data.
  - Address the refinement or development of guidelines defining expectations for providers and MHPs regarding the collection and maintenance of up-to-date provider information.
  - Evaluate MCP procedures for capturing provider network changes and determine how to limit gaps or deficiencies in data submitted to MDHHS or published to members.
- Implementation of a QIP to identify and implement effective QI interventions that target the underlying causes of poor provider data quality and follow up with an evaluation of MHPs' improvement.
  - Update the contract, as necessary, to clarify MDHHS's expectations regarding the submission of accurate provider data. Include performance standards and thresholds to hold MHPs accountable for performance and improvement.
  - Develop supplemental guidelines describing requirements for the submission of provider data and outline key data elements.

To increase the percentage of children, adolescents, and adults receiving regular preventive care from their PCPs, HSAG recommends MDHHS initiate a QIP to specifically target this issue. The QIP could include the following activities:

- Leverage claims data to identify which individuals have not seen a PCP and what support is needed to assist them in establishing a usual source of care.
- Identification of the common and covariate characteristics among member who are not seeing their PCPs and not receiving regular preventive services, including visits that would fall under *Children and Adolescents' Access to Primary Care Practitioners* and *Adults' Access to Preventive/Ambulatory Health Services* HEDIS measures. These characteristics may include such factors as health status, geographical location, ethnicity, primary language, care management arrangement status, etc.
- Consideration of the selection of at least one group within each child and adult population that is less likely to see a PCP and focus efforts to improve this group's PCP utilization. For example, if a geographic region or linguistic group predicts not having a regular PCP, the MHP may want to select a particular county in Michigan or specific linguistic group.
- Additional analysis of the selected group(s) to identify additional predictive attributes and key drivers such as assignment to the same PCP groups; diagnoses of other conditions, such as behavioral health conditions; or family members with trends of noncompliance with treatments.
- Based on results from the secondary analysis, development of one or more targeted interventions to test for improvement in children's and adults' access to their PCPs and receipt of preventive services. These interventions might include working with PCPs to teach engagement strategies for improving members' treatment plan adherence; providing targeted education to identified families; or implementing alternative means to facilitate visits, such as inviting families to mobile clinics, using visiting nurse practitioners to conduct preventive services, or providing additional transportation services.

Along with awarding financial incentives for high performance in designated HEDIS measures and to assist MHPs with prioritizing efforts around Access to Care measures, specifically *Children and Adolescents' Access to Primary Care Practitioners* and *Adults' Access to Preventive/Ambulatory Health Services*, MDHHS could consider establishing incremental sanctions for MHPs that do not meet MDHHS-established minimum performance thresholds. MDHHS could consider implementing the following:

- Establish minimum performance standards for Access to Care measures based on national percentages, such as above the national Medicaid 25th percentile or based on aggregated statewide average performance.
- At the conclusion of the PMV activity, MHPs not meeting the established minimum performance standards could receive a request for a CAP that should be implemented within a specified period of time (such as 30 days).
- Require MHPs to provide an assessment of performance at six-month intervals, that include any changes to interventions based on current MHP-audited performance rates.

- At the conclusion of the next annual PMV, MHPs not meeting the established threshold or improving performance by a certain percentage could receive financial penalties or auto-assignment withholds.

Pregnancy Care

For every 1,000 Michigan live births, almost seven infants die before reaching their first birthday. In 2017, 762 infants under the age of 1 year died, resulting in an infant mortality rate of 6.8 per 1,000 live births. Women receiving inadequate prenatal care experienced infant mortality rates three times as high as those women receiving adequate prenatal care.[6-3] Additionally, the infant mortality rates for African-American and American Indian infants are more than twice that of Caucasian Americans.[6-4] In alignment with Michigan's priority to keep babies alive, MDHHS has implemented several initiatives and projects aimed at improving the high rate of infant mortality, including the FY18–FY20 Low Birth Weight Project, which uses the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP *Live Births Weighing Less Than 2,500 Grams (LBW-CH)* measure. The goal of the Low Birth Weight Project is to identify health disparities and methods to improve quality of care and services to pregnant women and infants, which aligns with Michigan's 2016–2019 Infant Mortality Reduction Plan and the statewide Regional Perinatal Quality Collaborative Efforts, which have similar goals. HSAG recommends MDHHS leverage the existing Low Birth Weight Project initiative and the *Addressing Disparities in Prenatal Care* PIP, and along with the MHPs, consider incorporating the following:

- Use the data analysis results of LBW rates by race/ethnicity and compare to claims data/data from the *Prenatal and Postpartum Care* HEDIS performance measures to identify any trends. The following questions could be considered:
  - For those infants identified as having LBWs, was a corresponding prenatal encounter available?
  - Could the timing of the prenatal encounter impact the LBW of the infant (e.g., when was the first prenatal visit)?
  - Did the mother continue prenatal care throughout pregnancy?
  - Was the mother identified as high risk and receiving progesterone treatment?
- Using the results of the above analysis, the MHPs could tailor initiatives to a very specific subpopulation (e.g., mothers who were high risk but not receiving progesterone treatment).
- Develop partnerships with organizations that can help support the initiatives for the specific subpopulation (e.g., community health workers, birthing hospitals, health departments).
- Require the MHPs to clearly identify their related initiatives and interventions within the QAPIP workplans, including the methods they are using to support the existing Michigan and MDHHS projects related to LBW and pregnancy care.
- Develop a sustain and spread plan for the most effective interventions and initiatives.

[6-3] Michigan Department of Community Health. Infant Death Statistics. Available at: https://www.mdch.state.mi.us/osr/InDxMain/Infsum05.asp. Accessed on: Feb 12, 2019.

[6-4] Michigan Department of Health & Human Services. Infant Mortality. Available at: https://www.michigan.gov/infantmortality/. Accessed on: Feb 11, 2019.