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State Fiscal Year 2020 External Quality Review Technical Report for the MI Choice Waiver Program

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

MI Choice is a Section 1915(c) waiver used to deliver home- and community-based services (HCBS) to elderly and disabled individuals meeting Michigan's nursing facility level of care (NFLOC) who, but for the provision of such services, would require services provided in a nursing facility. The goal of the waiver is to provide HCBS and supports to participants using a person-centered planning process that allows them to maintain or improve their health, welfare, and quality of life. The waiver is administered by MDHHS, Medical Services Administration (MSA), which is the single state Medicaid agency. MDHHS exercises administrative discretion in the administration and supervision of the waiver, as well as all related policies, rules, and regulations. The MI Choice Waiver Program is a Medicaid managed care program and its participants receive services from entities classified as prepaid ambulatory health plans (PAHPs), otherwise referred to as "waiver agencies." MDHHS contracts with waiver agencies to carry out its waiver obligations, and each waiver agency must sign a provider agreement with MDHHS assuring that it meets all program requirements. The waiver agencies contracted with MDHHS during state fiscal year (SFY) 2020 are displayed in Table 1-1.

Table 1-1—PAHP Waiver Agencies in Michigan

Waiver Agency Name
A&D Home Health Care
Agency on Aging of Northwest Michigan
Area Agency on Aging 1B
Area Agency on Aging of Western Michigan
Detroit Area Agency on Aging
MORC Home Care
Northern Healthcare Management
Region 2 Area Agency on Aging
Region 3B
Region IV Area Agency on Aging
Region VII Area Agency on Aging
Region 9 Area Agency on Aging

Waiver Agency Name
Reliance Community Care Partners
Senior Resources
Senior Services
The Information Center
The Senior Alliance
Tri-County Office on Aging
UPCAP Care Management, Inc.
Valley Area Agency on Aging

Scope of External Quality Review Activities

To conduct this assessment, HSAG used the results of mandatory external quality review (EQR) activities, as described in 42 CFR §438.358. The purpose of these activities, in general, is to improve the states' ability to oversee and manage the waiver agencies that they contract with for services, and help the waiver agencies improve their performance with respect to quality of, timeliness of, and access to care and services. Effective implementation of the EQR-related activities will facilitate state efforts to purchase cost-effective, high-value care and to achieve higher performing healthcare delivery systems for their Medicaid waiver members. For the SFY 2020 assessment, HSAG used findings from the mandatory EQR activities displayed in Table 1-2 to derive conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by each waiver agency. HSAG also assessed MDHHS' adherence to the protocols issued by the Centers for Medicare & Medicaid Services (CMS) for each EQR-related activity (CMS EQR protocols)[1-1] and provides recommendations as appropriate to further support quality improvement using industry-standard methodologies. Detailed information about each activity's methodology is provided in Appendix A.

Table 1-2—EQR Activities

Activity	Description	EQR Protocol
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by a waiver agency used sound methodology in its design, implementation, analysis, and reporting.	Protocol 1. Validation of Performance Improvement Projects
Performance Measure Validation (PMV)	This activity assesses the accuracy of performance measures reported by the waiver agencies and determines the extent to which performance measures reported	Protocol 2. Validation of Performance Measures

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Sept 3, 2021.

Activity	Description	EQR Protocol
	by the waiver agencies follow State specifications and reporting requirements.	
Compliance Review	This activity determines the extent to which a waiver is in compliance with federal standards and associated state-specific requirements, when applicable.	Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations

Statewide Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from the preceding 12 months to comprehensively assess the waiver agencies' performance in providing quality, timely, and accessible healthcare services to MDHHS' waiver members. For each waiver agency reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the waiver agency's performance, which can be found in Section 3. The overall findings and conclusions for all waiver agencies were also compared, as appropriate, and analyzed to develop overarching conclusions and recommendations for MDHHS and the MI Choice Waiver Program. Table 1-3 highlights substantive findings and actionable state-specific recommendations for MDHHS to further promote its goals and objectives in the 2020–2023 MDHHS Comprehensive Quality Strategy (MDHHS CQS). Refer to Section 6 for more details.

Table 1-3—Statewide Substantive Findings

Program Strengths
• The overarching aggregated findings from the PIPs, PMV, and Compliance Review activities demonstrate that MDHHS has focused its quality improvement efforts on care management processes and person-centered planning to support waiver members' **access to timely services** in accordance with their individualized health needs. Additionally, MDHHS and its contracted waiver agencies are focusing strategies on **quality of care** by implementing quality improvement initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes. Further, MDHHS mandates immediate corrective action when issues are identified that may impact a member's ability to maintain optimal function, make informed choices, preserve independence and community integration, and/or create barriers to **quality care** or **access to timely and necessary services**.

Program Weaknesses
• HSAG's assessment of the waiver agencies' quality management plans (QMPs) and annual activities and outcomes reports, the MI Choice performance measure report, and the compliance review results and succeeding corrective action plans (CAPs) indicated the MI Choice Waiver Program has opportunities to enhance its EQR-related processes for overseeing and managing its contracted waiver agencies and subsequently assisting them to improve their performance with respect to **quality**, **timeliness**, and **access to care**, which should support an improvement in the MI Choice Waiver Program's overall performance in these performance domains. • HSAG's assessment identified that the weaknesses within the MI Choice Waiver Program were primarily related to the gaps in MDHHS' processes for conducting EQR-related activities, as there were noted

Program Weaknesses
discrepancies within the data reviewed or the data were not available as expected. The discrepant and incomplete data created challenges in evaluating each waiver agency's performance in the domains of **quality**, **timeliness**, and **access to care** as it relates to member outcomes.

Program Recommendations
Associated Quality Strategy Goal and/or Objective
In consideration of the goals of the MDHHS CQS and the assessment of all activities related to **quality**, **timely**, and **accessible care and services**, HSAG recommends the following quality improvement initiatives, which focus on the EQR-related processes designed to provide a sound understanding of the strengths and weaknesses of the waiver agencies' performance related to **quality**, **timeliness**, and **access to care**, and primarily target goals #1 and #3 and the associated objectives within the MDHHS CQS. • **Goal #1:** Ensure high quality and high levels of access to care. • **Goal #3:** Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external).
HSAG Recommendations
• Implementation of EQR-related activities in accordance with 42 CFR §438.358 and in alignment with the CMS EQR protocols will improve MDHHS' ability to oversee and manage the waiver agencies, and should lead to more comprehensive, accurate, and reliable data to assess the MI Choice Waiver Program's performance related to **quality**, **timeliness**, and **access to care**. As such, HSAG recommends MDHHS conduct its EQR-related activities following the Medicaid and CHIP Managed Care Final Rule and the CMS EQR protocols. • In accordance with 42 CFR §438.330(d), MDHHS must require through its contracts that each PAHP establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its members. HSAG recommends MDHHS host a work group with representation of each waiver agency's quality improvement team to enhance the QMPs and the annual QMP evaluation. As part of this work group, the waiver agencies should research best practices for developing a comprehensive quality assessment and performance improvement program and share those practices through the work group. As part of the development process, MDHHS should considering requiring each waiver agency to develop a quality assessment and performance improvement program description, a separate work plan, and a comprehensive annual evaluation.

2. Overview of the MI Choice Waiver Agencies

Managed Care in Michigan

In Michigan, management of the Medicaid program is spread across two different administrations and four separate divisions within MDHHS. Physical health, children's and adult dental services, and mild-to-moderate behavioral health services are managed by the Managed Care Plan Division in the MSA. Long-term services and supports (LTSS) are implemented by three different MDHHS program areas, including the Long-Term Care Services Division (MI Choice Waiver Program); the Integrated Care Division (MI Health Link Medicaid/Medicare Dual Eligible Demonstration and the Program of All-Inclusive Care for the Elderly); and the Behavioral Health and Developmental Disabilities Administration (BHDDA) Quality Division. BHDDA also administers Medicaid waivers for people with intellectual/developmental disabilities, mental illness, and serious emotional disturbance, and it administers prevention and treatment services for substance use disorders. Table 2-1 displays the Michigan Medicaid managed care programs, the MCE(s) responsible for providing services to members, and the MDHHS division accountable for the administration of the benefits included under each applicable program.

Table 2-1—Michigan Medicaid Managed Care Programs

Medicaid Managed Care Program	MCEs	MDHHS Division
Comprehensive Health Care Program (CHCP), including: • Children's Health Insurance Program (CHIP)—MIChild • Children's Special Health Care Services Program • Healthy Michigan Plan (Medicaid Expansion) • Flint Medicaid Expansion Waiver	Medicaid Health Plans (MHPs)	MSA
Managed LTSS, including: • MI Health Link Demonstration • MI Choice Waiver Program • Program of All-Inclusive Care for the Elderly	Integrated Care Organizations (ICOs) Prepaid Inpatient Health Plans (PIHPs) PAHPs	MSA
Dental Managed Care Programs, including: • Healthy Kids Dental • Pregnant Women Dental • Healthy Michigan Plan Dental	PAHPs	MSA
Behavioral Health Managed Care	PIHPs	BHDDA

MI Choice Waiver Program

MI Choice is a waiver program to deliver HCBS to elderly persons and other adults with physical disabilities who meet the Michigan NFLOC criteria. The waiver is approved by CMS under sections 1915(b) and 1915(c) of the Social Security Act. The MI Choice Waiver Program began in 1992 as the Home and Community Based Services for the Elderly and Disabled (HCBS/ED) waiver program, which became available in all Michigan counties effective October 1, 1998. The program allows individuals to live independently while receiving LTSS in their home or a community-based setting. MI Choice is limited to serving older adults (age 65 and over) and persons with disabilities (age 18 and older). The goal of MI Choice is to provide HCBS to participants using a person-centered planning process that allows them to maintain or improve their health, welfare, and quality of life.

Overview of Waiver Agencies

During the SFY 2020 review period, MDHHS contracted with 20 waiver agencies. These waiver agencies are responsible for the provision of waiver services to MI Choice Waiver Program members within designated regions within the State of Michigan. Table 2-2 provides a profile for each waiver agency, including the region(s) of the state where services are provided and whether the waiver agency maintained case management accreditation through the National Committee for Quality Assurance (NCQA) or the Commission on Accreditation of Rehabilitation Facilities (CARF) during the time period under review.

Table 2-2—Waiver Agency Profiles[2-1]

Agency	Covered Services	Service Area/ Regions Served	Accreditation Status/Accrediting Body
A&D Home Health Care	• Adult day health (adult day care) • Chore services • Community health worker • Community living supports • Community transportation • Counseling • Environmental accessibility adaptations • Fiscal intermediary • Goods and services	Region 7	Accredited—NCQA
Agency on Aging of Northwest Michigan		Region 10	Accredited—NCQA
Area Agency on Aging 1B		Region 1B	Accredited—NCQA
Area Agency on Aging of Western Michigan		Region 8	Accredited—CARF
Detroit Area Agency on Aging		Region 1A	Accredited—NCQA
MORC Home Care		Region 1B	Accredited—NCQA
Northern Healthcare Management		Region 10	Accredited—NCQA
Region 2 Area Agency on Aging		Region 2	Accredited—NCQA
Region 3B		Regions 3 and 4	Not Accredited

[2-1] Michigan Department of Health and Human Services. MI Choice Waiver Program. 2021. Available at: https://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943_4857-16263--,00.html#list. Accessed on: Sept 7, 2021.

Agency	Covered Services	Service Area/ Regions Served	Accreditation Status/Accrediting Body
Region IV Area Agency on Aging	• Home delivered meals • Nursing services • Personal emergency response systems (PERS) • Private duty nursing/respiratory care • Respite services • Specialized medical equipment and supplies • Training in a variety of independent living skills	Region 4	Not Accredited
Region VII Area Agency on Aging		Region 7	Accredited—NCQA
Region 9 Area Agency on Aging		Region 9	Accredited—NCQA
Reliance Community Care Partners		Regions 8 and 14	Accredited—NCQA
Senior Resources		Region 14	Accredited—CARF
Senior Services		Region 3	Accredited—NCQA
The Information Center		Region 1C	Accredited—NCQA
The Senior Alliance		Region 1C	Accredited—NCQA
Tri-County Office on Aging		Region 6	Accredited—NCQA
UPCAP Care Management, Inc.		Region 11	Not Accredited
Valley Area Agency on Aging		Region 5	Accredited—NCQA

Quality Strategy

The MDHHS CQS provides a summary of the initiatives in place in Michigan to assess and improve the quality of care and services provided and reimbursed by all MDHHS Medicaid managed care programs, including MI Choice. The MDHHS CQS document is intended to meet the required Medicaid and CHIP Managed Care Final Rule, at 42 CFR §438.340. Through the development of the 2020–2023 MDHHS CQS, MDHHS strived to incorporate each managed care program's individual accountability, population characteristics, provider network, and prescribed authorities into a common strategy with the intent of guiding all Medicaid managed care programs toward aligned goals that address equitable, quality healthcare and services. The MDHHS CQS also aligns with CMS' Quality Strategy and the U.S. Department of Health and Human Services (HHS) National Quality Strategy (NQS), wherever applicable, to improve the delivery of healthcare services, patient health outcomes, and population health. The MDHHS CQS is organized around the three aims of the NQS—better care, healthy people and communities, and affordable care—and the six associated priorities. The goals and objectives of the MDHHS CQS pursue an integrated framework for both overall population health improvement as well as the commitment to eliminating unfair outcomes within subpopulations in Medicaid managed care. These goals and objectives are summarized in Table 2-3 and align with MDHHS' vision to *deliver health and opportunity to all Michiganders, reducing intergenerational poverty and health inequity*, and were specifically designed to *give all kids a healthy start* (MDHHS pillar/strategic priority #1), and to *serve the whole person* (MDHHS pillar/strategic priority #3).

Table 2-3—MDHHS CQS Goals and Ojectives[2-2]

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

[2-2] Michigan Department of Health and Human Services. *Comprehensive Quality Strategy, 2020–2023*. Available at: https://www.michigan.gov/documents/mdhhs/Quality_Strategy_2015_FINAL_for_CMS_112515_657260_7.pdf. Accessed on: Sept 7, 2021.

MDHHS CQS Medicaid Managed Care Program Goals	MDHHS Strategic Priorities	Objectives
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external)		
NQS Aim #1: Better Care MDHHS Pillar #3: Serve the whole person	Address food and nutrition, housing, and other social determinants of health Integrate services, including physical and behavioral health, and medical care with long-term support services	**Objective 3.1:** Establish common program-specific quality metrics and definitions to collaborate meaningfully across program areas and delivery systems.
		Objective 3.2: Support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations.
		Objective 3.3: Promote the use of and adoption of health information technology and health information exchange to connect providers, payers, and programs to optimize patient outcomes.
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes		
NQS Aim #1: Better Care MDHHS Pillar #1: Give all kids a healthy start MDHHS Pillar #3: Serve the whole person	Improve maternal-infant health and reduce outcome disparities Address food and nutrition, housing, and other social determinants of health Integrate services, including physical and behavioral health, and medical care with long-term support services	**Objective 4.1:** Use a data-driven approach to identify root causes of racial and ethnic disparities and address health inequity at its source whenever possible.
		Objective 4.2: Gather input from stakeholders at all levels (MDHHS, beneficiaries, communities, providers) to ensure people of color are engaged in the intervention design and implementation process.
		Objective 4.3: Promote and ensure access to and participation in health equity training.
		Objective 4.4: Create a valid/reliable system to quantify and monitor racial/ethnic disparities to identify gaps in care and reduce identified racial disparities among the managed care populations.
		Objective 4.5: Expand and share promising practices for reducing racial disparities.
		Objective 4.6: Collaborate and expand partnerships with community-based organizations and public health entities across the state to address racial inequities.

MDHHS CQS Medicaid Managed Care Program Goals	MDHHS Strategic Priorities	Objectives
Goal #5: Improve quality outcomes and disparity reduction through value-based initiatives and payment reform		
NQS Aim #3: Affordable Care MDHHS Pillar #4: Use data to drive outcomes	Drive value in Medicaid Ensure we are managing to outcomes and investing in evidence-based solutions	**Objective 5.1:** Promote the use of value-based payment models to improve quality of care.
		Objective 5.2: Align value-based goals and objectives across programs.

The MDHHS CQS also includes a common set of performance measures to address the required Medicaid and CHIP Managed Care Final Rule. The common domains include:

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

These domains address the required state-defined network adequacy and availability of services standards, and take into consideration the health status of all populations served by the MCEs in Michigan. Each program also has identified performance measures that are specific to the populations it serves.

MDHHS employs various methods to regularly monitor and assess the quality of care and services provided by the managed care programs. MDHHS also intends to conduct a formal comprehensive assessment of performance against the MDHHS CQS performance objectives annually. Findings will be summarized in the Michigan Medicaid Comprehensive Quality Strategy Annual Effectiveness Review, which drives program activities and priorities for the upcoming year and identifies modifications to the MDHHS CQS.

Quality Initiatives and Interventions

To accomplish its objectives, MDHHS, through the MI Choice Waiver Program, has implemented several initiatives and interventions that focus on quality improvement. Examples of these initiatives and interventions include:

- **Quality Structure/Committee**—The Quality Management Committee (QMC) advises and provides insight into the development and review of MI Choice quality management activities and initiatives. Through the QMC, members, waiver agencies, program directors, advocates, and providers review

quality outcomes, identify barriers and improvement opportunities, and develop service delivery remediation strategies. Members and advocates also contribute their valuable perspectives during the implementation of care options such as person-centered planning and self-determination.

- **MI Choice Quality Improvement Strategy (QIS)**—The QIS describes how the program assesses and improves the quality of services and supports managed by the waiver agencies. The QIS outlines the methods used to gather data and measure individual and system performance including: the MDHHS QMP, waiver agency-specific QMPs, Clinical Quality Assurance Review (CQAR), Administrative Quality Assurance Review (AQAR) and Critical Incident Reporting System. Waiver agencies are required to develop their own QMP every other year to address CMS and MDHHS quality requirements. MDHHS reviews and analyzes the QMPs and associated yearly reports, and complies and compares individual waiver agency quality indicator data and statewide averages to monitor agency performance, as indicated.
- **Performance Monitoring**—MDHHS monitors the waiver agencies using multiple methods including established performance measures in six waiver assurances and requirements in the areas of service adequacy, access, provider network training, care plans, satisfaction and quality of life, and incidents. Quality indicator selection, measurement, reporting and improvement activities also assess participant health status outcomes in the following domains: nutrition, incontinence, skin ulcers, physical and cognitive function, pain, and safety/environment. Quarterly reports are generated and shared with MDHHS for review and analysis. The QMC selects five indicators for focused quality improvement efforts over a minimum, two-year period and regularly meets with local consumer advisory teams to collaborate on related activities.
- **Performance Bonus**—MDHHS withholds a portion of the approved capitation payment from each MI Choice waiver agency, which are used for the agency's annual performance bonus incentive. The incentives are distributed to the agencies after the end of the year according to rankings based on criteria and standards established annually by MDHHS. Waiver agency rankings are calculated based on CQAR/AQAR performance indicators, encounter data, significant support participant (SSP), acuity, critical incidents reporting, waiver agency reports, and supports coordinator per participant.

3. Assessment of Waiver Agency Performance

HSAG used findings across mandatory and optional EQR activities conducted during the SFY 2020 review period to comprehensively evaluate the performance of the waiver agencies on providing quality, timely, and accessible healthcare services to MI Choice Waiver Program members. Quality, as it pertains to EQR, means the degree to which the waiver agency increased the likelihood of desired outcomes of its members through its structural and operational characteristics; the provision of services that were consistent with current professional, evidenced-based knowledge; and interventions for performance improvement. Access relates to members' timely use of services to achieve optimal outcomes, as evidenced by how effective the waiver agencies were at successfully demonstrating and reporting on outcome information for the availability and timeliness of services.

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

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in SFY 2020 to provide context for the resulting findings of each EQR activity. As HSAG does not conduct the EQR-related activities for the MI Choice waiver agencies, MDHHS provided the data and the information sources necessary for HSAG to complete the annual EQR. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, refer to Appendix A.

Validation of Performance Improvement Projects

Each waiver agency develops a QMP biennially that addresses CMS and MDHHS quality requirements. MDHHS also requires each waiver agency to compile an annual report, called the MI Choice Summary of Quality Management Plan Activities & Outcomes Report, which provides a description of the waiver agency's quality management activities and outcomes. Throughout this report, the QMP and the annual report are collectively referred to as "QMP reports." Every two years, the QMC members vote on five quality indicators to initiate PIPs, referred to as quality improvement projects (QIPs), and associated goals and strategies. Progress of these quality indicators are reported annually to MDHHS through the MI Choice Summary of Quality Management Plan Activities & Outcomes Report. Table 3-1 outlines the selected five QIP quality indicators for the waiver agencies for the SFY 2020 and SFY 2021 review years, and the MDHHS-defined statewide goals for each indicator. Of note, a lower percentage indicates better performance.

Table 3-1—QIP Quality Indicators and Goals

Quality Indicators	MDHHS Statewide Goals
1. *Prevalence of Neglect/Abuse*	3%
2. *Prevalence of Pain With Inadequate Pain Control*	20%
3. *Prevalence of Falls*	23%
4. *Prevalence of Any Injuries*	3%
5. *Prevalence of Dehydration*	1.5%

Performance Measure Validation

The PMV activity comprised information derived from the CQAR, in which reviewers from the Michigan Public Health Institute (MPHI) evaluated a sample of records from each waiver agency to validate information included in the Form CMS-372(S) Annual Report on Home and Community-Based Services (HCBS) Waivers and Supporting Regulations (CMS-372 report) complied with the requirements of the MI Choice Waiver Program. MDHHS also used internal systems and reports to evaluate financial information, critical incident data, claims data, and other performance measure data. The performance measure domains included Administrative Authority, Evaluation/Reevaluation of Level of Care, Participant Services, Participant-Centered Planning and Service Delivery, Participant Safeguards, and Financial Accountability. Of note, for all measures submitted as part of the CMS-372 report, the performance measure percentage rate was calculated at the statewide rate, and not for each individual waiver agency. While MDHHS maintained the numerators and denominators for each waiver agency for several performance measures and the individual scores for each standard included as part of the CQAR, MDHHS did not calculate an individual waiver agency performance measure rate. Additionally, for statewide reporting, MDHHS maintained the CQAR tool for each waiver agency for those performance measures that rely on the CQAR as the data source. These performance measures are highlighted in blue in Table 3-2. For other data sources, MDHHS had the capability of analyzing data available in the performance measure's associated data base (i.e., critical incident data base for Participant Safeguards measures). Table 3-2 lists the performance measures reported by MDHHS to CMS in compliance with waiver requirements. Table 3-2 also includes the data source(s) and sampling approach used to calculate the performance measure results as specified in the CMS-approved Section 1915(c) waiver application for the MI Choice Waiver Program.

Table 3-2—Performance Measures and Source Data

	Performance Measures	Source Data	Sampling Approach
	Administrative Authority		
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.*	Record reviews	Representative sample
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.*	Record reviews	Representative sample
3	*Number and percent of waiver agencies who submit annual Quality Management Plan (QMP) activity and outcome reports that illustrate they are adhering to their QMP.*	Reports	100% review
4	*Number and percent of appropriate level of care determinations (LOCDs) found after MDHHS review.*	NFLOC system*	100% review
5	*Number and percent of corrective action plans that were provided by waiver agencies according to requirements set by the Michigan Department of Health and Human Services (MDHHS) or the External Quality Review Organization (EQRO).*	Record reviews	100% review
	Evaluation/Reevaluation of Level of Care		
6	*Number and percent of new MI Choice waiver participants who meet the NFLOC criteria prior to waiver enrollment.*	Online database	100% review
7	*Number and percent of LOCDs made by a qualified evaluator.*	Record reviews	Representative sample
8	*Number and percent of participants who had initial LOCDs where the NFLOC criteria were accurately applied.*	Record reviews	Representative sample
9	*Number and percent of MI Choice disenrollments based upon no longer meeting NFLOC criteria that were determined correctly.*	LOCD data in the Community Health Automated Medicaid Processing System (CHAMPS)	100% review
10	*Number and percent of providers continuing to meet applicable licensure & certification standards in accordance with state law following initial enrollment.*	Record reviews	100% review (Waiver agencies review 20% of records; MDHHS reviews 100% of those records reviewed by waiver agencies)

	Performance Measures	Source Data	Sampling Approach
11	*Number and percent of new waiver service provider applications that meet initial licensure/certification standards in accordance with state law prior to the provision of waiver services.*	Record reviews	100% review
12	*Number and percent of non-licensed or non-certified waiver providers that initially met provider qualifications.*	Record reviews	100% review
13	*Number and percent of non-licensed or non-certified waiver providers that continue to meet provider qualifications.*	Record reviews	100% review (Waiver agencies review 20% of records; MDHHS reviews 100% of those records reviewed by waiver agencies)
14	*Number and percent of providers who meet provider training requirements.*	Record reviews	100% review (Waiver agencies review 20% of records; MDHHS reviews 100% of those records reviewed by waiver agencies)
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.*	Record reviews	Representative sample
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.*	Record reviews	Representative sample
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.*	Record reviews	Representative sample
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.*	Record reviews	Representative sample
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.*	Record reviews	Representative sample
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.*	Record reviews	Representative sample
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.*	Record reviews	Representative sample

	Performance Measures	Source Data	Sampling Approach
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.*	Record reviews	Representative sample
	Participant Safeguards		
23	*Number and percent of participant critical incidents for which investigations by the waiver agencies were resolved within 60 days.*	Critical events and incident reports	100% review
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.*	Record reviews	Representative sample
25	*Number and percent of critical incidents due to unexplained death reported within two business days of notification that the incident occurred.*	Critical incident reporting database	100% review
26	*Number and percent of all critical incidents EXCEPT unexplained death reported within 30 days of notification that the incident occurred.*	Critical incident reporting database	100% review
27	*Number and percent of waiver agencies that utilize the critical incident database to track incidents through effective resolution.*	Critical incident reporting database	100% review
28	*Number and percent of waiver agencies with staff who have completed required training to prevent incidents.*	Record reviews	100% review
29	*Number and percent of unauthorized use of restraints, restrictive interventions, or seclusions that were reported as a critical incident.*	Critical incident reporting database	100% review
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of caregiver).*	Record reviews	Representative sample
31	*Number and percent of participant suicide attempts that resulted in follow up by the waiver agency.*	Critical incident reporting database	100% review
32	*Number and percent of participants requiring emergency medical treatment or hospitalization due to medication error.*	Critical incident reporting database	100% review
33	*Number and percent of critical incidents reporting hospitalization or emergency room visit within 30 days of the previous hospitalization due to neglect or abuse.*	Critical incident reporting database	100% review
34	*Number and percent of properly reported suicide attempts in the critical incident database.*	Critical events and incident reports	100% review (MDHHS) Representative sample (Contracted reviewers)

Performance Measures		Source Data	Sampling Approach
Financial Accountability Performance Measures			
35	*Number and percent of encounters submitted to MDHHS with all required data elements.*	Online database	100% review
36	*Number and percent of capitation payments made to the waiver agencies only for MI Choice participants with active Medicaid eligibility.*	Online database	100% review
37	*Number and percent of encounters submitted to MDHHS within required timeframes.*	Online database	100% review
38	*Number and percent of service plans that supported paid services.*	Record reviews	Representative sample
39	*Number and percent of capitation payments that have been paid at rates approved by the Actuary.*	Medicaid Management Information System (MMIS) data for capitation payments	100% review

*Although these performance measures were included as part of the SFY 2020 CQAR tool, the MI Choice Waiver Program indicates a data source other than the CQAR.

Indicates the performance measures that rely on the CQAR as the data source for reporting.

Compliance Review

MPHI, on behalf of MDHHS, completes a CQAR for every waiver agency each state fiscal year that consists of a record review and home interview. During the CQAR, reviewers examine case records and other information to gauge the level of compliance with program standards and to assess the quality of waiver agency service to each member. The CQAR includes a review of whether person-centered service plans and service delivery are in compliance with State and federal requirements. Each review element is assigned a value of *Evident* (compliant), *Non-Evident* (non-compliant), or *N/A*. A percentage of *Evident* for each focus area is derived from the total number of elements assigned a value of *Evident* divided by the number of total applicable elements. Each standard is then assigned an overall compliance determination based on a compliance level determination matrix. The SFY 2020 CQAR consisted of 18 standards (focus areas) identified in Table 3-3. Table 3-3 also identifies the standards included as part of the record review and the home interview.

Table 3-3—CQAR Standards

Standards		Record Review	Home Interview
Focus I	Level of Care Determination	✓	✓
Focus I.B	Communication		✓
Focus II	Freedom of Choice	✓	
Focus III	Release of Information	✓	
Focus IV	Status	✓	

Standards		Record Review	Home Interview
Focus V	Pre-Planning	✓	✓
Focus VI	Assessment	✓	✓
Focus VII	Medication Record	✓	✓
Focus VIII	Person-Centered Service Planning	✓	✓
Focus IX	MI Choice Services	✓	✓
Focus X	Linking and Coordinating	✓	✓
Focus XI	Follow-Up and Monitoring	✓	✓
Focus XII	Service Provider	✓	
Focus XIII	Contingency Plan	✓	✓
Focus XIV	Critical Incidents	✓	✓
Focus XV	Adverse Benefit Determination	✓	
Focus XVI	Complaints and Grievances	✓	
Focus XVII	Home and Community Based		✓

EQR Activity Results

A&D Home Health Care

Validation of Performance Improvement Projects

Performance Results

Table 3-4 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2020. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **A&D Home Health Care** met its internal SFY 2020 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **A&D Home Health Care** did not meet its internal SFY 2020 QIP goal or the statewide goal. Any interventions described within **A&D Home Health Care**'s QMP reports are also provided in Table 3-4. The results in Table 3-4 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-4—QIP Results

QIP Topic	Goal*	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Reduce the number of participants identifying the prevalence of neglect/abuse to be at or under the identified statewide percentage of 3.0%	SFY 2019 = 2.9% SFY 2020 = 3.10% ☒
Actions/Activities/Interventions: According to **A&D Home Health Care**'s MI Choice Quality Management Report FY 2020–2021 dated January 13, 2020, **A&D Home Health Care** planned to complete the following tasks: • Quarterly review the iHC [InterRAI Home Care Assessment] QI [quality improvement] Summary and Detailed Reports for tracking and trending of participants identifying the prevalence of neglect/abuse at the Management Team meeting the following month of the quarter. • When trends are discovered, additional education will be provided to Waiver staff to ensure the participants remain safe and free from neglect/abuse. • Continue to report critical incidents involving neglect/abuse via the Critical Incident Portal within the contract designated time frames. • Provide annual Abuse, Neglect and Exploitation training to all supports coordinators. The **A&D Home Health Care** MI Choice Quality Management Report Activities & Outcomes Report FY 2020 dated January 31, 2021 identified the following: • Final conclusions indicate that current processes are working with the discovering and implementing solutions to decrease the prevalence of neglect/abuse. Additional measures will need to be implemented to assist in decreasing the prevalence of neglect/abuse to below the optimal standard of 3.0%.		

QIP Topic	Goal*	Measurement and Outcome
• Plans for additional measures include: continued clinical supervision regarding ways to prevent abuse and neglect.		
2. *Prevalence of Pain With Inadequate Pain Control*	Reduce the prevalence of pain with inadequate pain control to below the statewide average of 20.0%	SFY 2019 = 22.8% SFY 2020 = 20.85% ☒
Actions/Activities/Interventions: According to **A&D Home Health Care**'s MI Choice Quality Management Report FY 2020–2021 dated January 13, 2020, **A&D Home Health Care** planned to complete the following tasks: • Quarterly review the iHC QI Summary and Detailed Reports for tracking and trending of participants identifying the prevalence of pain with Inadequate Pain Control at the Management Team meeting the following month of the quarter. • When trends are discovered, additional education will be provided to Waiver staff to ensure the participants will indicate satisfactory pain control. • The Clinical Educator will be completing training for nurses and social workers regarding pain and alternative pain control techniques, as she has received a credential in pain management. The training included: – Re-directing your attention: Guided imagery—A relaxation technique that uses mental images to influence how you feel and reduce pain – Stretching/Exercise—Use simple stretches and light exercise to help manage pain; Go for a walk – Relaxation techniques: Music therapy—Listen to soft relaxing music/favorite music – Massage • In addition, training will be provided to supports coordinators to assist participants in communicating with their physicians when the current pain regimen is not effective and alternative techniques have been utilized. The **A&D Home Health Care** MI Choice Quality Management Report Activities & Outcomes Report FY 2020 dated January 31, 2021 identified the following: • In addition to quarterly and monthly reviews of the iHC QI data, **A&D Home Health Care** is reviewing all data with staff members to ensure knowledge and understanding of participants who may benefit from alternative pain control techniques. • Final conclusions indicate that **A&D Home Health Care** is reducing the prevalence of pain with inadequate pain control. Current processes are working and will be improved upon to ensure this standard is at or below the statewide goal of 20.0%		
3. *Prevalence of Falls*	Reduce the prevalence of falls to be at or below the statewide goal of 23.0%	SFY 2019 = 25.6% SFY 2020 = 23.16% ☒
Actions/Activities/Interventions: According to **A&D Home Health Care**'s MI Choice Quality Management Report FY 2020–2021 dated January 13, 2020, **A&D Home Health Care** planned to complete the following tasks: • Quarterly review the iHC QI Summary and Detailed Reports for tracking and trending of participants identifying the prevalence of falls at the Management Team meeting the following month of the quarter.		

QIP Topic	Goal*	Measurement and Outcome
• When trends are discovered, additional education will be provided to Waiver staff on fall prevention and in home safety. • The Clinical Educator will be utilizing the contracted Occupational Therapist to request she speak at an upcoming local consumer quality council meeting about safe transfers and fall prevention. • All supports coordinators have completed the Model of Care certification and will utilize the resources obtained from the program as individuals with fall risks are identified. The **A&D Home Health Care** MI Choice Quality Management Report Activities & Outcomes Report FY 2020 dated January 31, 2021 identified the following: • **A&D Home Health Care** will continue to combat participant falls by doing the following: – The Clinical Educator will be utilizing the contracted Occupational Therapist to request she speak at an upcoming local consumer quality council meeting about safe transfers and fall prevention. – All supports coordinators have completed the Model of Care certification and will utilize the resources and strategies obtained from the program as individuals with fall risks are identified.		
4. *Prevalence of Any Injuries*	Reduce the prevalence of any injury to be at or below the statewide goal of 3.0%	SFY 2019 = 6.9% SFY 2020 = 8.23% ☒
Actions/Activities/Interventions: According to **A&D Home Health Care**'s MI Choice Quality Management Report FY 2020–2021 dated January 13, 2020, **A&D Home Health Care** planned to complete the following tasks: • Quarterly review the iHC QI Summary and Detailed Reports for tracking and trending of participants identifying the prevalence of any injury at the Management Team meeting the following month of the quarter. • Quality assurance will complete a 5-10% randomized audit on the individual participants reporting injuries to identify trends and possible solutions to decrease the prevalence of any injury. All results will be presented to the Management Team at the month following the quarter. • When trends are discovered, additional education will be provided to Waiver staff on the prevalence of injuries. The **A&D Home Health Care** MI Choice Quality Management Report Activities & Outcomes Report FY 2020 dated January 31, 2021 identified the following: • In addition to quarterly and monthly reviews of the iHC QI data, **A&D Home Health Care** is reviewing all data with staff members to ensure knowledge and understanding of participants who may not meet the identified criteria for the prevalence of any injuries. • Education is being provided to all staff to increase understanding of the documentation and reporting mechanisms. Education includes in services and education plans for individual staff. With the understanding and implementation of the education this should lead to a natural decrease in the numerator.		

QIP Topic	Goal*	Measurement and Outcome
5. *Prevalence of Dehydration*	Reduce the risk of dehydration to be at or below the statewide goal of 1.5%	SFY 2019 = 2.1% SFY 2020 = 1.97% ☒

Actions/Activities/Interventions:

According to **A&D Home Health Care**'s MI Choice Quality Management Report FY 2020–2021 dated January 13, 2020, **A&D Home Health Care** planned to complete the following tasks:

- Quarterly review the iHC QI Summary and Detailed Reports for tracking and trending of participants identifying the prevalence of dehydration at the Management Team meeting the following month of the quarter.
- When trends are discovered, additional education will be provided to Waiver staff on the prevalence of dehydration.
- Clinical Educator will be doing a quarterly audit of the identified participants, per the iHC QI Detailed report, to ensure identified participant's fluid needs are within their normal, medically prescribed limits.
- Additionally, for NCQA [National Committee for Quality Assurance] Accreditation, **A&D Home Health Care** will be completing several presentations on dehydration and the effect is has on participants. The focus of the education is to decrease the prevalence of dehydration.

The **A&D Home Health Care** MI Choice Quality Management Report Activities & Outcomes Report FY 2020 dated January 31, 2021 identified the following:

- Education with the staff included a documentation education webinar, a review of the identified participants notating dehydration and a further follow up with the Supports Coordinators. Due to these steps taken, the overall percentage has decreased.
- Noted at this time, additional education is needed to ensure that individuals under a medically recommended fluid restriction are not noted as dehydrated, rather than following their physician's orders. The additional education will be taking place during the upcoming fiscal year.

SFY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
*Goals in the QMP differed from the goals in the annual report. As the goals identified in the annual report were more stringent, HSAG used these goals to determine performance.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: While **A&D Home Health Care** did not meet its established goal for all five QIPs, three QIPs demonstrated a decrease in prevalence rates (*Prevalence of Pain With Inadequate Pain Control*, *Prevalence of Falls*, and *Prevalence of Dehydration*), suggesting that **A&D Home Health Care**'s implemented interventions had a positive impact on prevalence rates, and members experienced better pain control, and less falls and dehydration than the prior year.

Weaknesses and Recommendations

Weakness #1: A&D Home Health Care's SFY 2020–2021 QMP and SFY 2020 annual report included conflicting goals, which made it difficult to determine the actual goal established by **A&D Home Health Care** when initiating the QIPs. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each quality indicator needs to be clearly and consistently documented.

Why the weakness exists: A&D Home Health Care's SFY 2020–2021 QMP identified different goals for each QIP than the SFY 2020 annual report. The SFY 2020 goal within the annual report aligned with MDHHS' established statewide goals. However, the goals identified in the SFY 2020–2021 QMP were listed under a heading titled "FY 2021 Quality Improvement Projects, Goals, Strategies, and Results" (e.g., the QMP indicated the percentage goal for the *Prevalence of Neglect/Abuse* QIP as 4.95 percent; however, the annual report indicated the goal for this QIP as 3 percent). Since the QMP was dated January 2020, it was unclear if these "FY 2021" goals were actually for SFY 2020 or if the QMP was updated with new goals for SFY 2021, but the date on the QMP was not revised. Further, if the goal was updated for SFY 2021 based on SFY 2020 results, it also did not align with the statewide percentage rate for SFY 2020.

Recommendation: HSAG recommends that **A&D Home Health Care** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should be consistently documented within its QMP reports and should not change through the measurement period of the QIP unless documentation is provided to support the rationale for the change. Additionally, **A&D Home Health Care** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers.

Weakness #2: The interventions implemented by **A&D Home Health Care** did not appear to be effective in improving outcomes as prevalence rates increased for the *Prevalence of Neglect/Abuse* and *Prevalence of Any Injuries* QIPs. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly documented. **A&D Home Health Care**'s choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential for the waiver agency's success in achieving the desired outcomes for the QIPs.

Why the weakness exists: A&D Home Health Care's SFY 2020–2021 QMP listed planned activities; however, the SFY 2020 annual report did not clearly identify the interventions implemented during SFY 2020 for all QIPs, or support that a causal/barrier analysis was conducted and that an evaluation occurred for each intervention to determine its effectiveness and ensure each intervention was logically linked to any identified barriers. The SFY 2020 annual report suggested that **A&D Home Health Care**'s current processes are working for two QIPs, but these current processes or specific interventions that supported the improvement were not clearly identified.

Additionally, for some QIPs it was unclear if the interventions listed in the SFY 2020 annual report were interventions implemented during SFY 2020 or were planned interventions for the future.

Recommendation: HSAG recommends that **A&D Home Health Care** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **A&D Home Health Care** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **A&D Home Health Care** should analyze and interpret results at multiple points in time and test for statistical significance. **A&D Home Health Care** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #3: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **A&D Home Health Care**'s QIPs must be designed in a methodically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions.

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2020 annual report included limited details on the design developed and the methodology followed by **A&D Home Health Care** when implementing its QIPs.

Recommendation: HSAG recommends that **A&D Home Health Care** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **A&D Home Health Care** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2020, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For eight of the 39 performance measures calculated by MDHHS, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Those performance measures with a statewide rate of 100 percent reported through the CMS-372 report were not included as part of the assessment. Table 3-5 displays the eight performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rate as calculated by MDHHS for the CMS-372 report, the statewide percentage rate as calculated by HSAG using the CQAR standard scores associated with each performance measure, and **A&D Home Health Care**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **A&D Home Health Care**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate as calculated by HSAG, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-5—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* VIII.1, VIII.2, VIII.4, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39	91.27	92.11	92.19
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* I.1, I.2, I.3, I.5, II.1, II.2, II.3, II.4, II.5, II.6, II.7, II.8, II.9, IV.1, IV.2, IV.3, IV.5, IV.6, VI.1, VI.2, VI.3, X.1	96.83	98.82	98.26
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* V.3, IX.1, IX.2, IX.3, IX.6	93.65	94.16	86.57
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* VIII.7, VIII.8	98.94	99.07	96.88

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* VIII.3, VIII.5, VIII.6, VIII.11	**98.41**	**98.81**	**99.22**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* V.1, V.2, V.3, V.5, V.10, V.11, V.13, V.15, VI.12, VI.14, VI.16, VIII.1, VIII.2, VIII.3 VIII.4,VIII.5, VIII.6, VIII.11, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39, VIII.40, VIII.41, IX.1, IX.2, IX.3, IX.4, IX.6	**94.97**	**94.13**	**90.31**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* VIII.28, VIII.29, VIII.30, VIII.31, VIII.32, VIII.33, VIII.34, IX.5	**96.03**	**95.54**	**92.81**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* XI.1, XI.3, XI.4	**89.68**	**93.52**	**91.67**

* The individual waiver agency performance measure rates were derived from the standards outlined in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report.

**Statewide percentage rates are displayed as reported by MDHHS. HSAG's calculations may differ from MDHHS' calculations as HSAG summed all numerators and denominators related to the CQAR standards included as part of each performance measure, while MDHHS calculated performance measure rates for the CMS-372 report using a total count of CQAR records reviewed across the waiver agencies and removing those records from the numerator when a standard included as part of the performance measure was deficient ("*Non-Evident*").

‡ The statewide percentage rates determined by HSAG were based on results of the SFY 2020 CQAR and the standards associated with each performance measure as indicated in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source." The statewide percentage rates determined by HSAG are displayed for comparison purposes to the MDHHS statewide percentages. Additionally, the HSAG calculated rates were made available for this report to ensure an appropriate representation to the rates calculated for each waiver agency.

Indicates the performance measure rate is higher than the statewide rate as calculated by HSAG.

Indicates the performance measure rate is lower than the statewide rate as calculated by HSAG.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Although MDHHS has not established performance measure benchmarks, **A&D Home Health Care**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 7, 8, 12, 22, 24, 27, 28, 29, 31, 33, 34, 37, and 38. Performance Measures 36 and 39 also achieved a rate of 100 percent; however, performance in these measures are driven solely by MDHHS as they relate to capitation payments to the waiver agencies.

Weaknesses and Recommendations

Weakness #1: A&D Home Health Care performed substantially worse than other waiver agencies on Performance Measure 15, *number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that services were not always authorized consistent with member needs, service summaries did not consistently contain accurate and complete information, and services authorized did not consistently meet service standard requirements.

Why the weakness exists: A&D Home Health Care's performance rate for Performance Measure 15 fell 7.59 percentage points below HSAG's calculated statewide rate. Through the CQAR, of the 32 records reviewed, MPHI determined that three records did not include evidence that services were authorized consistent with the member's needs; six records did not include accurate and complete service summary information; and nine records did not meet all service standard requirements for authorized services.

Recommendation: MDHHS required **A&D Home Health Care** to submit a CAP to remediate the deficiencies associated with Performance Measure 15. **A&D Home Health Care**'s CAP included, but was not limited to, updates to its person-centered plan of care and self-determination policies; individual education for each supports coordinator out of compliance; education to all staff members on policy change; a process change where service summaries are printed and signed by the member/legal representative; a plan to reformat the self-determination program to streamline the process; and a review of 12 records per month by the management team. However, **A&D Home Health Care** also indicated that once standards show compliance of 90 percent, no further reporting will be required. Therefore, HSAG recommends that **A&D Home Health Care** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-6 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-6 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-6—Clinical Quality Assurance Reviews and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus I	Level of Care Determination	98.46%	100%	**4.00**
Focus I.B	Communication		100%	**4.00**
Focus II	Freedom of Choice	98.00%		**4.00**
Focus III	Release of Information	96.43%		**4.00**
Focus IV	Status	98.55%		**4.00**
Focus V	Pre-Planning	83.33%	100%	**3.33**
Focus VI	Assessment	95.00%	100%	**4.00**
Focus VII	Medication Record	85.71%	100%	**4.00**
Focus VIII	Person-Centered Service Planning	94.78%	100%	**4.00**
Focus IX	MI Choice Services	86.67%	100%	**3.33**
Focus X	Linking and Coordinating	94.32%	100%	**4.00**
Focus XI	Follow-Up and Monitoring	79.41%	100%	**2.67**
Focus XII	Service Provider	76.19%		**4.00**
Focus XIII	Contingency Plan	96.39%	100%	**4.00**
Focus XIV	Critical Incidents	80.00%	100%	**2.67**
Focus XV	Adverse Benefit Determination	67.65%		**1.00**
Focus XVI	Complaints and Grievances	80.00%		**3.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus XVII	Home and Community Based		100%	**4.00**
	Totals	**91.70%**	**100%**	**3.77**

	Indicates the standard was not reviewed as part of the record review or home visit.
	Indicates substantial compliance: 3.26 or higher.
	Indicates some compliance, needs improvement: 2.51 to 3.25.
	Indicates not full or substantial compliance: 1.76 to 2.50.
	Indicates compliance not demonstrated: 1.00 to 1.75.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: A review of 16 home visits was conducted and all reviews achieved full compliance. The purpose of the home visits is to confirm that providers furnish services according to the person-centered service plan and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested that members are receiving services in accordance with their service plans and preferences, and are satisfied with those services. It should be noted that while the home visit reviews achieved full compliance, the record review identified conflicting results in the areas of Pre-Planning, MI Choice Services, Follow-Up and Monitoring, and Critical Incidents.

Strength #2: A&D Home Health Care achieved a substantial compliance rating in 14 of the 18 standards reviewed as part of the CQAR. The purpose of the record review is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the person-centered service plan and care planning process, reassessment data) and to assess the quality of waiver agency services to each member; therefore, CQAR findings suggested that person-centered service plans and service delivery are being implemented in accordance with many State and federal requirements.

Weaknesses and Recommendations

Weakness #1: A&D Home Health Care did not consistently follow all Adverse Benefit Determination requirements; specifically, **A&D Home Health Care** did not consistently provide its members with an adverse benefit determination (ABD) notice or with an ABD that was complete and accurate. When a member no longer meets NFLOC, the MI Choice Section 1915(c) waiver requires the supports coordinator to initiate program discharge procedures and provider the member with an ABD notice. Complete and accurate ABD notices are necessary to ensure members/guardians understand their appeal rights and how to request an appeal.

Why the weakness exists: Through the CQAR, MPHI determined that four out of 18 applicable records did not include evidence that the waiver agency provided the member/guardian with an ABD notice for disenrollment due to not meeting NFLOC criteria and/or ABD for a service denial, reduction, suspension and/or termination from the MI Choice Waiver Program. Additionally, seven out of 16 applicable records did not include an ABD notice that was complete and contained accurate information. Both findings were recurring for the past two years.

Recommendation: MDHHS required **A&D Home Health Care** to submit a CAP to remediate the deficiencies. **A&D Home Health Care**'s CAP included, but was not limited to, updates to its notification of ABD policy; individual education for each supports coordinator out of compliance; education to all staff members on policy change; dissemination of an updated process manual to all staff members; updates to the ABD notice; management team review of all ABD notices prior to mailing; and a review of 12 records per month by the management team. However, **A&D Home Health Care** also indicated that once standards show compliance of 80 percent, no further reporting will be required. Therefore, HSAG recommends that **A&D Home Health Care** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

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

To identify strengths and weaknesses and draw conclusions for **A&D Home Health Care**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **A&D Home Health Care** across all EQR activities. The overarching aggregated findings showed that **A&D Home Health Care**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **A&D Home Health Care** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

HSAG's assessment of **A&D Home Health Care** also identified opportunities for **A&D Home Health Care** to enhance its quality assessment and performance improvement program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **A&D Home Health Care** had a QMP that included brief descriptions of its quality management activities, its QMP should be modified to more comprehensively align with the requirements and best practices for a quality assessment and performance improvement program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Agency on Aging of Northwest Michigan

Validation of Performance Improvement Projects

Performance Results

Table 3-7 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2020. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Agency on Aging of Northwest Michigan** met its internal SFY 2020 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Agency on Aging of Northwest Michigan** did not meet its internal SFY 2020 QIP goal or the statewide goal. Any interventions described within **Agency on Aging of Northwest Michigan**'s QMP reports are also provided in Table 3-7. The results in Table 3-7 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-7—QIP Results

QIP Topic	Goal	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Reduce the prevalence of abuse and neglect to below the state average [5.1%]	SFY 2019 = 5.5% SFY 2020* = 3.6% ☑
Actions/Activities/Interventions: According to **Agency on Aging of Northwest Michigan**'s MI Choice Summary of Quality Management Plan Activities and Outcomes Report FY 2020–FY 2021 dated January 15, 2020; while the goal is to reduce the prevalence of abuse and neglect to below the statewide average, the unintended consequence of underreporting is at the forefront throughout the quality improvement process. Supports Coordination staff are skilled in identifying exploitation, abuse, and neglect. SC's [supports coordinators] are also able to offer intervention or alternative options to reduce the participant's risk. **Agency on Aging of Northwest Michigan** staff are required to complete annual training on identifying and reporting abuse. According to **Agency on Aging of Northwest Michigan**'s MI Choice Summary of Quality Management Plan Activities and Outcomes Report FY 2020 dated December 22, 2020, **Agency on Aging of Northwest Michigan** completed the following activities: • Throughout the COVID-19 pandemic, Supports Coordinators have increased the frequency in which monitoring calls are made to participants, due to decrease in home visits. During these monitoring contacts, Supports Coordinators have been assessing for any signs of abuse or neglect. Given the inability to see many of the participants (during the pandemic) and the decrease of in-home services, this assessment is vital to the safety of all participants. If any signs of neglect/abuse are identified, critical incident reporting is done per policy and necessary interventions put in place for the safety of the participant.		

QIP Topic	Goal	Measurement and Outcome
2. *Prevalence of Pain With Inadequate Pain Control*	Reduce the prevalence of pain with inadequate pain control to below 20%	SFY 2019 = 22% SFY 2020* = 23.8% ☒
Actions/Activities/Interventions: According to **Agency on Aging of Northwest Michigan**'s MI Choice Quality Management Plan Activities and Outcomes Report FY 2020–FY 2021 dated January 15, 2020; Support Coordinators are trained to assess for pain and document accordingly. However, in an effort to promote quality, the SCs will complete at least one training on adequate pain control and assessing for pain. Pain will also be a topic of focus for ongoing peer reviews. According to **Agency on Aging of Northwest Michigan**'s MI Choice Quality Management Report Activities and Outcomes Report FY 2020 dated December 22, 2020, **Agency on Aging of Northwest Michigan** completed the following activities: • **Agency on Aging of Northwest Michigan** Consumer Quality Collaborative has been working throughout SFY 2020 towards interventions aimed to improve the rate of pain with inadequate pain control for **Agency on Aging of Northwest Michigan** MI Choice participants. This work has included research of pain clinics in the region and recommended nonpharmacological interventions for pain. This work was done in conjunction with a Supports Coordinator working to receive a BSN [Bachelor of Science in Nursing] degree. This resource has been shared with all Supports Coordinators to include in assessments and person-centered planning.		
3. *Prevalence of Falls*	Reduce the prevalence of falls to less than 25%	SFY 2019 = 27.9% SFY 2020* = 29.6% ☒
Actions/Activities/Interventions: According to **Agency on Aging of Northwest Michigan**'s MI Choice Quality Management Plan Activities and Outcomes Report FY 2020–FY 2021 dated January 15, 2020; with the implementation of the MiCapable Model of care, Support Coordinators will be able to ensure clients are in an appropriate environment and using the most appropriate equipment to promote independence. Safety is and will remain a priority of **Agency on Aging of Northwest Michigan**'s staff and by utilizing the MiCapable Model, safety and independence will impact the rate in which participants fall. According to **Agency on Aging of Northwest Michigan**'s MI Choice Quality Management Report Activities and Outcomes Report FY 2020 dated December 22, 2020, **Agency on Aging of Northwest Michigan** completed the following activities: • **Agency on Aging of Northwest Michigan** has incorporated the STEADI [Stopping Elderly Accidents, Deaths & Injuries] program information and resources to be used with participants and family caregivers to aid in the reduction of falls. Home safety checklists are provided to all participants at enrollment, which includes tips to reduce safety hazards within the home. Additionally, **Agency on Aging of Northwest Michigan** has provided staff and the Consumer Quality Collaborative education from the local fire department on safety strategies within the home.		

QIP Topic	Goal	Measurement and Outcome
4. *Prevalence of Any Injuries*	Reduce the prevalence of any injuries to 5% or less	SFY 2019 = 5.8% SFY 2020* = 3.9% ☑
Actions/Activities/Interventions: According to **Agency on Aging of Northwest Michigan**'s MI Choice Quality Management Plan Activities and Outcomes Report FY 2020–FY 2021 dated January 15, 2020; implementing the MiCapable model of care could impact the number of factures due to falls or improper equipment. In addition to providing ongoing education to Supports Coordinators regarding skin integrity and falls, **Agency on Aging of Northwest Michigan**'s Consumer Quality Collaborative will have a guest speaker providing similar education to those in attendance According to **Agency on Aging of Northwest Michigan**'s MI Choice Quality Management Report Activities and Outcomes Report FY 2020 dated December 22, 2020, **Agency on Aging of Northwest Michigan** completed the following activities: • **Agency on Aging of Northwest Michigan** has incorporated the STEADI program information and resources to be used with participants and family caregivers to aid in the reduction of injuries. Home safety checklists are provided to all participants at enrollment, which includes tips to reduce safety hazards within the home. Additionally, **Agency on Aging of Northwest Michigan** has provided staff and the Consumer Quality Collaborative education from the local fire department on safety strategies within the home. **Agency on Aging of Northwest Michigan** Supports Coordinators collaborate with skilled care providers, PCPs [primary care providers], and others within the participant's health team to implement interventions for participants with major skin issues, as well as collaborative efforts to identify and reduce risks of injuries.		
5. *Prevalence of Dehydration*	Below the state average [2.6%] and the agency's plan is to maintain the current average	SFY 2019 = 1.7% SFY 2020* = 2.5% ☒
Actions/Activities/Interventions: According to **Agency on Aging of Northwest Michigan**'s MI Choice Quality Management Plan Activities and Outcomes Report FY 2020–FY 2021 dated January 15, 2020; quarterly review of quality indicator reports will provide **Agency on Aging of Northwest Michigan** a list of participants that will be monitored by the primary support coordinator. This allows **Agency on Aging of Northwest Michigan**'s support coordinators to provide those identified participants with the support or intervention needed to improve fluid intake and nutrition. According to **Agency on Aging of Northwest Michigan**'s MI Choice Quality Management Report Activities and Outcomes Report FY 2020 dated December 22, 2020, **Agency on Aging of Northwest Michigan** completed the following activities: • **Agency on Aging of Northwest Michigan** Supports Coordinators collaborate with skilled care providers, PCPs, and others within the participant's health team to implement interventions for participants with poor fluid intake.		

FY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
*Performance rate was based off data obtained from April 2020 through September 2020 only.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Agency on Aging of Northwest Michigan met its established goals for the *Prevalence of Neglect/Abuse* and *Prevalence of Any Injuries* QIPs, suggesting that **Agency on Aging of Northwest Michigan** implemented interventions that had a positive effect on prevalence rates, and members experienced less incidents of neglect/abuse and injuries than the prior year.

Weaknesses and Recommendations

Weakness #1: Agency on Aging of Northwest Michigan did not clearly identify its goal for two QIPs, *Prevalence of Neglect/Abuse* and *Prevalence of Dehydration*. While the goal was to reduce prevalence to below the statewide average, the statewide average was not provided by **Agency on Aging of Northwest Michigan** in the QMP reports. HSAG's assumption is that the references to the statewide average refer to the SFY 2019 baseline statewide average, which HSAG used to determine if **Agency on Aging of Northwest Michigan** met or did not meet its goals. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each measure needs to be clearly and consistently documented.

Why the weakness exists: Agency on Aging of Northwest Michigan's goals as identified in the SFY 2020–2021 QMP did not align with the statewide goals established by MDHHS for all five QIPs. Additionally, two QIP goals were related to the statewide average; however, **Agency on Aging of Northwest Michigan** did not identify the actual statewide rate. Additionally, **Agency on Aging of Northwest Michigan**'s percentage rates for each QIP for SFY 2020 were identified under a heading titled "FY 2021 Quality Improvement Projects, Goals, Strategies, and Results" in the SFY 2020 annual report; however, it was unclear why **Agency on Aging of Northwest Michigan**'s rates for SFY 2020 would be reported under a "SFY 2021" heading, which lead to confusion. Lastly, **Agency on Aging of Northwest Michigan**'s SFY 2020 annual report did not include a thorough analysis as to whether it met its established goals.

Recommendation: HSAG recommends that **Agency on Aging of Northwest Michigan** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should align with the goals established by MDHHS. Additionally, **Agency on Aging of Northwest Michigan** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers.

Weakness #2: Agency on Aging of Northwest Michigan's QIP performance results reported in the SFY 2020 annual report were not comparable to the prevalence rates reported by other waiver agencies.

Why the weakness exists: The performance rates, numerators, and denominators in the SFY 2020 annual report identified a data time frame of April 2020 to September 2020 for all QIPs. It is unknown why the **Agency on Aging of Northwest Michigan** only reported data for a six-month period for the SFY 2020 annual results.

Recommendation: HSAG recommends that **Agency on Aging of Northwest Michigan**'s annual SFY report, include an evaluation of the full year's performance results for each QIP quality indicator.

Weakness #3: The interventions implemented by **Agency on Aging of Northwest Michigan** did not appear to be appropriate, active interventions as prevalence rates increased for three QIPs; *Prevalence of Pain With Inadequate Pain Control*, *Prevalence of Falls*, and *Prevalence of Dehydration*. **Agency on Aging of Northwest Michigan**'s choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential for the waiver agency's success in achieving the desired outcomes for the QIPs.

Why the weakness exists: The SFY 2020–2021 QMP provided a brief summary of planned interventions and the SFY 2020 annual report briefly summarized activities that occurred during SFY 2020. However, the annual report did not support that a causal/barrier analysis was conducted, or an evaluation occurred for each intervention to determine its effectiveness and ensure each intervention was logically linked to any identified barriers.

Recommendation: HSAG recommends that **Agency on Aging of Northwest Michigan** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Agency on Aging of Northwest Michigan** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address the identified barriers to improve outcomes. **Agency on Aging of Northwest Michigan** should analyze and interpret results at multiple points in time and test for statistical significance. **Agency on Aging of Northwest Michigan** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #4: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **Agency on Aging of Northwest Michigan**'s QIPs must be designed in a methodically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions.

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2020 annual report included limited details on the design developed and the methodology followed by **Agency on Aging of Northwest Michigan** when implementing its QIPs.

Recommendation: HSAG recommends that **Agency on Aging of Northwest Michigan** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Agency on Aging of Northwest Michigan** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2020, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For eight of the 39 performance measures calculated by MDHHS, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Those performance measures with a statewide rate of 100 percent reported through the CMS-372 report were not included as part of the assessment. Table 3-8 displays the eight performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rate as calculated by MDHHS for the CMS-372 report, the statewide percentage rate as calculated by HSAG using the CQAR standard scores associated with each performance measure, and **Agency on Aging of Northwest Michigan**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Agency on Aging of Northwest Michigan**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate as calculated by HSAG, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-8—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* VIII.1, VIII.2, VIII.4, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39	**91.27**	**92.11**	**88.33**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* I.1, I.2, I.3, I.5, II.1, II.2, II.3, II.4, II.5, II.6, II.7, II.8, II.9, IV.1, IV.2, IV.3, IV.5, IV.6, VI.1, VI.2, VI.3, X.1	**96.83**	**98.82**	**96.85**

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* V.3, IX.1, IX.2, IX.3, IX.6	**93.65**	**94.16**	**86.00**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* VIII.7, VIII.8	**98.94**	**99.07**	**91.67**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* VIII.3, VIII.5, VIII.6, VIII.11	**98.41**	**98.81**	**97.92**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* V.1, V.2, V.3, V.5, V.10, V.11, V.13, V.15, VI.12, VI.14, VI.16, VIII.1, VIII.2, VIII.3 VIII.4,VIII.5, VIII.6, VIII.11, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39, VIII.40, VIII.41, IX.1, IX.2, IX.3, IX.4, IX.6	**94.97**	**94.13**	**93.26**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* VIII.28, VIII.29, VIII.30, VIII.31, VIII.32, VIII.33, VIII.34, IX.5	**96.03**	**95.54**	**94.55**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* XI.1, XI.3, XI.4	**89.68**	**93.52**	**100**

* The individual waiver agency performance measure rates were derived from the standards outlined in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report.

**Statewide percentage rates are displayed as reported by MDHHS. HSAG's calculations may differ from MDHHS' calculations as HSAG summed all numerators and denominators related to the CQAR standards included as part of each performance measure, while MDHHS calculated performance measure rates for the CMS-372 report using a total count of CQAR records reviewed across the waiver agencies and removing those records from the numerator when a standard included as part of the performance measure was deficient ("*Non-Evident*").

‡ The statewide percentage rates determined by HSAG were based on results of the SFY 2020 CQAR and the standards associated with each performance measure as indicated in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source." The statewide percentage rates determined by HSAG are displayed for comparison purposes to the MDHHS statewide percentages. Additionally, the HSAG calculated rates were made available for this report to ensure an appropriate representation to the rates calculated for each waiver agency.

Indicates the performance measure rate is higher than the statewide rate as calculated by HSAG.

Indicates the performance measure rate is lower than the statewide rate as calculated by HSAG.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Although MDHHS has not established performance measure benchmarks, **Agency on Aging of Northwest Michigan**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 7, 8, 12, 22, 24, 27, 28, 29, 31, 33, 34, 37, and 38. Performance Measures 36 and 39 also achieved a rate of 100 percent; however, performance in these measures are driven solely by MDHHS as they relate to capitation payments to the waiver agencies.

Strength #2: Agency on Aging of Northwest Michigan received a 100 percent performance rating for Performance Measure 20, indicating that person-centered service plans reviewed as part of the CQAR were updated according to MDHHS requirements. This suggested that **Agency on Aging of Northwest Michigan** supports coordinators are updating person centered service plans in accordance with established time frame requirements, at the request of the member, and when a change in needs are identified; ensuring members are achieving or have made progress toward achieving their goals; and including and evaluating outcome evaluations for each goal according to established time frame requirements.

Weaknesses and Recommendations

Weakness #1: Agency on Aging of Northwest Michigan performed substantially worse than other waiver agencies on Performance Measure 15, *number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This suggested that service summaries did not consistently contain accurate and complete information, and services authorized did not consistently meet service standard requirements.

Why the weakness exists: Agency on Aging of Northwest Michigan's performance rate for Performance Measure 15 fell 8.16 percentage points below HSAG's calculated statewide rate. Through the CQAR, of the 12 records reviewed, MPHI determined that one record did not include accurate and complete service summary information; and six records did not meet all service standard requirements for authorized services.

Recommendation: MDHHS required **Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies associated with Performance Measure 15. **Agency on Aging of Northwest Michigan**'s CAP included, but was not limited to, staff training and one-to-one training with supports coordinators if necessary; a review of 12 member records through peer reviews and supervisory reviews; and additional or modified staff training, if necessary, based on the results of the review. However, the CAP also indicated internal monitoring is required by **Agency on Aging of Northwest Michigan** until compliance in excess of 90 percent is achieved. Therefore, HSAG

recommends that **Agency on Aging of Northwest Michigan** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #2: Agency on Aging of Northwest Michigan performed substantially worse than other waiver agencies on Performance Measure 16, *number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This suggested that member health and welfare issues were not consistently identified.

Why the weakness exists: Agency on Aging of Northwest Michigan's performance rate for Performance Measure 16 fell 7.4 percentage points below HSAG's calculated statewide rate. Through the CQAR, of the 12 records reviewed, MPHI determined that two records did not include evidence that the supports coordinator identified member health and welfare issues.

Recommendation: MDHHS required **Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies associated with Performance Measure 16. **Agency on Aging of Northwest Michigan**'s CAP included, but was not limited to, staff training and one-to-one training with supports coordinators if necessary; a review of 12 member records through peer reviews and supervisory reviews; and additional or modified staff training if necessary based on the results of the review. However, the CAP also indicated internal monitoring is required by **Agency on Aging of Northwest Michigan** until compliance in excess of 90 percent is achieved. Therefore, HSAG recommends that **Agency on Aging of Northwest Michigan** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-9 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-9 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-9—Clinical Quality Assurance Reviews and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus I	Level of Care Determination	91.67%	100%	**4.00**
Focus I.B	Communication		100%	**4.00**
Focus II	Freedom of Choice	97.30%		**4.00**
Focus III	Release of Information	100%		**4.00**
Focus IV	Status	100%		**4.00**
Focus V	Pre-Planning	100%	100%	**4.00**
Focus VI	Assessment	95.88%	100%	**4.00**
Focus VII	Medication Record	88.31%	100%	**4.00**
Focus VIII	Person-Centered Service Planning	92.16%	100%	**4.00**
Focus IX	MI Choice Services	86.36%	100%	**3.33**
Focus X	Linking and Coordinating	95.12%	100%	**4.00**
Focus XI	Follow-Up and Monitoring	66.67%	100%	**2.00**
Focus XII	Service Provider	90.91%		**4.00**
Focus XIII	Contingency Plan	92.86%	100%	**4.00**
Focus XIV	Critical Incidents	100%	100%	**4.00**
Focus XV	Adverse Benefit Determination	90.00%		**4.00**
Focus XVI	Complaints and Grievances	83.33%		**3.00**
Focus XVII	Home and Community Based		N/A	**4.00**
	Totals	**93.24%**	**100%**	**3.91**

Indicates the standard was not reviewed as part of the record review or home visit.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: A review of six home visits was conducted and all reviews achieved full compliance. The purpose of the home visits is to confirm that providers furnish services according to the person-centered service plan and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested that members are receiving services in accordance with their service plans and preferences, and are satisfied with those services. It should be noted that, while the home visit reviews achieved full compliance, the record review identified conflicting results in the area of Follow-Up and Monitoring.

Strength #2: Agency on Aging of Northwest Michigan achieved a substantial compliance rating in 16 of the 18 standards reviewed as part of the CQAR. The purpose of the record review is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the person-centered service plan and care planning process, reassessment data) and to assess the quality of waiver agency services to each member; therefore, CQAR findings suggested that person-centered service plans and service delivery are being implemented in accordance with most State and federal requirements.

Weaknesses and Recommendations

Weakness #1: Agency on Aging of Northwest Michigan did not consistently follow all Follow-Up and Monitoring requirements; specifically, contacting the member for follow-up and monitoring. Waiver agencies are required to contact each member to ensure services are implemented as planned. When services are not implemented as planned or when the planned services require adjustments, waiver agencies should implement corrective actions to resolve problems and issues.

Why the weakness exists: Through the CQAR, MPHI determined that eight out of 12 applicable records did not include evidence that the waiver agency contacted the member/guardian for follow-up and monitoring as specified in the person-centered service plan.

Recommendation: MDHHS required **Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies. **Agency on Aging of Northwest Michigan**'s CAP included, but was not limited to, staff training and one-to-one training with supports coordinators, if necessary; a review of 12 member records through peer reviews and supervisory reviews; and additional or modified staff training if necessary based on the results of the review. However, the CAP also indicated internal monitoring is required by **Agency on Aging of Northwest Michigan** until compliance in excess of 80 percent is achieved. Therefore, HSAG recommends that **Agency on Aging of Northwest Michigan** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

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

To identify strengths and weaknesses and draw conclusions for **Agency on Aging of Northwest Michigan**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Agency on Aging of Northwest Michigan** across all EQR activities. The overarching aggregated findings showed that **Agency on Aging of Northwest Michigan**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Agency on Aging of Northwest Michigan** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

HSAG's assessment of **Agency on Aging of Northwest Michigan** also identified opportunities for **Agency on Aging of Northwest Michigan** to enhance its quality assessment and performance improvement program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Agency on Aging of Northwest Michigan** had a QMP that included brief descriptions of its quality management activities, its QMP should be modified to more comprehensively align with the requirements and best practices for a quality assessment and performance improvement program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Area Agency on Aging 1B

Validation of Performance Improvement Projects

Performance Results

Table 3-10 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2020. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Area Agency on Aging 1B** met its internal SFY 2020 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Area Agency on Aging 1B** did not meet its internal SFY 2020 QIP goal or the statewide goal. Any interventions described within **Area Agency on Aging 1B**'s QMP reports are also provided in Table 3-10. The results in Table 3-10 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-10—QIP Results

QIP Topic	Goal	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Decrease the percentage of participants reporting being neglected/abused, have poor hygiene, are fearful of family member, or have been restrained to be equal to or below the statewide goal of 3.0%	SFY 2019 = 24.75% SFY 2020 = 28.49% ☒
Actions/Activities/Interventions: According to **Area Agency on Aging 1B**'s MI Choice Quality Management Plan Fiscal Years 2020–2021 dated January 6, 2020; **Area Agency on Aging 1B**'s Clinical and Quality departments work together to determine improvement project strategies which are communicated to staff through training and implementation. According to **Area Agency on Aging 1B**'s MI Choice Summary of Quality Management Plan (QMP) Activities and Outcome Report Fiscal Year 2020 dated January 29, 2021, **Area Agency on Aging 1B** has taken the following actions: • Training/discussions with all clinical staff surrounding CCIRs [Critical Incidents and Incident Reports], Neglect, Abuse, Exploitation, and the iHC (with a specific focus on restraints). • Training/discussions surrounding internal and external audit findings and monthly one-on-one coaching. • The Quality Indicator workgroup and the MI Choice Quality Assurance Team reviews quality indicator findings and focus on process improvement activities that concentrate on state-wide quality goals and internal metrics. • Consumer Advisory Team meets at least quarterly to discuss quality metrics and ways to address state-wide quality goals.		

QIP Topic	Goal	Measurement and Outcome
2. *Prevalence of Pain With Inadequate Pain Control*	Decrease the percentage of participants that report pain with inadequate pain control to be equal to or below the statewide goal of 20%	SFY 2019 = 30.75% SFY 2020 = 29.96% ☒

Actions/Activities/Interventions:

According to **Area Agency on Aging 1B**'s MI Choice Quality Management Plan Fiscal Years 2020–2021 dated January 6, 2020; **Area Agency on Aging 1B**'s Clinical and Quality departments work together to determine improvement project strategies which are communicated to staff through training and implementation.

According to **Area Agency on Aging 1B**'s MI Choice Summary of Quality Management Plan (QMP) Activities and Outcomes Report Fiscal Year 2020 dated January 29, 2021, **Area Agency on Aging 1B** has taken the following actions:

- Training/discussions surrounding pain and appropriate coding of the iHC, with a special focus on the importance of probing questions that allow for a clear description of the participant's experience with pain and pain control.
- Training/discussions surrounding internal and external audit findings and monthly one-on-one coaching.
- The Quality Indicator workgroup and the MI Choice Quality Assurance Team reviews quality indicator findings and focus on process improvement activities that concentrate on state-wide quality goals and internal metrics.
- Consumer Advisory Team [CAT] meets at least quarterly to discuss quality metrics and ways to address state-wide quality goals. In SFY 20, the CAT members participated in a joint meeting with MORC; a presentation on pain and pain management was provided and all members participated in an open discussion about their pain.

3. *Prevalence of Falls*	Decrease the percentage of participants that report a fall within the last 90 days, post initial assessment to be at or below the statewide goal of 23%	SFY 2019 = 26.7% SFY 2020 = 18.16% ☑

Actions/Activities/Interventions:

According to **Area Agency on Aging 1B**'s MI Choice Quality Management Plan Fiscal Years 2020–2021 dated January 6, 2020; **Area Agency on Aging 1B**'s Clinical and Quality departments work together to determine improvement project strategies which are communicated to staff through training and implementation.

According to **Area Agency on Aging 1B**'s MI Choice Summary of Quality Management Plan (QMP) Activities and Outcomes Report Fiscal Year 2020 dated January 29, 2021, **Area Agency on Aging 1B** has taken the following actions:

- Training/discussions surrounding injuries and appropriate coding of the iHC, with a special focus on coding falls within the last 90 days post initial assessment and clear documentation of the issue within the summary section.
- Training/discussions surrounding internal and external audit findings and monthly one-on-one coaching.
- The Quality Indicator workgroup and the MI Choice Quality Assurance Team reviews quality indicator findings and focus on process improvement activities that concentrate on state-wide quality goals and internal metrics.

QIP Topic	Goal	Measurement and Outcome
• Consumer Advisory Team meets at least quarterly to discuss quality metrics and ways to address state-wide quality goals. During our June 2020 CAT meeting, the participants received additional information about our evidence-based programs, with a special emphasis on our "Matter of Balance" classes, to assist with improving strength and reducing falls.		
4. *Prevalence of Any Injuries*	Decrease the percentage of participants that report an injury to be at or below the statewide goal of 3%	SFY 2019 = 5.9% SFY 2020 = 2.20% ☑
Actions/Activities/Interventions: According to **Area Agency on Aging 1B**'s MI Choice Quality Management Plan Fiscal Years 2020–2021 dated January 6, 2020; **Area Agency on Aging 1B**'s Clinical and Quality departments work together to determine improvement project strategies which are communicated to staff through training and implementation. According to **Area Agency on Aging 1B**'s MI Choice Summary of Quality Management Plan (QMP) Activities and Outcomes Report Fiscal Year 2020 dated January 29, 2021, **Area Agency on Aging 1B** has taken the following actions: • Training/discussions surrounding injuries and appropriate coding of the iHC, with a special focus on coding of major skin problems vs. pressure sores and clear documentation of the issue within the summary section. • Training/discussions surrounding internal and external audit findings and monthly one-on-one coaching. • The Quality Indicator workgroup and the MI Choice Quality Assurance Team reviews quality indicator findings and focus on process improvement activities that concentrate on state-wide quality goals and internal metrics. • Consumer Advisory Team meets at least quarterly to discuss quality metrics and ways to address state-wide quality goals.		
5. *Prevalence of Dehydration*	Decrease the percentage of participants that report dehydration to be at or below the statewide goal of 1.5%	SFY 2019 = 5% SFY 2020 = 2.64% ☒
Actions/Activities/Interventions: According to **Area Agency on Aging 1B**'s MI Choice Quality Management Plan Fiscal Years 2020–2021 dated January 6, 2020; **Area Agency on Aging 1B**'s Clinical and Quality departments work together to determine improvement project strategies which are communicated to staff through training and implementation. According to **Area Agency on Aging 1B**'s MI Choice Summary of Quality Management Plan (QMP) Activities and Outcomes Report Fiscal 2020 dated January 29, 2021, **Area Agency on Aging 1B** has taken the following actions: • Training/discussions surrounding dehydration and appropriate coding of the iHC, with a special focus on any liquid, not just water and clear documentation of the issue within the summary section. • Training/discussions surrounding internal and external audit findings and monthly one-on-one coaching. • The Quality Indicator workgroup and the MI Choice Quality Assurance Team reviews quality indicator findings and focus on process improvement activities that concentrate on state-wide quality goals and internal metrics.		

QIP Topic	Goal	Measurement and Outcome
• Consumer Advisory Team meets at least quarterly to discuss quality metrics and ways to address state-wide quality goals.		

FY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Area Agency on Aging 1B met its established goals for two QIPs (*Prevalence of Falls* and *Prevalence of Any Injuries*) and, while it did not meet its goals for the remaining three QIPs, **Area Agency on Aging 1B** demonstrated a decrease to prevalence rates for two of those three QIPs (*Prevalence of Pain With Inadequate Pain Control* and *Prevalence of Dehydration*), suggesting that **Area Agency on Aging 1B** implemented interventions that had a positive effect on prevalence rates, and members experienced less falls, injuries, inadequate pain control, and dehydration than the prior year.

Weaknesses and Recommendations

Weakness #1: Area Agency on Aging 1B's SFY 2020–2021 QMP and SFY 2020 annual report included conflicting goals, which made it difficult to determine the actual goal established by **Area Agency on Aging 1B** when initiating the QIPs. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each measure needs to be clearly and consistently documented.

Why the weakness exists: Area Agency on Aging 1B's SFY 2020–2021 QMP identified different goals for each QIP than the SFY 2020 annual report (e.g., the QMP indicated the percentage goal for the *Prevalence of Neglect/Abuse* QIP as 4.6 percent; however, the annual report indicated the goal for this QIP as 3 percent). The SFY 2020 goal within the annual report aligned with MDHHS' established statewide goal. However, the goals identified in the SFY 2020–2021 QMP were to reduce the quality indicators to at or below the statewide average as opposed to MDHHS' established statewide goal.

Recommendation: HSAG recommends that **Area Agency on Aging 1B** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should be consistently documented within its QMP reports. Additionally, **Area Agency on Aging 1B** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers.

Weakness #2: The interventions implemented by **Area Agency on Aging 1B** did not appear to be appropriate, active interventions as the prevalence rates increased for the *Prevalence of Neglect/Abuse* QIP. **Area Agency on Aging 1B**'s choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential for the waiver agency's success in achieving the desired outcomes for the QIPs. Additionally, a review of prevalence rates for neglect/abuse for all waiver agencies demonstrated **Area Agency on Aging 1B** as an outlier with prevalence significantly higher than all other waiver agencies, suggesting that **Area Agency on Aging 1B**'s members are experiencing more incidents of abuse and neglect or the prevalence rate is not being appropriately calculated by **Area Agency on Aging 1B**.

Why the weakness exists: While the SFY 2020 annual report included an assessment of the data, identified the data to support the QIPs, actions taken by **Area Agency on Aging 1B**, and any significant trends of findings, the root cause analysis appeared to be primarily focused on whether assessments were coded correctly and not a causal/barrier analysis or evaluation for each intervention to determine its effectiveness and ensure each intervention is logically linked to any identified barriers.

Recommendation: HSAG recommends that **Area Agency on Aging 1B** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Area Agency on Aging 1B** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Area Agency on Aging 1B** should analyze and interpret results at multiple points in time and test for statistical significance. **Area Agency on Aging 1B** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. HSAG further recommends that **Area Agency on Aging 1B** conduct an analysis of the data to determine if the prevalence rate is being appropriately calculated to determine the percentage of members being reported as abused and/or neglected.

Weakness #3: While more robust than reported by most other waiver agencies, details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were limited. **Area Agency on Aging 1B**'s QIPs must be designed in a methodically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions.

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2020 annual report included minimal details on the design developed and methodology followed by **Area Agency on Aging 1B** when implementing its QIPs.

Recommendation: HSAG recommends that **Area Agency on Aging 1B** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Area Agency on Aging 1B** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2020, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For eight of the 39 performance measures calculated by MDHHS, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Those performance measures with a statewide rate of 100 percent reported through the CMS-372 report were not included as part of the assessment. Table 3-11 displays the eight performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rate as calculated by MDHHS for the CMS-372 report, the statewide percentage rate as calculated by HSAG using the CQAR standard scores associated with each performance measure, and **Area Agency on Aging 1B**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Area Agency on Aging 1B**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate as calculated by HSAG.

Table 3-11—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* VIII.1, VIII.2, VIII.4, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39	**91.27**	**92.11**	**100**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* I.1, I.2, I.3, I.5, II.1, II.2, II.3, II.4, II.5, II.6, II.7, II.8, II.9, IV.1, IV.2, IV.3, IV.5, IV.6, VI.1, VI.2, VI.3, X.1	**96.83**	**98.82**	**99.63**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* V.3, IX.1, IX.2, IX.3, IX.6	**93.65**	**94.16**	**98.00**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* VIII.7, VIII.8	**98.94**	**99.07**	**100**

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* VIII.3, VIII.5, VIII.6, VIII.11	**98.41**	**98.81**	**100**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* V.1, V.2, V.3, V.5, V.10, V.11, V.13, V.15, VI.12, VI.14, VI.16, VIII.1, VIII.2, VIII.3 VIII.4,VIII.5, VIII.6, VIII.11, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39, VIII.40, VIII.41, IX.1, IX.2, IX.3, IX.4, IX.6	**94.97**	**94.13**	**99.46**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* VIII.28, VIII.29, VIII.30, VIII.31, VIII.32, VIII.33, VIII.34, IX.5	**96.03**	**95.54**	**97.30**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* XI.1, XI.3, XI.4	**89.68**	**93.52**	**95.83**

* The individual waiver agency performance measure rates were derived from the standards outlined in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report.

**Statewide percentage rates are displayed as reported by MDHHS. HSAG's calculations may differ from MDHHS' calculations as HSAG summed all numerators and denominators related to the CQAR standards included as part of each performance measure, while MDHHS calculated performance measure rates for the CMS-372 report using a total count of CQAR records reviewed across the waiver agencies and removing those records from the numerator when a standard included as part of the performance measure was deficient ("*Non-Evident*").

‡ The statewide percentage rates determined by HSAG were based on results of the SFY 2020 CQAR and the standards associated with each performance measure as indicated in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source." The statewide percentage rates determined by HSAG are displayed for comparison purposes to the MDHHS statewide percentages. Additionally, the HSAG calculated rates were made available for this report to ensure an appropriate representation to the rates calculated for each waiver agency.

Indicates the performance measure rate is higher than the statewide rate as calculated by HSAG.

Indicates the performance measure rate is lower than the statewide rate as calculated by HSAG.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Although MDHHS has not established performance measure benchmarks, **Area Agency on Aging 1B**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 7, 8, 12, 22, 24, 27, 28, 29, 31, 33, 34, 37, and 38. Performance Measures 36 and 39 also achieved a rate of 100 percent; however, performance in these measures are driven solely by MDHHS as they relate to capitation payments to the waiver agencies.

Strength #2: Area Agency on Aging 1B received a 100 percent performance rating for Performance Measures 1, 16, and 17, indicating that person-centered service plans reviewed as part of the CQAR were completed timely, included strategies to address member-assessed health and safety risks, and included individualized goals and preferences. This suggested that **Area Agency on Aging 1B** supports coordinators are ensuring members/guardians are making informed choices and identifying member-specific health and welfare issues; taking into consideration waiver members' individualized needs, including member-specific health risks and member preferences for service delivery when creating service plans; ensuring members are achieving or have made progress toward achieving their goals; and including and evaluating outcome evaluations for each goal according to established time frame requirements.

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any weaknesses for **Area Agency on Aging 1B**. **Area Agency on Aging 1B**'s performance rates were above HSAG's calculated statewide performance rates for all performance measures, with Performance Measures 1, 16, and 17 achieving a 100 percent performance rating.

Why the weakness exists: This section is not applicable as no weaknesses were identified.

Recommendation: This section is not applicable as no weaknesses were identified; therefore, HSAG has no recommendations for improvement.

Compliance Review

Performance Results

Table 3-12 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-12 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-12—Clinical Quality Assurance Reviews and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus I	Level of Care Determination	100%	100%	**4.00**
Focus I.B	Communication		100%	**4.00**
Focus II	Freedom of Choice	100%		**4.00**
Focus III	Release of Information	100%		**4.00**
Focus IV	Status	98.15%		**4.00**
Focus V	Pre-Planning	98.60%	100%	**4.00**
Focus VI	Assessment	97.40%	100%	**4.00**
Focus VII	Medication Record	94.74%	94.44%	**4.00**
Focus VIII	Person-Centered Service Planning	99.37%	100%	**4.00**
Focus IX	MI Choice Services	96.24%	100%	**4.00**
Focus X	Linking and Coordinating	96.20%	100%	**4.00**
Focus XI	Follow-Up and Monitoring	89.58%	100%	**4.00**
Focus XII	Service Provider	93.75%		**4.00**
Focus XIII	Contingency Plan	96.72%	100%	**4.00**
Focus XIV	Critical Incidents	85.00%	100%	**3.33**
Focus XV	Adverse Benefit Determination	68.97%		**1.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus XVI	Complaints and Grievances	100%		**4.00**
Focus XVII	Home and Community Based		100%	**4.00**
	Totals	**97.52%**	**99.48%**	**3.91**

	Indicates the standard was not reviewed as part of the record review or home visit.
	Indicates substantial compliance: 3.26 or higher.
	Indicates some compliance, needs improvement: 2.51 to 3.25.
	Indicates not full or substantial compliance: 1.76 to 2.50.
	Indicates compliance not demonstrated: 1.00 to 1.75.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: A review of 12 home visits was conducted and all reviews achieved full compliance with the exception of one focus area (Medication Record). The purpose of the home visits is to confirm that providers furnish services according to the person-centered service plan and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested providers are consistently adhering to these requirements.

Strength #2: Area Agency on Aging 1B achieved a substantial compliance rating in 17 of the 18 standards reviewed as part of the CQAR. The purpose of the record review is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the person-centered service plan and care planning process, reassessment data) and to assess the quality of waiver agency services to each member; therefore, CQAR findings suggested that person-centered service plans and service delivery are being implemented in accordance with most State and federal requirements.

Weaknesses and Recommendations

Weakness #1: Area Agency on Aging 1B did not consistently follow all Adverse Benefit Determination requirements; specifically, **Area Agency on Aging 1B** did not consistently provide its members with an ABD notice. When a member no longer meets NFLOC, the MI Choice Section 1915(c) waiver requires the supports coordinator to initiate program discharge procedures and provide the member with an ABD notice. Complete and accurate ABD notices are necessary to ensure members/guardians understand their appeal rights and how to request an appeal.

Why the weakness exists: Through the CQAR, MPHI determined that eight out of 16 applicable records did not include evidence that the waiver agency provided the member/guardian with an ABD notice for disenrollment due to not meeting NFLOC criteria and/or ABD for a service denial, reduction, suspension and/or termination from the MI Choice Waiver Program.

Recommendation: MDHHS required **Area Agency on Aging 1B** to submit a CAP to remediate the deficiencies. **Area Agency on Aging 1B**'s CAP included, but was not limited to, reviewing each finding with and providing one-on-one training with the responsible supports coordinator; providing additional training to all supports coordinators; and a random record review of each supports coordinator an average of five times per year. However, the CAP also indicated that internal monitoring was required by **Area Agency on Aging 1B** until compliance in excess of 80 percent is achieved. While the CAP also indicated that monthly audits are completed and continual monitoring occurs throughout the year, HSAG recommends that **Agency on Aging of Northwest Michigan** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

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

To identify strengths and weaknesses and draw conclusions for **Area Agency on Aging 1B**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Area Agency on Aging 1B** across all EQR activities. The overarching aggregated findings showed that **Area Agency on Aging 1B**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Area Agency on Aging 1B** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

HSAG's assessment of **Area Agency on Aging 1B** also identified opportunities for **Area Agency on Aging 1B** to enhance its quality assessment and performance improvement program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Area Agency on Aging 1B** had a QMP that included brief descriptions of its quality management activities, its QMP should be modified to more comprehensively align with the requirements and best practices for a quality assessment and performance improvement program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Area Agency on Aging of Western Michigan

Validation of Performance Improvement Projects

Performance Results

Table 3-13 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2020. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Area Agency on Aging of Western Michigan** met its internal SFY 2020 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Area Agency on Aging of Western Michigan** did not meet its internal SFY 2020 QIP goal or the statewide goal. Any interventions described within **Area Agency on Aging of Western Michigan**'s QMP reports are also provided in Table 3-13. The results in Table 3-13 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-13—QIP Results

QIP Topic	Goal	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Review persons triggered for this QI and maintain prevalence of 2.4% by 9/30/20	SFY 2019 = 2.4% SFY 2020 = 2.4%* ☑
Actions/Activities/Interventions: According to **Area Agency on Aging of Western Michigan**'s MI Choice Summary of Quality Management Plan (QMP) FY 2020–2021 dated January 15, 2020; QA [quality assurance] will be examining CI's [critical incidents] attributed to neglect and abuse and look for trends. Discuss with CM [care management] Advisory Committee/staff for ideas/approaches to mitigate risk of these behaviors. Some assessment answers that potentially trigger for neglect/abuse may not be attributed to these issues at all. **Area Agency on Aging of Western Michigan**'s MI Choice Summary of Quality Management Plan (QMP) Activities and Outcomes Report FY 2020 dated January 15, 2021, indicated that QA will continue to record and identify trends within Critical Incidents attributed to neglect and abuse. Discuss with CM Management/staff for ideas/approaches to mitigate risk of these behaviors.		
2. *Prevalence of Pain With Inadequate Pain Control*	10% reduction in prevalence for appropriate persons, or prevalence of 22% by 9/30/20	SFY 2019 = 24.7% SFY 2020 = 25%* ☒
Actions/Activities/Interventions: According to **Area Agency on Aging of Western Michigan**'s MI Choice Summary of Quality Management Plan (QMP) FY 2020–2021 dated January 15, 2020; **Area Agency on Aging of Western Michigan** will look at Pain Supplement information for additional insight and ideas for approaches – and confirm correct responses for sample of 5% of triggered records to questions related to pain on the assessment to confirm accuracy of QI percentage. **Area Agency on Aging of Western Michigan**'s MI Choice Summary of Quality Management Plan (QMP) FY 2020–2021 dated January 15, 2020, indicated that in collaboration with the Care Management supervisors, QA		

QIP Topic	Goal	Measurement and Outcome
will perform a review of records to confirm correct coding of pain. Continuing education will be provided to Care Management staff regarding pain control. In addition, **Area Agency on Aging of Western Michigan** will review information/education materials regarding pain management sent to participants.		
3. *Prevalence of Falls*	10% reduction in prevalence for appropriate persons, or prevalence of 23% by 9/30/20	SFY 2019 = 25.4% SFY 2020 = 30%* ☒
Actions/Activities/Interventions: According to **Area Agency on Aging of Western Michigan**'s MI Choice Summary of Quality Management Plan (QMP) FY 2020–2021 dated January 15, 2020, **Area Agency on Aging of Western Michigan** is examining all assessment questions pertinent to fall risk in an attempt to pull this data and identify not just persons that have fallen but may be at risk for falls. An independent fall risk tool was also reviewed, but cannot aggregate this info [information] in COMPASS [information system] to pull data. Education materials and other community resources are being identified. A protocol will be created for addressing falls and fall risk. **Area Agency on Aging of Western Michigan**'s MI Choice Quality Management Plan Activities and Outcomes Report FY 2020 dated January 15, 2021, indicated that Fall prevention education materials were sent to participants in October 2020 and suggested that continuing education for Care Management staff will be provided and focus on fall prevention.		
4. *Prevalence of Any Injuries*	10% reduction in prevalence for appropriate persons, or prevalence of 5% by 9/30/20	SFY 2019 = 5.4% SFY 2020 = 6%* ☒
Actions/Activities/Interventions: According to **Area Agency on Aging of Western Michigan**'s MI Choice Summary of Quality Management Plan (QMP) FY 2020–2021 dated January 15, 2020, **Area Agency on Aging of Western Michigan** will assess how closely these numbers are correlated to falls–and whether interventions that address fall risk will improve prevalence of injuries. **Area Agency on Aging of Western Michigan**'s MI Choice Quality Management Plan Activities and Outcomes Report FY 2020 dated January 15, 2021, indicated that **Area Agency on Aging of Western Michigan** will assess how closely these numbers are correlated to falls – and whether interventions that address fall risk will improve prevalence of injuries.		
5. *Prevalence of Dehydration*	10% reduction in prevalence for appropriate persons, or prevalence of 2.2% by 9/30/20	SFY 2019 = 2.5% SFY 2020 = 2.5%* ☒
Actions/Activities/Interventions: According to **Area Agency on Aging of Western Michigan**'s MI Choice Quality Management Plan Activities and Outcomes Report FY 2020–2021 dated January 15, 2020, **Area Agency on Aging of Western Michigan** has two handouts related to dehydration that will be added to the participant handbook and reviewed individually per CM for all appropriate persons that trigger for this QI. If participants wish to add increasing their fluid intake to prevent the risk of dehydration to their PCSP [person-centered service plan], this issue will be added and their goal related to this issue reviewed at in-person contacts.		

QIP Topic	Goal	Measurement and Outcome
Area Agency on Aging of Western Michigan's MI Choice Quality Management Plan Activities and Outcomes Report FY 2020 dated January 15, 2021, indicated that **Area Agency on Aging of Western Michigan** has two handouts related to dehydration that will be added to the participant handbook and reviewed individually per CM for all appropriate persons that trigger for this QI. If participants wish to add increasing their fluid intake to prevent the risk of dehydration to their PCSP, this issue will be added and their goal related to this issue reviewed at in-person contacts.		

FY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
*Percentage rates displayed as reported by the waiver agency; however, the rates reported do not align with HSAG's calculation using the numerators and denominators reported by the waiver agency.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Although **Area Agency on Aging of Western Michigan** maintained its prevalence rate for two QIPs, HSAG did not identify any substantial strengths for **Area Agency on Aging of Western Michigan**.

Weaknesses and Recommendations

Weakness #1: There was a disconnect between the QMP reports as the goals established by **Area Agency on Aging of Western Michigan** in the SFY 2020–2021 QMP were not addressed or analyzed in the SFY 2020 annual report. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each measure needs to be clearly and consistently documented.

Why the weakness exists: **Area Agency on Aging of Western Michigan**'s goals as identified in the SFY 2020–2021 QMP did not align with the statewide goals established by MDHHS. While two QIP goals were more stringent than the MDHHS-established goals and therefore acceptable, **Area Agency on Aging of Western Michigan** established goals that did not align with the intent of the MDHHS statewide goals for three QIPs (e.g., although the statewide goal for the *Prevalence of Dehydration* QIP was 1.5 percent, the waiver agency indicated a goal of 2.2 percent). Additionally, **Area Agency on Aging of Western Michigan**'s SFY 2020 annual report compared its SFY 2020 percentage rates against the SFY 2020 statewide percentage rates; however, it did not include an analysis of whether **Area Agency on Aging of Western Michigan** met its SFY 2020 goals as established in the SFY 2020–2021 QMP. Lastly, **Area Agency on Aging of Western Michigan**'s goals for each QIP in the SFY 2020–2021 QMP were identified under a heading titled "FY 2021 Quality Improvement Projects, Goals, Strategies, and Results." While the narrative under this section

suggested that the goals applied to SFY 2020, it is unclear why **Area Agency on Aging of Western Michigan**'s goals for SFY 2020 would be reported under a "SFY 2021" heading, which lead to confusion.

Recommendation: HSAG recommends that **Area Agency on Aging of Western Michigan** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should align with the goals established by MDHHS. Additionally, **Area Agency on Aging of Western Michigan** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers.

Weakness #2: The interventions implemented by **Area Agency on Aging of Western Michigan** to meet performance goals were unclear. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly documented. **Area Agency on Aging of Western Michigan**'s choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential for the waiver agency's success in achieving the desired outcomes for the QIPs.

Why the weakness exists: **Area Agency on Aging of Western Michigan**'s SFY 2020–2021 QMP listed high-level planned activities, and the SFY 2020 annual report primarily focused on high-level activities to be conducted in the future. The SFY 2020 annual report did not clearly identify the interventions implemented during SFY 2020 for all QIPs, or support that a causal/barrier analysis was conducted and that an evaluation occurred for each intervention to determine its effectiveness and ensure each intervention is logically linked to any identified barriers.

Recommendation: HSAG recommends that **Area Agency on Aging of Western Michigan** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Area Agency on Aging of Western Michigan** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Area Agency on Aging of Western Michigan** should analyze and interpret results at multiple points in time and test for statistical significance. **Area Agency on Aging of Western Michigan** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #3: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **Area Agency on Aging of Western Michigan**'s QIPs must be designed in a methodically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic

data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions.

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2020 annual report included limited details on the design developed and methodology followed by **Area Agency on Aging of Western Michigan** when implementing its QIPs.

Recommendation: HSAG recommends that **Area Agency on Aging of Western Michigan** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Area Agency on Aging of Western Michigan** in a methodologically sound manner.

Weakness #4: The results submitted to MDHHS via **Area Agency on Aging of Western Michigan**'s SFY 2020 annual report did not all appear to be accurate and **Area Agency on Aging of Western Michigan**'s performance appeared worse or better than reported.

Why the weakness exists: The prevalence rates provided by **Area Agency on Aging of Western Michigan** in the SFY 2020 annual report did not correlate to the identified numerators and denominators. The prevalence rate provided by **Area Agency on Aging of Western Michigan** for the *Prevalence of Neglect/Abuse* QIP was 2.4 percent; however, HSAG's calculation of the numerator and denominator (12/530) equals 2.26 percent. The prevalence rate provided by **Area Agency on Aging of Western Michigan** for the *Prevalence of Pain With Inadequate Pain Control* QIP was 25 percent; however, HSAG's calculation of the numerator and denominator (140/529) equals 26.47 percent. The prevalence rate provided by **Area Agency on Aging of Western Michigan** for the *Prevalence of Falls* QIP was 30 percent. However, HSAG's calculation of the numerator and denominator (154/499) equals 30.86 percent. The prevalence rate provided by **Area Agency on Aging of Western Michigan** for the *Prevalence of Any Injuries* QIP was 6 percent. However, HSAG's calculation of the numerator and denominator (26/530) equals 4.91 percent. The prevalence rate provided by **Area Agency on Aging of Western Michigan** for the *Prevalence of Dehydration* QIP was 2.5 percent. However, HSAG's calculation of the numerator and denominator (15/530) equals 2.83 percent.

Recommendation: HSAG recommends that **Area Agency on Aging of Western Michigan** re-evaluate the data reported to MDHHS in the SFY 2020 annual report. Further, **Area Agency on Aging of Western Michigan** should enhance internal validation processes to ensure data reported to MDHHS are valid and accurate.

Performance Measure Validation

Performance Results

In SFY 2020, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For eight of the 39 performance measures calculated by MDHHS, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Those performance measures with a statewide rate of 100 percent reported through the CMS-372 report were not included as part of the assessment. Table 3-14 displays the eight performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rate as calculated by MDHHS for the CMS-372 report, the statewide percentage rate as calculated by HSAG using the CQAR standard scores associated with each performance measure, and **Area Agency on Aging of Western Michigan**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Area Agency on Aging of Western Michigan**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate as calculated by HSAG, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-14—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* VIII.1, VIII.2, VIII.4, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39	**91.27**	**92.11**	**96.80**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* I.1, I.2, I.3, I.5, II.1, II.2, II.3, II.4, II.5, II.6, II.7, II.8, II.9, IV.1, IV.2, IV.3, IV.5, IV.6, VI.1, VI.2, VI.3, X.1	**96.83**	**98.82**	**97.52**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* V.3, IX.1, IX.2, IX.3, IX.6	**93.65**	**94.16**	**97.41**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* VIII.7, VIII.8	**98.94**	**99.07**	**100**

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* VIII.3, VIII.5, VIII.6, VIII.11	98.41	98.81	100
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* V.1, V.2, V.3, V.5, V.10, V.11, V.13, V.15, VI.12, VI.14, VI.16, VIII.1, VIII.2, VIII.3 VIII.4,VIII.5, VIII.6, VIII.11, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39, VIII.40, VIII.41, IX.1, IX.2, IX.3, IX.4, IX.6	94.97	94.13	98.01
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* VIII.28, VIII.29, VIII.30, VIII.31, VIII.32, VIII.33, VIII.34, IX.5	96.03	95.54	98.11
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* XI.1, XI.3, XI.4	89.68	93.52	90.00

* The individual waiver agency performance measure rates were derived from the standards outlined in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report.

**Statewide percentage rates are displayed as reported by MDHHS. HSAG's calculations may differ from MDHHS' calculations as HSAG summed all numerators and denominators related to the CQAR standards included as part of each performance measure, while MDHHS calculated performance measure rates for the CMS-372 report using a total count of CQAR records reviewed across the waiver agencies and removing those records from the numerator when a standard included as part of the performance measure was deficient ("*Non-Evident*").

‡ The statewide percentage rates determined by HSAG were based on results of the SFY 2020 CQAR and the standards associated with each performance measure as indicated in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source." The statewide percentage rates determined by HSAG are displayed for comparison purposes to the MDHHS statewide percentages. Additionally, the HSAG calculated rates were made available for this report to ensure an appropriate representation to the rates calculated for each waiver agency.

Indicates the performance measure rate is higher than the statewide rate as calculated by HSAG.

Indicates the performance measure rate is lower than the statewide rate as calculated by HSAG.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Although MDHHS has not established performance measure benchmarks, **Area Agency on Aging of Western Michigan**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 7, 8, 12, 22, 24, 27, 28, 29, 31, 33, 34, 37, and 38. Performance Measures 36 and 39 also achieved a rate of 100 percent; however, performance in these measures are driven solely by MDHHS as they relate to capitation payments to the waiver agencies.

Strength #2: **Area Agency on Aging of Western Michigan** received a 100 percent performance rating for Performance Measures 16 and 17, indicating that person-centered service plans reviewed as part of the CQAR addressed member-assessed health and safety risks, and included individualized goals and preferences. This suggested that **Area Agency on Aging of Western Michigan** staff members are ensuring members/guardians are making informed choices and identifying member-specific health and welfare issues; and taking into consideration waiver members' individualized needs, including member-specific health risks, and member preferences for service delivery when creating service plans.

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial trends of weakness. While Performance Measures 2 and 20 did not meet the statewide performance rate, neither performance measure fell below the statewide rate by more than 5 percentage points.

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: MDHHS required **Area Agency on Aging of Western Michigan** to submit a CAP to remediate the deficiencies identified through the CQAR that are used to calculate the performance rates for Performance Measures 2 and 20. **Area Agency on Aging of Western Michigan**'s CAP included, but was not limited to, staff training and one-to-one training with supports coordinators if necessary; a review of 11 member records per month by quality staff members; and the implementation of additional performance improvement strategies, if necessary, based on the results of the review. However, the CAP also indicated internal monitoring is required by **Area Agency on Aging of Western Michigan** until compliance in excess of 80 or 90 percent (depending on the requirement) is achieved. Therefore, HSAG recommends that **Area Agency on Aging of Western Michigan** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-15 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-15 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-15—Clinical Quality Assurance Reviews and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus I	Level of Care Determination	93.33%	100%	**4.00**
Focus I.B	Communication		100%	**4.00**
Focus II	Freedom of Choice	97.77%		**4.00**
Focus III	Release of Information	97.99%		**4.00**
Focus IV	Status	100%		**4.00**
Focus V	Pre-Planning	99.19%	100%	**4.00**
Focus VI	Assessment	95.41%	100%	**4.00**
Focus VII	Medication Record	97.14%	100%	**4.00**
Focus VIII	Person-Centered Service Planning	98.15%	100%	**4.00**
Focus IX	MI Choice Services	95.63%	100%	**4.00**
Focus X	Linking and Coordinating	96.59%	100%	**4.00**
Focus XI	Follow-Up and Monitoring	77.59%	100%	**2.67**
Focus XII	Service Provider	89.47%		**4.00**
Focus XIII	Contingency Plan	95.45%	100%	**4.00**
Focus XIV	Critical Incidents	100%	100%	**4.00**
Focus XV	Adverse Benefit Determination	100%		**4.00**
Focus XVI	Complaints and Grievances	88.89%		**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus XVII	Home and Community Based		N/A	**N/A**
	Totals	**96.87%**	**100%**	**3.97**

N/A designation indicates that the focus area was not applicable to the review year.

	Indicates the standard was not reviewed as part of the record review or home visit.
	Indicates substantial compliance: 3.26 or higher.
	Indicates some compliance, needs improvement: 2.51 to 3.25.
	Indicates not full or substantial compliance: 1.76 to 2.50.
	Indicates compliance not demonstrated: 1.00 to 1.75.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: A review of 14 home visits was conducted and all reviews achieved full compliance. The purpose of the home visits is to confirm that providers furnish services according to the person-centered service plan and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested providers are consistently adhering to these requirements.

Strength #2: Area Agency on Aging of Western Michigan achieved a substantial compliance rating in 17 of the 18 standards reviewed as part of the CQAR. The purpose of the record review is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the person-centered service plan and care planning process, reassessment data) and to assess the quality of waiver agency services to each member; therefore, CQAR findings suggested that person-centered service plans and service delivery are being implemented in accordance with most State and federal requirements.

Weaknesses and Recommendations

Weakness #1: Area Agency on Aging of Western Michigan did not receive any compliance determinations that were in the *not full or substantial compliance* or *compliance not demonstrated* rating categories; therefore, no substantial weaknesses were identified.

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: Although no substantial weaknesses were identified within any of the program areas under review, **Area Agency on Aging of Western Michigan** had noted deficiencies in multiple program standards, indicating there are opportunities for improvement related to these performance areas. MDHHS required a CAP for the noted areas of deficiency; however, HSAG recommends **Area Agency on Aging of Western Michigan** implement an ongoing and robust

internal auditing process of individual supports coordinators to ensure all program requirements are being met, assuring **Area Agency on Aging of Western Michigan**'s waiver members are afforded all rights under Medicaid and waiver requirements, and are able to access timely and quality services as indicated in their person-centered service plans.

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

To identify strengths and weaknesses and draw conclusions for **Area Agency on Aging of Western Michigan**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Area Agency on Aging of Western Michigan** across all EQR activities. The overarching aggregated findings showed that **Area Agency on Aging of Western Michigan**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Area Agency on Aging of Western Michigan** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

HSAG's assessment of **Area Agency on Aging of Western Michigan** also identified opportunities for **Area Agency on Aging of Western Michigan** to enhance its quality assessment and performance improvement program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Area Agency on Aging of Western Michigan** had a QMP that included brief descriptions of its quality management activities, its QMP should be modified to more comprehensively align with the requirements and best practices for a quality assessment and performance improvement program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Detroit Area Agency on Aging

Validation of Performance Improvement Projects

Performance Results

Table 3-16 displays the results for each QIP implemented during SFY 2020. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Detroit Area Agency on Aging** met its internal SFY 2020 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Detroit Area Agency on Aging** did not meet its internal SFY 2020 QIP goal or the statewide goal. Any interventions described within **Detroit Area Agency on Aging**'s QMP reports are also provided in Table 3-16. The results in Table 3-16 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-16—QIP Results

QIP Topic	Goal	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Potential and or actual neglect, verbal and/or physical abuse will be reduced by 1% through September 30, 2020	SFY 2019 = [No baseline data reported] SFY 2020* = [3.50%] ☒
Actions/Activities/Interventions: According to **Detroit Area Agency on Aging**'s MI Choice Quality Management Plan Fiscal Years 2020 and 2021 dated January 14, 2020, planned actions to achieve the goal are: • The SC will report within 24 hours of notification of any suspected or actual abuse and/or neglect to adult protective services • SC will provide education to participant • SC will conduct comprehensive assessment of the living environment According to **Detroit Area Agency on Aging**'s MI Choice Quality Management Plan Fiscal Years 2020 and 2021 dated January 28, 2021, **Detroit Area Agency on Aging** completed the following activities and achieved outcomes: *Activities* • Provided training on elder abuse and neglect for participants via the Advisory Consumer Council meeting. • Assessed participants for neglect/abuse monthly *Outcomes* • Training was offered virtually twice during FY 2020 • All participants were assessed monthly for neglect and abuse via monthly contact calls.		

QIP Topic	Goal	Measurement and Outcome
2. *Prevalence of Pain With Inadequate Pain Control*	Improve individuals' reported pain level from severe to moderate by 5% through September 2020	SFY 2019 = [No baseline data reported] SFY 2020* = [28.29%] ☒
Actions/Activities/Interventions: According to **Detroit Area Agency on Aging**'s MI Choice Quality Management Plan Fiscal Years 2020 and 2021 dated January 14, 2020, planned actions to achieve the goal are: • Education and interventions to help reduce pain • Engage services of Community Health Worker • Refer to MI Choice Certification Program According to **Detroit Area Agency on Aging**'s MI Choice Quality Management Plan Fiscal Years 2020 and 2021 dated January 28, 2021, **Detroit Area Agency on Aging** completed the following activities: • Supports Coordinators assessed for pain at initial assessment and every subsequent assessment • Supports Coordinators educated participants and referred to physician or pain clinic as ordered.		
3. *Prevalence of Falls*	[Goal not identified by waiver agency in QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020* = [17.33%] ☑
According to **Detroit Area Agency on Aging**'s MI Choice Quality Management Plan Fiscal Years 2020 and 2021 dated January 28, 2021, **Detroit Area Agency on Aging** completed the following activities and achieved outcomes: *Activities* • SCs assess at every assessment as well as every monthly contact • SCs evaluate for an provide assistive devices as needed to help reduce falls • SCs evaluate for an provide personal emergency response system (PERS) when necessary *Outcomes* • Participants were educated on methods to increase their safety measures, reduce falls, and utilize the PERS when applicable		
4. *Prevalence of Any Injuries*	To improve skin integrity issues by 5% for SFY 2020[1]	SFY 2019 = [No baseline data reported] SFY 2020* = [Unable to determine][2] ☒
Actions/Activities/Interventions: According to **Detroit Area Agency on Aging**'s MI Choice Quality Management Plan Fiscal Years 2020 and 2021 dated January 14, 2020, planned actions to achieve the goal are: • Follow up for all skin problems until skin integrity is at best possible state • RN will make one or more visits as indicated to all participants with skin integrity issues until skin issue is resolved or maintained. According to **Detroit Area Agency on Aging**'s MI Choice Quality Management Plan Fiscal Years 2020 and 2021 dated January 28, 2021, **Detroit Area Agency on Aging** completed the following activities:		

QIP Topic	Goal	Measurement and Outcome
• SCs assess for fractures and major skin issues at each assessment • If issues are identified, the SC will make appropriate referrals to physician, wound nurse, etc. and re-assess monthly Participants reported a decrease in pain levels reduced by 4% through September 30, 2020.		
5. *Prevalence of Dehydration*	To increase or maintain participant functionality and hydration by 3% for SFY 2020	SFY 2019 = [No baseline data reported] SFY 2020* = [5.57%] ☒
Actions/Activities/Interventions: According to **Detroit Area Agency on Aging**'s MI Choice Quality Management Plan Fiscal Years 2020 and 2021 dated January 14, 2020, planned actions to achieve the goal are: • Education and interventions to increase or maintain functionality and hydration • Engage services of Community Health Worker • Refer to MI Choice Certification Program According to **Detroit Area Agency on Aging**'s MI Choice Quality Management Plan Fiscal Years 2020 and 2021 dated January 28, 2021, **Detroit Area Agency on Aging** completed the following activities: • Provided training for Advisory Consumer Council participants regarding incontinence and dehydration • SCs assess for dehydration at each assessment • Incontinence supplies are provided to participants at times when services are not available		

FY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
*The SFY 2020 rate was calculated by HSAG based on the numerators and denominators provided by the waiver agency in the QMP annual report. The outcome was based on the results provided by the waiver agency in the QMP annual report, or based on a comparison to the statewide goal. This information was not validated by HSAG or confirmed as validated by MDHHS.
[1] The QMP only included clinical performance measures and not the identified QIP indicators. HSAG assumed that the performance measure goal aligned with the QIP indicator for *Prevalence of Any Injuries*.
[2] Refer to *Why the weakness exists* under *Weakness #1* for an explanation.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Detroit Area Agency on Aging, through the SFY 2020 annual report, included statements that reductions in the prevalence of pain and dehydration occurred, indicating **Detroit Area Agency on Aging**'s waiver members experienced less uncontrolled pain and dehydrations from the previous year.

Weaknesses and Recommendations

Weakness #1: Inconsistencies within the SFY 2020–2021 QMP and SFY 2020 annual report created significant challenges in deciphering the QIP-related goals, interventions, prevalence rates, and outcomes.

Why the weakness exists: **Detroit Area Agency on Aging**'s SFY 2020–2021 QMP included a goal to focus on clinical performance measures. Under this goal were several objectives that appeared to relate to the quality indicators for the *Prevalence of Pain With Inadequate Pain Control*, *Prevalence of Dehydration*, and potentially *Prevalence of Any Injuries* (i.e., improve skin integrity issues) QIPs. An additional goal focused on decreasing potential and/or actual neglect and verbal and/or physical abuse. These goals included an established benchmark to evaluate performance. The QMP did not include any goals associated with falls and did not include a section that specifically identified the required QIPs. The SFY 2020 annual report included a summary of performance of the clinical performance measures and the goal to decrease potential and/or actual neglect and verbal and/or physical abuse in alignment with the QMP stated goals and objectives. However, as part of the outcomes summary within this section of the report, **Detroit Area Agency on Aging** identified the percentage rate of improvement but did not provide a summary of whether the actual goal as stated in the QMP was met or not met. The SFY 2020 annual report also included a section that specifically identified each of the five QIPs required by MDHHS; however, no goals were identified and, although numerators and denominators were included within the QIP section of the report, it was not clear whether these numerators and denominators tied to the outcomes identified within the clinical performance measures and the performance goal to decrease potential and/or actual neglect and verbal and/or physical abuse. Additionally, because there were no identified goals in the QIP section of the annual report, it was not clear how performance was evaluated using the numerators and denominators. Further, although the SFY 2020–2021 QMP contained a clinical performance measure with an objective to improve skin integrity issues (which was also included in the SFY 2020 annual report), and **Detroit Area Agency on Aging** reported that skin integrity issues were improved by 2 percent and performance was 4 percent lower than the statewide average, the *Prevalence of Any Injuries* QIP quality indicator within this same report indicated the numerator included participants with fractures or major skin problems, excluding current pressure or stasis ulcers. Therefore, HSAG was not able to clearly determine a performance rate related to the skin integrity issues as the QIP numerators and denominators included skin integrity issues and participants with fractures.

Recommendation: HSAG recommends that **Detroit Area Agency on Aging** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals that include baseline data, and these goals should specifically be identified as the state-required QIP indicators. Additionally, **Detroit Area Agency on Aging** should ensure that its annual report identifies the QIP goals and performance benchmarks, and an analysis on whether **Detroit Area Agency on Aging** met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating any identified barriers.

Weakness #2: The interventions implemented by **Detroit Area Agency on Aging** to meet performance goals were unclear as the SFY 2020–2021 QMP did not specifically describe the interventions related to the QIP indicators, except when these indicators specifically aligned with the clinical performance measure goals. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly documented. **Detroit Area Agency on Aging**'s choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential for the waiver agency's success in achieving the desired outcomes for the QIPs.

Why the weakness exists: **Detroit Area Agency on Aging**'s SFY 2020–2021 QMP did not list interventions specific to the QIP indicators and, although the SFY 2020 annual report included interventions, documentation did not support that a comprehensive causal/barrier analysis was conducted and that an evaluation occurred for each intervention to determine its effectiveness and ensure each intervention was logically linked to any identified barriers.

Recommendation: HSAG recommends that **Detroit Area Agency on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes) and innovative (e.g., not an activity already included as part of the expected care management processes). **Detroit Area Agency on Aging** should also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Detroit Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Detroit Area Agency on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #3: **Detroit Area Agency on Aging**'s SFY 2020–2021 QMP did not include details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs. **Detroit Area Agency on Aging**'s QIPs must be designed in a methodically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions.

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2020 annual report included minimal details on the design developed and methodology followed by **Detroit Area Agency on Aging** when implementing its QIPs.

Recommendation: HSAG recommends that **Detroit Area Agency on Aging** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Detroit Area Agency on Aging** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2020, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For eight of the 39 performance measures calculated by MDHHS, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Those performance measures with a statewide rate of 100 percent reported through the CMS-372 report were not included as part of the assessment. Table 3-17 displays the eight performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rate as calculated by MDHHS for the CMS-372 report, the statewide percentage rate as calculated by HSAG using the CQAR standard scores associated with each performance measure, and **Detroit Area Agency on Aging**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Detroit Area Agency on Aging**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate as calculated by HSAG, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-17—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* VIII.1, VIII.2, VIII.4, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39	**91.27**	**92.11**	**84.51**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* I.1, I.2, I.3, I.5, II.1, II.2, II.3, II.4, II.5, II.6, II.7, II.8, II.9, IV.1, IV.2, IV.3, IV.5, IV.6, VI.1, VI.2, VI.3, X.1	**96.83**	**98.82**	**98.12**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* V.3, IX.1, IX.2, IX.3, IX.6	**93.65**	**94.16**	**93.75**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* VIII.7, VIII.8	**98.94**	**99.07**	**100**

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* VIII.3, VIII.5, VIII.6, VIII.11	98.41	98.81	99.34
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* V.1, V.2, V.3, V.5, V.10, V.11, V.13, V.15, VI.12, VI.14, VI.16, VIII.1, VIII.2, VIII.3 VIII.4,VIII.5, VIII.6, VIII.11, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39, VIII.40, VIII.41, IX.1, IX.2, IX.3, IX.4, IX.6	94.97	94.13	89.86
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* VIII.28, VIII.29, VIII.30, VIII.31, VIII.32, VIII.33, VIII.34, IX.5	96.03	95.54	90.43
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* XI.1, XI.3, XI.4	89.68	93.52	87.18

* The individual waiver agency performance measure rates were derived from the standards outlined in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report.

**Statewide percentage rates are displayed as reported by MDHHS. HSAG's calculations may differ from MDHHS' calculations as HSAG summed all numerators and denominators related to the CQAR standards included as part of each performance measure, while MDHHS calculated performance measure rates for the CMS-372 report using a total count of CQAR records reviewed across the waiver agencies and removing those records from the numerator when a standard included as part of the performance measure was deficient ("*Non-Evident*").

‡ The statewide percentage rates determined by HSAG were based on results of the SFY 2020 CQAR and the standards associated with each performance measure as indicated in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source." The statewide percentage rates determined by HSAG are displayed for comparison purposes to the MDHHS statewide percentages. Additionally, the HSAG calculated rates were made available for this report to ensure an appropriate representation to the rates calculated for each waiver agency.

Indicates the performance measure rate is higher than the statewide rate as calculated by HSAG.

Indicates the performance measure rate is lower than the statewide rate as calculated by HSAG.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Although MDHHS has not established performance measure benchmarks, **Detroit Area Agency on Aging**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 7, 8, 12, 22, 24, 27, 28, 29, 31, 33, 34, 37, and 38. Performance Measures 36 and 39 also achieved a rate of 100 percent; however, performance in these measures are driven solely by MDHHS as they relate to capitation payments to the waiver agencies.

Strength #2: **Detroit Area Agency on Aging** received a 100 percent performance rating for Performance Measure 16, indicating the person-centered service plans reviewed as part of the CQAR included appropriate strategies to address members' assessed health and safety risks. The strong performance in this area suggested that **Detroit Area Agency on Aging** staff members are taking into consideration waiver members' individualized needs, including member-specific health and safety risks.

Weaknesses and Recommendations

Weakness #1: **Detroit Area Agency on Aging** received a score of 84.51 percent for Performance Measure 1, *number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS*. This indicated that supports coordinators were not completing service plans timely.

Why the weakness exists: **Detroit Area Agency on Aging**'s performance rate for Performance Measure 1 fell 7.6 percentage points below HSAG's calculated statewide rate. Through the CQAR, of the 38 records reviewed, MPHI determined that 10 records did not list services and supports that helped the participant achieve goals; 10 records did not include both waiver and non-waiver services and supports when applicable; and 31 records did not include an acknowledgement that informal supports agreed to provide uncompensated services and supports.

Recommendation: MDHHS required **Detroit Area Agency on Aging** to develop a CAP to remediate the deficiencies. The completed CAP indicated that **Detroit Area Agency on Aging** would conduct education and training for staff members and the quality department would use reports to audit compliance to determine if individual CAPs need to be developed. HSAG recommends **Detroit Area Agency on Aging** continue to conduct audits of individual supports coordinators/care managers on an ongoing basis to ensure person-centered service plans are completed within the required 10 days of enrollment. Additionally, HSAG recommends that **Detroit Area Agency on Aging** ensure mechanisms are in place that verify timely completion of the person-centered service plan as required.

Weakness #2: Detroit Area Agency on Aging performed substantially worse than other waiver agencies on Performance Measure 19, *number and percent of participant person-centered service plans that are updated according to requirements by MDHHS*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This indicated that supports coordinators were not outreaching to members timely to assess their current health needs and, subsequently, evaluate their goals to determine if existing services and supports were adequate.

Why the weakness exists: Detroit Area Agency on Aging's performance rate for Performance Measure 19 fell 5.11 percentage points below HSAG's calculated statewide rate. Through the CQAR, of the 38 records reviewed, MPHI determined that six records did not include evidence that the supports coordinator updated the person-centered service plan within 180-day intervals; five records did not support that the supports coordinator evaluated each goal within 180-day intervals; and one of eight applicable records reviewed did not demonstrate that the supports coordinator updated the person-centered service plan when there was an identified change in the member's needs.

Recommendation: MDHHS required **Detroit Area Agency on Aging** to develop a CAP to remediate the deficiencies that were associated with Performance Measure 19. The completed CAP indicated that **Detroit Area Agency on Aging** would conduct education and training for staff members and audit a select number of records until the compliance threshold was met; however, HSAG recommends **Detroit Area Agency on Aging** continue to conduct audits of individual supports coordinators on an ongoing basis to ensure all person-centered service planning requirements are adhered to and compliance is maintained.

Weakness #3: Detroit Area Agency on Aging received a score of 87.18 percent for Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan.* This indicated that members were not receiving all of the services and supports that were identified in their service plans.

Why the weakness exists: Detroit Area Agency on Aging's performance rate for Performance Measure 20 fell 6.34 percentage points below HSAG's calculated statewide rate. Through the CQAR, of the 38 records reviewed, MPHI determined that five records did not include that the waiver agent ensured service delivery according to MDHHS policy, including the use of the participant's back-up plan or an out-of-network provider.

Recommendation: MDHHS required **Detroit Area Agency on Aging** to develop a CAP to remediate the deficiencies. The completed CAP indicated that **Detroit Area Agency on Aging** would conduct education and training for staff members and the quality department would use reports to audit compliance to determine if individual CAPs need to be developed. HSAG recommends **Detroit Area Agency on Aging** continue to conduct audits of individual supports coordinators/care managers on an ongoing basis to ensure person-centered service plans are completed within the required 10 days of enrollment. Additionally, HSAG recommends that **Detroit Area Agency on Aging** ensure mechanisms are in place that verify timely completion of the person-centered service plan as required.

Compliance Review

Performance Results

Table 3-18 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-18 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-18—Clinical Quality Assurance Reviews and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus I	Level of Care Determination	100%	100%	**4.00**
Focus I.B	Communication		100%	**4.00**
Focus II	Freedom of Choice	97.93%		**4.00**
Focus III	Release of Information	92.00%		**4.00**
Focus IV	Status	96.43%		**4.00**
Focus V	Pre-Planning	85.50%	100%	**4.00**
Focus VI	Assessment	96.41%	100%	**4.00**
Focus VII	Medication Record	86.52%	97.98%	**4.00**
Focus VIII	Person-Centered Service Planning	90.36%	100%	**4.00**
Focus IX	MI Choice Services	95.15%	100%	**4.00**
Focus X	Linking and Coordinating	100%	100%	**4.00**
Focus XI	Follow-Up and Monitoring	68.83%	100%	**2.00**
Focus XII	Service Provider	73.68%		**3.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus XIII	Contingency Plan	82.61%	100%	**4.00**
Focus XIV	Critical Incidents	80.00%	100%	**2.67**
Focus XV	Adverse Benefit Determination	46.88%		**1.00**
Focus XVI	Complaints and Grievances	92.86%		**4.00**
Focus XVII	Home and Community Based		100%	**4.00**
	Totals	**90.52%**	**99.83%**	**3.83**

Indicates the standard was not reviewed as part of the record review or home visit.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: A review of 19 home visits was conducted and all reviews achieved full compliance with the exception of one focus area (Medication Record). The purpose of the home visits is to confirm that providers furnish services according to the person-centered service plan and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested providers are consistently adhering to these requirements. It should be noted that, while the home visit reviews achieved full compliance, the record review identified conflicting results in the area of Follow-Up and Monitoring.

Strength #2: Detroit Area Agency on Aging achieved a substantial compliance rating in 14 out of 18 standards reviewed as part of the CQAR. The purpose of the record review is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the person-centered service plan and care planning process, reassessment data) and to assess the quality of waiver agency services to each member; therefore, CQAR findings suggested that person-centered service plans and service delivery are being implemented in accordance with many State and federal requirements.

Weaknesses and Recommendations

Weakness #1: Detroit Area Agency on Aging did not consistently follow all Follow-Up and Monitoring requirements as required; specifically, for follow-up and monitoring and ensuring service delivery in accordance with MDHHS requirements. Waiver agencies are required to contact each member to ensure services are implemented as planned. When services are not implemented as planned or when the planned services require adjustments, waiver agencies should implement corrective actions to resolve problems and issues.

Why the weakness exists: Through the CQAR, MPHI determined that 19 out of 38 records did not include evidence that the waiver agency contacted the member for follow-up and monitoring as specified in the person-centered service plan. Additionally, five out of 25 applicable records did not include evidence to support the waiver agency ensured service delivery, including the use of the member's back-up plan or an out-of-network provider when appropriate.

Recommendation: Detroit Area Agency on Aging was required to submit a CAP to address these findings, which was approved by MDHHS; however, HSAG recommends that **Detroit Area Agency on Aging** develop a mechanism to monitor for underutilization of services on an ongoing basis and use this information to determine whether additional service providers are necessary to support the membership and needs of the enrolled waiver members.

Weakness #2: Detroit Area Agency on Aging did not consistently provide the member/guardian with an ABD notice for disenrollment due to not meeting the NFLOC criteria and/or an ABD notice for service denial, reduction, suspension, and/or termination, including termination from the MI Choice Waiver Program. Further, the ABD notices were not complete and/or contained inaccurate information. Complete and accurate ABD notices are important to ensure members understand their appeal rights and the process to request an appeal.

Why the weakness exists: Through the CQAR, MPHI determined that 10 out of 20 applicable records did not include evidence that the member/guardian was provided with an ABD notice when required. Additionally, seven of 12 applicable ABD notices were either incomplete or contained inaccurate information.

Recommendation: MDHHS required **Detroit Area Agency on Aging** to submit a CAP to remediate the deficiencies. **Detroit Area Agency on Aging**'s CAP indicated that further education and training would be provided to all supports coordinators, and quality staff members would conduct weekly audits, in addition to peer-to-peer and self-audits. HSAG recommends that **Detroit Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met. HSAG further recommends that **Detroit Area Agency on Aging** implement a quality assurance process of its ABD notices before they are sent to members to ensure the notices contain all required federal and state-specific content and comply with the language and format requirements under 42 CFR §438.10(d).

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

To identify strengths and weaknesses and draw conclusions for **Detroit Area Agency on Aging**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Detroit Area Agency on Aging** across all EQR activities. The overarching aggregated findings showed that **Detroit Area Agency on Aging**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Detroit Area Agency on Aging** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

HSAG's assessment of **Detroit Area Agency on Aging** also identified opportunities for **Detroit Area Agency on Aging** to enhance its quality assessment and performance improvement program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Detroit Area Agency on Aging** had a QMP that included brief descriptions of its quality management activities, its QMP should be modified to more comprehensively align with the requirements and best practices for a quality assessment and performance improvement program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

MORC Home Care

Validation of Performance Improvement Projects

Performance Results

Table 3-19 displays the results for each QIP implemented during SFY 2020. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **MORC Home Care** met its internal SFY 2020 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **MORC Home Care** did not meet its internal SFY 2020 QIP goal or the statewide goal. Any interventions described within **MORC Home Care**'s QMP reports are also provided in Table 3-19. The results in Table 3-19 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-19—QIP Results

QIP Topic	Goal	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020 = 4.9% [Quarter 1 results only] ☒
Actions/Activities/Interventions: **MORC Home Care**'s Quality Management Plan (QMP) FY 2020 and 2021 dated January 15, 2020 did not include specific interventions but reported the following: • Utilize the COMPASS QI Detail Report to track and monitor prevalence of neglect and abuse and will report quarterly for the fiscal year of October 1 to September 30. The results will be sent to the Clinical Supervisor and Program Director and will monitor and review with clinical staff at monthly meeting. According to **MORC Home Care**'s MI Choice Summary of Quality Management Plan (QMP) Activities and Outcomes Report FY 2020 dated January 30, 2020[1], **MORC Home Care** identified that **MORC Home Care** will utilize the COMPASS QI Detail Report to track and monitor prevalence of neglect and abuse and will report quarterly for the fiscal year. The results will be sent to the Clinical Supervisor and Program Director and will monitor and review with clinical staff.		
2. *Prevalence of Pain With Inadequate Pain Control*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020 = 14.9% [Quarter 1 results only] ☑
Actions/Activities/Interventions: **MORC Home Care**'s Quality Management Plan (QMP) FY 2020 and 2021 dated January 15, 2020 did not include specific interventions but reported the following:		

QIP Topic	Goal	Measurement and Outcome
• Utilize the COMPASS QI Detail Report to track and monitor prevalence of pain with inadequate pain control and will report quarterly for the fiscal year of October 1 to September 30. The results will be sent to the Clinical Supervisor and Program Director and will monitor and review with clinical staff at monthly meeting. According to **MORC Home Care**'s MI Choice Summary of Quality Management Plan (QMP) Activities and Outcomes Report FY 2020 dated January 30, 2020[1], **MORC Home Care** identified that **MORC Home Care** will utilize the COMPASS QI Detail Report to track and monitor prevalence of pain with inadequate pain control and will report quarterly for the fiscal year. The results will be sent to the Clinical Supervisor and Program Director and will monitor and review with clinical staff.		
3. *Prevalence of Falls*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020 = 23.3% [Quarter 1 results only] ☒
Actions/Activities/Interventions: **MORC Home Care**'s Quality Management Plan (QMP) FY 2020 and 2021 dated January 15, 2020 did not include specific interventions but reported the following: • Utilize the COMPASS QI Detail Report to track and monitor prevalence of falls and will report quarterly for the fiscal year of October 1 to September 30. The results will be sent to the Clinical Supervisor and Program Director and will monitor and review with clinical staff at monthly meeting. According to **MORC Home Care**'s MI Choice Summary of Quality Management Plan (QMP) Activities and Outcomes Report FY 2020 dated January 30, 2020, **MORC Home Care** identified that **MORC Home Care** will utilize the COMPASS QI Detail Report to track and monitor prevalence of falls and will report quarterly for the fiscal year. The results will be sent to the Clinical Supervisor and Program Director and will monitor and review with clinical staff.		
4. *Prevalence of Any Injuries*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020 = 4.1% [Quarter 1 results only] ☒
Actions/Activities/Interventions: **MORC Home Care**'s Quality Management Plan (QMP) FY 2020 and 2021 dated January 15, 2020 did not include specific interventions but reported the following: • Utilize the COMPASS QI Detail Report to track and monitor prevalence of any injuries and will report quarterly for the fiscal year of October 1 to September 30. The results will be sent to the Clinical Supervisor and Program Director and will monitor and review with clinical staff at monthly meeting. According to **MORC Home Care**'s MI Choice Summary of Quality Management Plan (QMP) Activities and Outcomes Report FY 2020 dated January 30, 2020[1], **MORC Home Care** identified that **MORC Home Care** will utilize the COMPASS QI Detail Report to track and monitor prevalence of falls and will report quarterly for the fiscal year. The results will be sent to the Clinical Supervisor and Program Director and will monitor and review with clinical staff.		

QIP Topic	Goal	Measurement and Outcome
5. *Prevalence of Dehydration*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020 = 2.2% [Quarter 1 results only] ☒
Actions/Activities/Interventions: **MORC Home Care**'s Quality Management Plan (QMP) FY 2020 and 2021 dated January 15, 2020 did not include specific interventions but reported the following: • Utilize the COMPASS QI Detail Report to track and monitor prevalence of dehydration and will report quarterly for the fiscal year of October 1 to September 30. The results will be sent to the Clinical Supervisor and Program Director and will monitor and review with clinical staff at monthly meeting. According to **MORC Home Care**'s MI Choice Summary of Quality Management Plan (QMP) Activities and Outcomes Report FY 2020 dated January 30, 2020[1], **MORC Home Care** identified that **MORC Home Care** will utilize the COMPASS QI Detail Report to track and monitor prevalence of dehydration and will report quarterly for the fiscal year. The results will be sent to the Clinical Supervisor and Program Director and will monitor and review with clinical staff.		

FY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
[1]HSAG made the assumption that the report dated January 30, 2020, was a typographical error as the annual report included a summary of data for SFY 2020 and was due to MDHHS in January 2021.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: MORC Home Care's *Prevalence of Pain With Inadequate Pain Control* QIP met the statewide goal, suggesting that **MORC Home Care**'s members experienced better pain control.

Weaknesses and Recommendations

Weakness #1: MORC Home Care's SFY 2020–2021 QMP and the SFY 2020 annual report did not identify the goal for any of the five state-required QIPs. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each measure needs to be clearly and consistently documented.

Why the weakness exists: Since **MORC Home Care** did not identify its internal QIP goals or the statewide goals established by MDHHS for the five QIPs, determining if **MORC Home Care** met its goals could not be verified due to the lack of information.

Recommendation: HSAG recommends that **MORC Home Care** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should align with the goals established by MDHHS. Additionally, **MORC Home Care** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers.

Weakness #2: The interventions implemented by **MORC Home Care** to impact performance were not identified in the QMP reports. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly documented. **MORC Home Care**'s choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential for the waiver agency's success in achieving the desired outcomes for the QIPs.

Why the weakness exists: MORC Home Care's SFY 2020–2021 QMP identified a process to track and monitor each QIP; however, neither the SFY 2020–2021 QMP or SFY 2020 annual report identified the interventions implemented during SFY 2020 for the QIPs. Additionally, there was no evidence to support that a causal/barrier analysis was conducted for any interventions to ensure they were logically linked to any identified barriers.

Recommendation: HSAG recommends that **MORC Home Care** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **MORC Home Care** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **MORC Home Care** should analyze and interpret results at multiple points in time and test for statistical significance. **MORC Home Care** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #3: MORC Home Care's QIP performance results reported in the SFY 2020 annual report were not comparable to the prevalence rates reported by other waiver agencies.

Why the weakness exists: The prevalence rates in the SFY 2020 annual report reported data only for the first quarter of SFY 2020. It is unknown why **MORC Home Care** only reported data for one quarter for the SFY 2020 annual results.

Recommendation: HSAG recommends that **MORC Home Care**'s annual report include the full year's performance results for each QIP quality indicator.

Weakness #4: MORC Home Care's SFY 2020–2021 QMP did not include details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs. **MORC Home Care**'s QIPs must be designed in a methodically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions.

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2020 annual report included minimal details on the design developed and methodology followed by **MORC Home Care** when implementing its QIPs.

Recommendation: HSAG recommends that **MORC Home Care** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **MORC Home Care** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2020, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For eight of the 39 performance measures calculated by MDHHS, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Those performance measures with a statewide rate of 100 percent reported through the CMS-372 report were not included as part of the assessment. Table 3-20 displays the eight performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rate as calculated by MDHHS for the CMS-372 report, the statewide percentage rate as calculated by HSAG using the CQAR standard scores associated with each performance measure, and **MORC Home Care**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **MORC Home Care**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate as calculated by HSAG, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-20—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* VIII.1, VIII.2, VIII.4, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39	91.27	92.11	80.00
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* I.1, I.2, I.3, I.5, II.1, II.2, II.3, II.4, II.5, II.6, II.7, II.8, II.9, IV.1, IV.2, IV.3, IV.5, IV.6, VI.1, VI.2, VI.3, X.1	96.83	98.82	100
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* V.3, IX.1, IX.2, IX.3, IX.6	93.65	94.16	97.56
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* VIII.7, VIII.8	98.94	99.07	100
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* VIII.3, VIII.5, VIII.6, VIII.11	98.41	98.81	100
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* V.1, V.2, V.3, V.5, V.10, V.11, V.13, V.15, VI.12, VI.14, VI.16, VIII.1, VIII.2, VIII.3 VIII.4,VIII.5, VIII.6, VIII.11, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39, VIII.40, VIII.41, IX.1, IX.2, IX.3, IX.4, IX.6	94.97	94.13	91.59
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* VIII.28, VIII.29, VIII.30, VIII.31, VIII.32, VIII.33, VIII.34, IX.5	96.03	95.54	100

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* XI.1, XI.3, XI.4	89.68	93.52	90.00

* The individual waiver agency performance measure rates were derived from the standards outlined in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report.

**Statewide percentage rates are displayed as reported by MDHHS. HSAG's calculations may differ from MDHHS' calculations as HSAG summed all numerators and denominators related to the CQAR standards included as part of each performance measure, while MDHHS calculated performance measure rates for the CMS-372 report using a total count of CQAR records reviewed across the waiver agencies and removing those records from the numerator when a standard included as part of the performance measure was deficient ("*Non-Evident*").

‡ The statewide percentage rates determined by HSAG were based on results of the SFY 2020 CQAR and the standards associated with each performance measure as indicated in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source." The statewide percentage rates determined by HSAG are displayed for comparison purposes to the MDHHS statewide percentages. Additionally, the HSAG calculated rates were made available for this report to ensure an appropriate representation to the rates calculated for each waiver agency.

Indicates the performance measure rate is higher than the statewide rate as calculated by HSAG.

Indicates the performance measure rate is lower than the statewide rate as calculated by HSAG.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Although MDHHS has not established performance measure benchmarks, **MORC Home Care**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 7, 8, 12, 22, 24, 27, 28, 29, 31, 33, 34, 37, and 38. Performance Measures 36 and 39 also achieved a rate of 100 percent; however, performance in these measures are driven solely by MDHHS as they relate to capitation payments to the waiver agencies.

Strength #2: MORC Home Care received a 100 percent performance rating for Performance Measures 2, 16, 17, and 19, indicating the person-centered service plans reviewed as part of the CQAR had appropriate strategies to address assessed health and safety risks, included individualized goals and participant preferences, and were updated according to MDHHS requirements; this demonstrated that **MORC Home Care** staff members are assessing members timely and developing person-centered service plans that support members are receiving services of the highest quality to meet their own specific and unique needs.

Weaknesses and Recommendations

Weakness #1: MORC Home Care received a score of 80 percent for Performance Measure 1, *number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This indicated that supports coordinators were not completing service plans for members in the time frame required by MDHHS.

Why the weakness exists: MORC Home Care's performance rate for Performance Measure 1 fell 12.11 percentage points below HSAG's calculated statewide rate. Through the CQAR, of the 10 records reviewed, MPHI determined that all 10 records did not include an acknowledgment that informal supports agreed to provide uncompensated services and supports; three records did not identify and assess the participant's needs and risk factors; three records did not list services and supports that helped the participant achieve goals; and three records did not include both waiver and non-waiver services and supports when applicable.

Recommendation: MDHHS required **MORC Home Care** to develop a CAP to remediate the deficiencies. The completed CAP indicated that **MORC Home Care** would conduct education and training for staff members and four case audits would be conducted by the clinical supervisor for each support coordinator. HSAG recommends **MORC Home Care** continue to conduct audits of individual supports coordinators/care managers on an ongoing basis to ensure person-centered service plans are completed within the required 10 days of enrollment. Additionally, HSAG recommends that **MORC Home Care** ensure mechanisms are in place that verify timely completion of the person-centered service plan as required.

Compliance Review

Performance Results

Table 3-21 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-21 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-21—Clinical Quality Assurance Reviews and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus I	Level of Care Determination	100%	100%	**4.00**
Focus I.B	Communication		100%	**4.00**
Focus II	Freedom of Choice	100%		**4.00**
Focus III	Release of Information	96.36%		**4.00**
Focus IV	Status	100%		**4.00**
Focus V	Pre-Planning	94.38%	100%	**4.00**
Focus VI	Assessment	93.98%	100%	**4.00**
Focus VII	Medication Record	87.93%	100%	**4.00**
Focus VIII	Person-Centered Service Planning	91.37%	100%	**4.00**
Focus IX	MI Choice Services	100%	100%	**4.00**
Focus X	Linking and Coordinating	92.00%	95.45%	**4.00**
Focus XI	Follow-Up and Monitoring	80.00%	100%	**3.33**
Focus XII	Service Provider	83.33%		**4.00**
Focus XIII	Contingency Plan	92.59%	100%	**4.00**
Focus XIV	Critical Incidents	N/A	100%	**4.00**
Focus XV	Adverse Benefit Determination	64.29%		**1.00**
Focus XVI	Complaints and Grievances	N/A		**N/A**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus XVII	Home and Community Based		N/A	**N/A**
	Totals	**93.11%**	**99.67%**	**3.92**

N/A indicates this focus area was non-applicable to the review year.

	Indicates the standard was not reviewed as part of the record review or home visit.
	Indicates substantial compliance: 3.26 or higher.
	Indicates some compliance, needs improvement: 2.51 to 3.25.
	Indicates not full or substantial compliance: 1.76 to 2.50.
	Indicates compliance not demonstrated: 1.00 to 1.75.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: A review of five home visits was conducted and all reviews achieved full compliance with the exception of one focus area (Linking and Coordinating). The purpose of the home visits is to confirm that providers furnish services according to the person-centered service plan and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested providers are consistently adhering to these requirements.

Strength #2: MORC Home Care achieved a substantial compliance rating in 15 out of 16 applicable standards reviewed as part of the CQAR. The purpose of the record review is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the person-centered service plan and care planning process, reassessment data) and to assess the quality of waiver agency services to each member; therefore, CQAR findings suggested that person-centered service plans and service delivery are being implemented in accordance with many State and federal requirements.

Weaknesses and Recommendations

Weakness #1: MORC Home Care did not consistently demonstrate that ABD notices were complete and contained accurate information.

Why the weakness exists: Through the CQAR, MPHI determined that five out of seven applicable records did not include ABD notices that were complete and contained accurate information.

Recommendation: MORC Home Care was required to submit a CAP to address the noted deficiencies, which included updating language in the ABD notice, providing staff training, and auditing records until an 80 percent compliance threshold is achieved. HSAG recommends that **MORC Home Care** continue conducting a specific number of record reviews (for example, 10 records) on an ongoing basis (e.g., monthly) regardless if the designated percent (e.g., 80 percent) of compliance is achieved as it is important to regularly monitor staff to ensure performance stays consistent and requirements are met.

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

To identify strengths and weaknesses and draw conclusions for **MORC Home Care**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **MORC Home Care** across all EQR activities. The overarching aggregated findings showed that **MORC Home Care**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **MORC Home Care** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

HSAG's assessment of **MORC Home Care** also identified opportunities for **MORC Home Care** to enhance its quality assessment and performance improvement program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **MORC Home Care** had a QMP that included brief descriptions of its quality management activities, its QMP should be modified to more comprehensively align with the requirements and best practices for a quality assessment and performance improvement program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Northern Healthcare Management

Validation of Performance Improvement Projects

Performance Results

Table 3-22 displays the results for each QIP implemented during SFY 2020. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Northern Healthcare Management** met its internal SFY 2020 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Northern Healthcare Management** did not meet its internal SFY 2020 QIP goal or the statewide goal. Any interventions described within **Northern Healthcare Management**'s QMP reports are also provided in Table 3-22. The results in Table 3-22 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-22—QIP Results

QIP Topic	Goal†	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Continue to have reporting abuse/neglect at or below the state average by assessing safety/environment of participants during assessments, face to face meetings, and as needs or environment changes	SFY 2019 = [No baseline data reported] SFY 2020* = [3.2%][2] ☒
Actions/Activities/Interventions: **Northern Healthcare Management**'s Quality Management Plan FY 2020 and 2021 dated January 14, 2020, identified that **Northern Healthcare Management** planned actions to achieve the goal are: • The QI Program Manager will look at the data and details of participants reporting inadequate neglect/abuse via QI Summary and Detail Report. Critical incidents will be submitted by the SCs to their supervisors for review and monitoring at the time of neglect/abuse being discovered/reported. • Educate staff on importance of providing services and assessments that will help decrease the risk for neglect/abuse. Provide resources and tools for SCs to use to better assist the participant. Provide education to staff regarding consistency and review of data collection. • The QI Program Manager will continue to monitor the number of participants reporting pain with inadequate pain control at least quarterly. According to **Northern Healthcare Management**'s Quality Management Plan FY 2020 dated January 27, 2020[1], **Northern Healthcare Management** identified the following: • State quality goal for each of the five determined goals is to improve reporting data at or below the state average to improve participant safety, health, and outcomes with Waiver services. The Program Administrator will continue to monitor data and details of participants for the state quality goals as least quarterly via Compass QI Summary and Detail Report. Staff will continue to receive education on the importance of providing services and assessments that will help decrease the risk for health of safety concerns/issues. Managers will continue to provide guidance, resources, and tools for SCs to use to better assist the participant.		

QIP Topic	Goal†	Measurement and Outcome
2. *Prevalence of Pain With Inadequate Pain Control*	Decrease percentage of participants reporting pain with inadequate pain control to a statewide averse of 25.6%.	SFY 2019 = [No baseline data reported] SFY 2020* = [31.86%] ☒

Actions/Activities/Interventions:

Northern Healthcare Management's Quality Management Plan FY 2020 and 2021 dated January 14, 2020, identified that **Northern Healthcare Management** planned actions to achieve the goal are:

- The QI Program Manager will look at the data and details of participants reporting inadequate pain control via QI Summary and Detail Report.
- Educate staff on importance of providing services that will help with pain control. Provide resources and tools for SCs to use to better assist the participant. Provide education to staff regarding consistency and review of data collection.
- The QI Program Manager will continue to monitor the number of participants reporting pain with inadequate pain control at least quarterly.

According to **Northern Healthcare Management**'s Quality Management Plan FY 2020 report dated January 27, 2020[1], **Northern Healthcare Management** identified the following:

- State quality goal for each of the five determined goals is to improve reporting data at or below the state average to improve participant safety, health, and outcomes with Waiver services. The Program Administrator will continue to monitor data and details of participants for the state quality goals as least quarterly via Compass QI Summary and Detail Report. Staff will continue to receive education on the importance of providing services and assessments that will help decrease the risk for health of safety concerns/issues. Managers will continue to provide guidance, resources, and tools for SCs to use to better assist the participant.

3. *Prevalence of Falls*	Decrease fall risks and fall percentages reported by participants by improving physical functioning to a statewide average of 27.4%	SFY 2019 = [No baseline data reported] SFY 2020* = [37.78%] ☒

Actions/Activities/Interventions:

Northern Healthcare Management's Quality Management Plan FY 2020 and 2021 dated January 14, 2020, identified that **Northern Healthcare Management** planned actions to achieve the goal are:

- The QI Program Manager will look at the data and details of participants reporting fall via QI Summary and Detail Report
- Educate staff on importance of providing services that will help improve physical functioning to reduce fall risks. Provide resources and tools for SCs to use to better assist the participant with reducing risk factors that contribute to falls. Provide education to staff regarding consistency and review of data collection.
- The QI Program Manager will continue to monitor the number of participants reporting falls at least quarterly.

According to **Northern Healthcare Management**'s Quality Management Plan FY 2020 report dated January 27, 2020[1], **Northern Healthcare Management** identified the following:

- State quality goal for each of the five determined goals is to improve reporting data at or below the state average to improve participant safety, health, and outcomes with Waiver services. The Program Administrator will continue to monitor data and details of participants for the state quality goals as least quarterly via

QIP Topic	Goal†	Measurement and Outcome
Compass QI Summary and Detail Report. Staff will continue to receive education on the importance of providing services and assessments that will help decrease the risk for health of safety concerns/issues. Managers will continue to provide guidance, resources, and tools for SCs to use to better assist the participant.		
4. *Prevalence of Any Injuries*	Decrease percentage of participants reporting any injury to a statewide average of 6.0% by assessing safety/environment.	SFY 2019 = [No baseline data reported] SFY 2020* = [11.2%] ☒
Actions/Activities/Interventions: **Northern Healthcare Management**'s Quality Management Plan FY 2020 and 2021 dated January 14, 2020, identified that **Northern Healthcare Management** planned actions to achieve the goal are: • The QI Program Manager will look at the data and details of participants reporting fall via QI Summary and Detail Report. • Educate staff on importance of providing services that will help improve safety/environment for individuals reporting any injuries within this standard. Provide resources and tools for SCs to use to better assist the participant with reducing risk factors that contribute to injuries. Provide education to staff regarding consistency and review of data collection. • The QI Program Manager will continue to monitor the number of participants reporting any qualifying injury for this standard at least quarterly. According to **Northern Healthcare Management**'s Quality Management Plan FY 2020 report dated January 27, 2020[1], **Northern Healthcare Management** identified the following: • State quality goal for each of the five determined goals is to improve reporting data at or below the state average to improve participant safety, health, and outcomes with Waiver services. The Program Administrator will continue to monitor data and details of participants for the state quality goals as least quarterly via Compass QI Summary and Detail Report. Staff will continue to receive education on the importance of providing services and assessments that will help decrease the risk for health of safety concerns/issues. Managers will continue to provide guidance, resources, and tools for SCs to use to better assist the participant.		
5. *Prevalence of Dehydration*	Decreasing percentage of participants reporting dehydration to a statewide average of 3.5% by increasing enough fluid intake.	SFY 2019 = [No baseline data reported] SFY 2020* = [2.94%] ☒
Actions/Activities/Interventions: **Northern Healthcare Management**'s Quality Management Plan FY 2020 and 2021 dated January 14, 2020, identified that **Northern Healthcare Management** planned actions to achieve the goal are: • The QI Program Manager will look at the data and details of participants reporting dehydration via QI Summary and Detail Report • Educate staff on importance of providing services that will help improve fluid intake for individuals reporting dehydration. Provide resources and tools for SCs to use to better assist the participant with reducing risk factors that to dehydration. Provide education to staff regarding consistency and review of data collection. • The QI Program Manager will continue to monitor the number of participants reporting dehydration at least quarterly.		

QIP Topic	Goal†	Measurement and Outcome
According to **Northern Healthcare Management**'s Quality Management Plan FY 2020 report dated January 27, 2020[1], **Northern Healthcare Management** identified the following: • State quality goal for each of the five determined goals is to improve reporting data at or below the state average to improve participant safety, health, and outcomes with Waiver services. The Program Administrator will continue to monitor data and details of participants for the state quality goals as least quarterly via Compass QI Summary and Detail Report. Staff will continue to receive education on the importance of providing services and assessments that will help decrease the risk for health of safety concerns/issues. Managers will continue to provide guidance, resources, and tools for SCs to use to better assist the participant.		

FY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
*Although the waiver agency provided numerators and denominators in the annual report, the reported percentage rates did not align with the numerators and denominators. To calculate a rate and outcomes, HSAG added the numerators and denominators from the quarters provided and compared those results to the end of the year SFY 2020 statewide average rate as provided by MDHHS.
†Goals presented were identified through the waiver agency's QMP although the annual report listed the statewide goal, which did not align with the QMP goals. Performance was determined based on the QMP goals.
[1]HSAG made the assumption that the report dated January 27, 2020, was a typographical error as the annual report included a summary of data for SFY 2020 and was due to MDHHS in January 2021.
[2] The FY 2020 1st/2nd quarter numerator was reported as "85." Since the waiver agency reported a rate of 3.2 percent, HSAG assumed the numerator was a typographical error and it should have been reported as "5."

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: HSAG did not identify any substantial strengths for **Northern Healthcare Management**.

Weaknesses and Recommendations

Weakness #1: Northern Healthcare Management's SFY 2020–2021 QMP and SFY 2020 annual report included conflicting goals, which created confusion as to the true goals established by **Northern Healthcare Management** when initiating the QIPs. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each measure needs to be clearly and consistently documented and should not change through the measurement period of the QIP unless documentation is provided to support the rationale for the change. Additionally, the SFY 2020–2021 QMP did not include baseline data for any of the QIPs, which would allow for year-to-year comparative data. Lastly, two of the five QIP calculated performance rates for SFY 2020 could not be determined.

Why the weakness exists: **Northern Healthcare Management**'s goals as identified in the SFY 2020–2021 QMP did not align with the statewide goals established by MDHHS. Additionally, **Northern Healthcare Management**'s SFY 2020 annual report did not include an analysis of whether **Northern Healthcare Management** met its SFY 2020 goals as established in the SFY 2020–2021 QMP. Further, **Northern Healthcare Management**'s goals for each QIP in the SFY 2020–2021 QMP were identified under a heading titled "FY 2021 Quality Improvement Projects, goals, strategies, and results"; it is unclear why **Northern Healthcare Management**'s goals for SFY 2020 would be reported under a "SFY 2021" heading, which led to confusion. Lastly, the results presented in the annual report also contained errors in the rate calculation compared to the numerators and denominators provided, which suggested the QIP performance was not appropriately validated by **Northern Healthcare Management**.

Recommendation: HSAG recommends that **Northern Healthcare Management** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should consistently align with the goals established by MDHHS. Additionally, **Northern Healthcare Management** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers. Further, **Northern Healthcare Management** should develop a mechanism to validate QIP performance and present performance rates for the entire state fiscal year.

Weakness #2: The interventions implemented by **Northern Healthcare Management** to impact performance were unclear. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly documented. **Northern Healthcare Management**'s choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential for the waiver agency's success in achieving the desired outcomes for the QIPs. Additionally, **Northern Healthcare Management** did not achieve the goal for SFY 2020 for any of its QIPs.

Why the weakness exists: **Northern Healthcare Management**'s SFY 2020–2021 QMP listed planned activities; however, the SFY 2020 annual report did not clearly identify the interventions implemented during SFY 2020 for all QIPs, or support that a causal/barrier analysis was conducted and that an evaluation occurred for each intervention to determine its effectiveness and ensure each intervention was logically linked to any identified barriers.

Recommendation: HSAG recommends that **Northern Healthcare Management** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Northern Healthcare Management** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Northern Healthcare Management** should analyze and interpret results at multiple points in time and test for statistical significance. **Northern Healthcare Management** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #3: Northern Healthcare Management's SFY 2020–2021 QMP did not include details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs. **Northern Healthcare Management**'s QIPs must be designed in a methodically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions.

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2020 annual report included minimal details on the design developed and methodology followed by **Northern Healthcare Management** when implementing its QIPs.

Recommendation: HSAG recommends that **Northern Healthcare Management** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Northern Healthcare Management** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2020, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For eight of the 39 performance measures calculated by MDHHS, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Those performance measures with a statewide rate of 100 percent reported through the CMS-372 report were not included as part of the assessment. Table 3-23 displays the eight performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rate as calculated by MDHHS for the CMS-372 report, the statewide percentage rate as calculated by HSAG using the CQAR standard scores associated with each performance measure, and **Northern Healthcare Management**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Northern Healthcare Management**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate as calculated by HSAG, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-23—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* VIII.1, VIII.2, VIII.4, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39	91.27	92.11	92.00
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* I.1, I.2, I.3, I.5, II.1, II.2, II.3, II.4, II.5, II.6, II.7, II.8, II.9, IV.1, IV.2, IV.3, IV.5, IV.6, VI.1, VI.2, VI.3, X.1	96.83	98.82	100
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* V.3, IX.1, IX.2, IX.3, IX.6	93.65	94.16	93.02
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* VIII.7, VIII.8	98.94	99.07	100
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* VIII.3, VIII.5, VIII.6, VIII.11	98.41	98.81	100
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* V.1, V.2, V.3, V.5, V.10, V.11, V.13, V.15, VI.12, VI.14, VI.16, VIII.1, VIII.2, VIII.3 VIII.4,VIII.5, VIII.6, VIII.11, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39, VIII.40, VIII.41, IX.1, IX.2, IX.3, IX.4, IX.6	94.97	94.13	96.44
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* VIII.28, VIII.29, VIII.30, VIII.31, VIII.32, VIII.33, VIII.34, IX.5	96.03	95.54	100

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* XI.1, XI.3, XI.4	89.68	93.52	90.91

* The individual waiver agency performance measure rates were derived from the standards outlined in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report.

**Statewide percentage rates are displayed as reported by MDHHS. HSAG's calculations may differ from MDHHS' calculations as HSAG summed all numerators and denominators related to the CQAR standards included as part of each performance measure, while MDHHS calculated performance measure rates for the CMS-372 report using a total count of CQAR records reviewed across the waiver agencies and removing those records from the numerator when a standard included as part of the performance measure was deficient ("*Non-Evident*").

‡ The statewide percentage rates determined by HSAG were based on results of the SFY 2020 CQAR and the standards associated with each performance measure as indicated in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source." The statewide percentage rates determined by HSAG are displayed for comparison purposes to the MDHHS statewide percentages. Additionally, the HSAG calculated rates were made available for this report to ensure an appropriate representation to the rates calculated for each waiver agency.

Indicates the performance measure rate is higher than the statewide rate as calculated by HSAG.

Indicates the performance measure rate is lower than the statewide rate as calculated by HSAG.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Although MDHHS has not established performance measure benchmarks, **Northern Healthcare Management**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 7, 8, 12, 22, 24, 27, 28, 29, 31, 33, 34, 37, and 38. Performance Measures 36 and 39 also achieved a rate of 100 percent; however, performance in these measures are driven solely by MDHHS as they relate to capitation payments to the waiver agencies.

Strength #2: Northern Healthcare Management received a 100 percent performance rating for Performance Measures 2, 16, 17, and 19, indicating the person-centered service plans reviewed as part of the CQAR had appropriate strategies to address assessed health and safety risks, included individualized goals and participant preferences, and were updated according to MDHHS requirements; this demonstrated that **Northern Healthcare Management** staff members are assessing members timely and developing person-centered service plans that support members are receiving services of the highest quality to meet their own specific and unique needs.

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial trends of weakness. While Performance Measures 1, 15, and 20 did not meet the statewide performance rate, none of the performance measures fell below the statewide rate by more than 5 percentage points.

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: MDHHS required **Northern Healthcare Management** to submit a CAP to remediate the deficiencies identified through the CQAR that are used to calculate the performance rates for Performance Measures 1, 15, and 20. **Northern Healthcare Management**'s CAP included, but was not limited to, staff training and education; a review of 10 to 12 participant records per month by quality staff members; and the implementation of additional performance improvement strategies, if necessary, based on the results of the review. However, the CAP also indicated internal monitoring is required by **Northern Healthcare Management** until compliance is evident (percent compliance not noted). Therefore, HSAG recommends that **Northern Healthcare Management** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-24 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-24 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-24—Clinical Quality Assurance Reviews and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus I	Level of Care Determination	100%	100%	**4.00**
Focus I.B	Communication		100%	**4.00**
Focus II	Freedom of Choice	100%		**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus III	Release of Information	96.30%		**4.00**
Focus IV	Status	100%		**4.00**
Focus V	Pre-Planning	100 %	100%	**4.00**
Focus VI	Assessment	92.59%	100%	**4.00**
Focus VII	Medication Record	92.06%	100%	**4.00**
Focus VIII	Person-Centered Service Planning	96.56%	100%	**4.00**
Focus IX	MI Choice Services	94.74%	100%	**4.00**
Focus X	Linking and Coordinating	96.88%	93.33%	**4.00**
Focus XI	Follow-Up and Monitoring	85.71%	100%	**4.00**
Focus XII	Service Provider	100%		**4.00**
Focus XIII	Contingency Plan	95.83%	100%	**4.00**
Focus XIV	Critical Incidents	100%	100%	**4.00**
Focus XV	Adverse Benefit Determination	91.67%		**4.00**
Focus XVI	Complaints and Grievances	83.33%		**3.00**
Focus XVII	Home and Community Based		N/A	**N/A**
	Totals	**96.11%**	**99.35%**	**3.99**

N/A indicates this focus area was non-applicable to the review year.

Indicates the standard was not reviewed as part of the record review or home visit.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: A review of five home visits was conducted and all reviews achieved full compliance with the exception of one focus area (Linking and Coordinating). The purpose of the home visits is to confirm that providers furnish services according to the person-centered service plan and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested providers are consistently adhering to these requirements.

Strength #2: Northern Healthcare Management achieved a substantial compliance rating in 16 out of 17 applicable standards reviewed as part of the CQAR. The purpose of the record review is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the person-centered service plan and care planning process, reassessment data) and to assess the quality of waiver agency services to each member; therefore, CQAR findings suggested that person-centered service plans and service delivery are being implemented in accordance with many State and federal requirements.

Weaknesses and Recommendations

Weakness #1: Northern Healthcare Management did not receive any compliance determinations that were in the *not full or substantial compliance* or *compliance not demonstrated* rating categories; therefore, no substantial weaknesses were identified.

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: Although no substantial weaknesses were identified within any of the program areas under review, **Northern Healthcare Management** had noted deficiencies in the Complaints and Grievances standard, indicating there are opportunities for improvement related to resolving complaints or grievances at the supports coordinator level. MDHHS required a CAP for the noted area of deficiency. Although **Northern Healthcare Management** identified that the deficiency was an isolated incident and traced to one supports coordinator who had been on extended leave, HSAG recommends **Northern Healthcare Management** implement an ongoing and robust internal auditing process of individual supports coordinators to ensure all program requirements are being met, assuring that complaints and grievances received by **Northern Healthcare Management** are resolved timely and at the supports coordinator level.

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

To identify strengths and weaknesses and draw conclusions for **Northern Healthcare Management**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Northern Healthcare Management** across all EQR activities. The overarching aggregated findings showed that **Northern Healthcare Management**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Northern Healthcare Management** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

HSAG's assessment of **Northern Healthcare Management** also identified opportunities for **Northern Healthcare Management** to enhance its quality assessment and performance improvement program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Northern Healthcare Management** had a QMP that included brief descriptions of its quality management activities, its QMP should be modified to more comprehensively align with the requirements and best practices for a quality assessment and performance improvement program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Region 2 Area Agency on Aging

Validation of Performance Improvement Projects

Performance Results

Table 3-25 displays the results for each QIP implemented during SFY 2020. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Region 2 Area Agency on Aging** met its internal SFY 2020 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Region 2 Area Agency on Aging** did not meet its internal SFY 2020 QIP goal or the statewide goal. Any interventions described within **Region 2 Area Agency on Aging**'s QMP reports are also provided in Table 3-25. The results in Table 3-25 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-25—QIP Results

QIP Topic	Goal†	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Goal will be to be at or less than the state average for this Indicator	SFY 2019 = [No baseline data reported] SFY 2020* = [2.5%] ☑
Actions/Activities/Interventions: According to **Region 2 Area Agency on Aging**'s MI Choice Quality Management Plan FY 2020-FY2021 dated November 18, 2019, **Region 2 Area Agency on Aging** planned to complete the following tasks: • Monitor quality indicators at the Quality Improvement Risk Management Meeting (QIRM). • Review incident reports at least biweekly. • Utilize the Safe Haven Program for safe housing in situations where a participant is removed from the situation by APS [Adult Protective Services]. The **Region 2 Area Agency on Aging** MI Choice Summary of Quality Management Plan Activities and Outcomes Report for FY 2020 dated December 30, 2020, identified the following: • The reports are reviewed at QIRM. COVID-19 has disrupted the normal bimonthly meeting schedule in order for staff to meet the needs of the participants and the community members. • Supports coordinators (SC) have trainings at least annually regarding mandatory reporting of Abuse and Neglect. • SCs are trained on the Quality Indicators. • Incident reports are reviewed. From the Quality Indicator Detailed reports for FY 2020, there was one case that warranted a critical incident and it was entered into the portal. • Monthly audits are completed for one chart per SC per month. If any incidents of neglect or abuse noted, the critical incident portal is reviewed to ensure that it has been entered. • Safe Haven has been utilized to assist participants who have been neglected or abused. • COVID-19 has created a situation where there aren't as many caregivers or SCs going into the home.		

QIP Topic	Goal†	Measurement and Outcome
2. *Prevalence of Pain With Inadequate Pain Control*	Goal will be to be at or below the State wide average	SFY 2019 = [No baseline data reported] SFY 2020 = [16.07%] ☑

Actions/Activities/Interventions:

According to **Region 2 Area Agency on Aging**'s MI Choice Quality Management Plan FY 2020-FY2021 dated November 18, 2019, **Region 2 Area Agency on Aging** planned to complete the following tasks:

- Monitor quality indicators bimonthly at QIRM.
- SCs follow up with physician and assist the participant in exploring options for alternate therapies as needed.
- SCs will discuss the Pain Path Program with participants as part of the Person Centered Service Planning Process. For those participants willing to participate, arrangements will be made for them to attend.

The **Region 2 Area Agency on Aging** MI Choice Summary of Quality Management Plan Activities and Outcomes Report for FY 2020 dated December 30, 2020, identified the following:

- The reports are reviewed at the bimonthly QIRM meetings. COVID-19 interrupted the scheduling of these meetings.
- Education is provided on various Quality Indicators throughout the fiscal year.
- Medication Reconciliations are completed as warranted.
- Person-Centered Planning processes are used when discussing and planning services for participants.

3. *Prevalence of Falls*	Goal will be to be at the state average or below	SFY 2019 = [No baseline data reported] SFY 2020* = [35.37%] ☒

Actions/Activities/Interventions:

According to **Region 2 Area Agency on Aging**'s MI Choice Quality Management Plan FY 2020 - FY2021 dated November 18, 2019, **Region 2 Area Agency on Aging** planned to complete the following tasks:

- Monitor quality indicators bimonthly at QIRM meeting.
- Education has been provided to SCs to review reasons for fall and assist in putting preventative measures in place.
- SCs will offer Matter of Balance Classes to participant during the person-centered planning process. For those participants willing to participate, arrangements will be made for them to attend.

The **Region 2 Area Agency on Aging** MI Choice Summary of Quality Management Plan Activities and Outcomes Report for FY 2020 dated December 30, 2020, identified the following:

- Quality Indicators are reviewed at the bimonthly QIRM meetings
- Education is provided to SCs on fall prevention
- Environmental assessments are done at the new assessment and annual reassessment in non COVID times. This year has been difficult to assess the environment due to not being able to be in the homes.
- Referrals are made as needed to the Matter of Balance Classes as part of the person-centered planning process.

QIP Topic	Goal†	Measurement and Outcome
4. *Prevalence of Any Injuries*	Goal is to be at or below the state average	SFY 2019 = [No baseline data reported] SFY 2020* = [7.04%] ☒
Actions/Activities/Interventions: According to **Region 2 Area Agency on Aging**'s MI Choice Quality Management Plan FY 2020- FY2021 dated November 18, 2019, **Region 2 Area Agency on Aging** planned to complete the following tasks: • Monitor quality indicators bimonthly at QIRM meetings • Cases will be discussed and guidance given to SCs The **Region 2 Area Agency on Aging** MI Choice Summary of Quality Management Plan Activities and Outcomes Report for FY 2020 dated December 30, 2020, identified the following: • Quality Indicators are reviewed at the bimonthly QIRM meetings and findings are discussed. • Education is provided to SCs on the various Quality Indicators. • Quality Assistants audit one chart per SC per month. If issues are found, education is provided and follow up is completed. • Referrals to Chronic condition or Matter of Balance classes are made as part of the person-centered planning process.		
5. *Prevalence of Dehydration*	Goal is to be at or below the state average	SFY 2019 = [No baseline data reported] SFY 2020* = [0.53%] ☑
Actions/Activities/Interventions: According to **Region 2 Area Agency on Aging**'s MI Choice Quality Management Plan FY 2020 - FY2021 dated November 18, 2019, **Region 2 Area Agency on Aging** planned to complete the following tasks: • Monitor quality indicators bimonthly at QIRM meetings. • Cases will be reviewed for trends, education created for staff as we work towards our goal. The **Region 2 Area Agency on Aging** MI Choice Summary of Quality Management Plan Activities and Outcomes Report for FY 2020 dated December 30, 2020, identified the following: • Quality Indicators are reviewed at bimonthly QIRM meetings. • Education is provided to participants by SCs on the need to drink enough water. During the hot summer months, participants are reminded more frequently. • COVID-19 has disrupted the normal in person visits; phone assessments/visits are being done.		

FY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
*HSAG calculated the SFY 2020 performance rates using the numerators and denominators provided by the waiver agency in the annual report.

†The goals identified by the waiver agency did not include the percentage for the statewide average; therefore, HSAG measured performance outcomes using the statewide goal.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Region 2 Area Agency on Aging met the statewide goals for the *Prevalence of Neglect/Abuse* and *Prevalence of Pain With Inadequate Pain Control* QIPs, indicating that **Region 2 Area Agency on Aging**'s members are experiencing lower prevalence of neglect/abuse and uncontrolled pain as compared to the overall MI Choice Waiver Program.

Weaknesses and Recommendations

Weakness #1: The **Region 2 Area Agency on Aging** goals indicated in the SFY 2020–2021 QMP dated November 18, 2019, were not specific and measurable. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each measure needs to be clearly identified.

Why the weakness exists: The goals for each quality indicator were stated in the SFY 2020–2021 QMP dated November 18, 2019, under a header titled "FY 2021 Quality Improvement Projects, goals, strategies, and results"; since the QMP was dated November 18, 2019, it was unclear if the goals were for SFY 2020 or if the QMP was updated with new goals for SFY 2021, but the date on the QMP was not revised. Further, the goals were not specific as they were presented using the statewide average but did not include the statewide average percentage.

Recommendation: HSAG recommends that **Region 2 Area Agency on Aging** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should be consistently documented within its QMP. Additionally, the goals should include a static performance measurement and the measurement should not change through the QIP measurement period unless documentation is provided to support the rationale for the change (the statewide average will continually change; therefore, this fluid measurement may not lead to improvement).

Weakness #2: Region 2 Area Agency on Aging did not measure improvements to the quality indicators on an ongoing basis. To effectively measure improvement in the quality indicators, it is important to identify and measure a baseline rate.

Why the weakness exists: Region 2 Area Agency on Aging did not indicate the baseline rate for each quality indicator within its QMP reports.

Recommendation: HSAG recommends **Region 2 Area Agency on Aging** identify the baseline period and rate for each quality indicator and measure them frequently to determine if interventions implemented are effective.

Weakness #3: In the SFY 2020 annual report, **Region 2 Area Agency on Aging** reported the numerator and denominator for each quarter of SFY 2020 for each quality indicator, but did not calculate the percentages. It is important to monitor not only the numerator and denominator on an ongoing basis, but also the percentage in order to identify any significant increases or decreases in the rate.

Why the weakness exists: **Region 2 Area Agency on Aging** did not report percentages on its quality indicators in the annual report.

Recommendation: HSAG recommends that **Region 2 Area Agency on Aging** monitor the percentage results for each quality indicator on an ongoing basis to determine if interventions are successful throughout the time period of the QIP.

Weakness #4: The interventions implemented by **Region 2 Area Agency on Aging** to meet performance goals were unclear. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly documented.

Why the weakness exists: **Region 2 Area Agency on Aging**'s SFY 2020–2021 QMP dated November 18, 2019, listed planned activities; however, the SFY 2020 annual report did not clearly identify the interventions implemented during SFY 2020 for all QIPs, or include an assessment of whether a specific intervention(s) was successful or unsuccessful in achieving increased performance. Additionally, for some QIPs it was unclear if the interventions listed in the annual report were interventions implemented during SFY 2020 or were planned interventions for the future. Further, no conclusions were drawn regarding whether the interventions had an impact on the rate.

Recommendation: HSAG recommends that **Region 2 Area Agency on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Region 2 Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Region 2 Area Agency on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #5: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **Region 2 Area Agency on Aging**'s QIPs must be designed in a methodically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions.

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2020 annual report included limited details on the design developed and methodology followed by **Region 2 Area Agency on Aging** when implementing its QIPs.

Recommendation: HSAG recommends that **Region 2 Area Agency on Aging** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Region 2 Area Agency on Aging** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2020, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For eight of the 39 performance measures calculated by MDHHS, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Those performance measures with a statewide rate of 100 percent reported through the CMS-372 report were not included as part of the assessment. Table 3-26 displays the eight performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rate as calculated by MDHHS for the CMS-372 report, the statewide percentage rate as calculated by HSAG using the CQAR standard scores associated with each performance measure, and **Region 2 Area Agency on Aging**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Region 2 Area Agency on Aging**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate as calculated by HSAG, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-26—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* VIII.1, VIII.2, VIII.4, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39	91.27	92.11	95.68
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* I.1, I.2, I.3, I.5, II.1, II.2, II.3, II.4, II.5, II.6, II.7, II.8, II.9, IV.1, IV.2, IV.3, IV.5, IV.6, VI.1, VI.2, VI.3, X.1	96.83	98.82	99.52
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* V.3, IX.1, IX.2, IX.3, IX.6	93.65	94.16	96.30
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* VIII.7, VIII.8	98.94	99.07	100
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* VIII.3, VIII.5, VIII.6, VIII.11	98.41	98.81	98.68
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* V.1, V.2, V.3, V.5, V.10, V.11, V.13, V.15, VI.12, VI.14, VI.16, VIII.1, VIII.2, VIII.3 VIII.4,VIII.5, VIII.6, VIII.11, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39, VIII.40, VIII.41, IX.1, IX.2, IX.3, IX.4, IX.6	94.97	94.13	93.97
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* VIII.28, VIII.29, VIII.30, VIII.31, VIII.32, VIII.33, VIII.34, IX.5	96.03	95.54	99.08

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* XI.1, XI.3, XI.4	**89.68**	**93.52**	**91.30**

* The individual waiver agency performance measure rates were derived from the standards outlined in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report.

**Statewide percentage rates are displayed as reported by MDHHS. HSAG's calculations may differ from MDHHS' calculations as HSAG summed all numerators and denominators related to the CQAR standards included as part of each performance measure, while MDHHS calculated performance measure rates for the CMS-372 report using a total count of CQAR records reviewed across the waiver agencies and removing those records from the numerator when a standard included as part of the performance measure was deficient ("*Non-Evident*").

‡ The statewide percentage rates determined by HSAG were based on results of the SFY 2020 CQAR and the standards associated with each performance measure as indicated in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source." The statewide percentage rates determined by HSAG are displayed for comparison purposes to the MDHHS statewide percentages. Additionally, the HSAG calculated rates were made available for this report to ensure an appropriate representation to the rates calculated for each waiver agency.

Indicates the performance measure rate is higher than the statewide rate as calculated by HSAG.

Indicates the performance measure rate is lower than the statewide rate as calculated by HSAG.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Although MDHHS has not established performance measure benchmarks, **Region 2 Area Agency on Aging**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 7, 8, 12, 22, 24, 27, 28, 29, 31, 33, 34, 37, and 38. Performance Measures 36 and 39 also achieved a rate of 100 percent; however, performance in these measures are driven solely by MDHHS as they relate to capitation payments to the waiver agencies.

Strength #2: Region 2 Area Agency on Aging received a 100 percent performance rating for Performance Measure 16, indicating members were able to access services in the most appropriate care setting as determined by the member, member's guardian, and waiver agency staff members.

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial trends of weakness. While Performance Measures 17, 18, and 20 did not meet the statewide performance rate, none of the performance measures fell below the statewide rate by more than 5 percentage points.

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: MDHHS required **Region 2 Area Agency on Aging** to submit a CAP to remediate the deficiencies identified through the CQAR that are used to calculate the performance rates for Performance Measures 17, 18, and 20. **Region 2 Area Agency on Aging**'s CAP included, but was not limited to, tracking the process of sending the corrected version of the provider list to all participants; staff training; and a review of one chart per month per supports coordinator. However, the CAP also indicated internal monitoring is required by **Region 2 Area Agency on Aging** until compliance in excess of 90 percent is achieved. Therefore, HSAG recommends that **Region 2 Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-27 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-27 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-27—Clinical Quality Assurance Reviews and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus I	Level of Care Determination	100%	100%	**4.00**
Focus I.B	Communication		100%	**4.00**
Focus II	Freedom of Choice	100%		**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus III	Release of Information	100%		**4.00**
Focus IV	Status	97.50%		**4.00**
Focus V	Pre-Planning	87.21%	100%	**4.00**
Focus VI	Assessment	99.31%	100%	**4.00**
Focus VII	Medication Record	87.40%	100%	**4.00**
Focus VIII	Person-Centered Service Planning	97.48%	100%	**4.00**
Focus IX	MI Choice Services	97.22%	100%	**4.00**
Focus X	Linking and Coordinating	98.61%	100%	**4.00**
Focus XI	Follow-Up and Monitoring	76.19%	100%	**2.69**
Focus XII	Service Provider	100%		**4.00**
Focus XIII	Contingency Plan	85.11%	100%	**4.00**
Focus XIV	Critical Incidents	100%	100%	**4.00**
Focus XV	Adverse Benefit Determination	93.75%		**4.00**
Focus XVI	Complaints and Grievances	100%		**4.00**
Focus XVII	Home and Community Based		100%	**4.00**
	Totals	**95.25%**	**100%**	**3.97**

Indicates the standard was not reviewed as part of the record review or home visit.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: A review of 10 home visits was conducted and all reviews achieved full compliance. The purpose of the home visits is to confirm that providers furnish services according to the person-centered service plan and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested that members are receiving services in accordance with their service plans and preferences, and are satisfied with those services.

Strength #2: Region 2 Area Agency on Aging achieved a substantial compliance rating in 17 of the 18 standards reviewed as part of the CQAR. The purpose of the record review is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the person-centered service plan and care planning process, reassessment data) and to assess the quality of waiver agency services to each member; therefore, CQAR findings suggested that person-centered service plans and service delivery are being implemented in accordance with many State and federal requirements.

Weaknesses and Recommendations

Weakness #1: Region 2 Area Agency on Aging did not receive any compliance determinations that were in the *not full or substantial compliance* or *compliance not demonstrated* rating categories; therefore, no substantial weaknesses were identified.

Why the weakness exists: This section is not applicable as there were no substantial areas of weakness for **Region 2 Area Agency on Aging**.

Recommendation: Although no substantial weaknesses were identified within any of the program areas under review, **Region 2 Area Agency on Aging** had noted deficiencies in the Follow-Up and Monitoring standard; this indicated there are opportunities for improvement related to timely follow-up with the member, including ensuring the member is receiving services in accordance with MDHHS requirements. Although MDHHS required a CAP for the noted area of deficiency, HSAG also recommends **Region 2 Area Agency on Aging** implement an ongoing and robust internal auditing process to ensure all follow-up and monitoring program requirements are being met by **Region 2 Area Agency on Aging**.

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

To identify strengths and weaknesses and draw conclusions for **Region 2 Area Agency on Aging**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Region 2 Area Agency on Aging** across all EQR activities. The overarching aggregated findings showed that **Region 2 Area Agency on Aging**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Region 2 Area Agency on Aging** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

HSAG's assessment of **Region 2 Area Agency on Aging** also identified opportunities for **Region 2 Area Agency on Aging** to enhance its quality assessment and performance improvement program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Region 2 Area Agency on Aging** had a QMP that included brief descriptions of its quality management activities, its QMP should be modified to more comprehensively align with the requirements and best practices for a quality assessment and performance improvement program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Region 3B

Validation of Performance Improvement Projects

Performance Results

Table 3-28 displays the results for each QIP implemented during SFY 2020. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Region 3B** met its internal SFY 2020 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Region 3B** did not meet its internal SFY 2020 QIP goal or the statewide goal. Any interventions described within **Region 3B**'s QMP reports are also provided in Table 3-28. The results in Table 3-28 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-28—QIP Results

QIP Topic	Goal†	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Decrease number of participants who have been neglected/abused, have poor hygiene, are fearful of family member or who have been restrained to a 3% percentage less than statewide	SFY 2019 = [No baseline data reported] SFY 2020* = [4.22%] ☒
Actions/Activities/Interventions: According to **Region 3B**'s MI Choice Quality Management Plan dated January 15, 2020, **Region 3B** planned to complete the following tasks: • Initial training will be conducted for staff by Quality Assurance (QA) team to discuss assessing, monitoring, and documentation for this indicator. QA staff to review and audit indicator each month on 2-3 charts per SC. Findings will be tallied, analyzed, and discussed within the QA and management team. If findings are questionable, QA team to discuss with SC also. Quarterly findings to be reported at QA quarterly meeting. The **Region 3B** MI Choice Quality Management Plan Activities & Outcome Report FY2020 dated January 26, 2021 identified the following: • Education was provided at Care Management Meeting in February 2020 and a QI tool was created and provided to staff to assist SCs on the requirements of documentation and monitoring of QIs. • Monthly QI reports are generated, and information for each participant who triggers is entered onto a spreadsheet. The Quality Manager reviews documentation in progress notes to identify that there is a complete and accurate description of the neglect/abuse and that education was provided. SC interventions must include monitoring of neglect/abuse. The CI portal is checked for documentation. If any of the components are missing SCs and their supervisor are emailed with a request to complete any areas that are lacking. Documentation is reviewed once corrections are completed.		

QIP Topic	Goal†	Measurement and Outcome
2. *Prevalence of Pain With Inadequate Pain Control*	Decrease number of participants who experienced pain and inadequate pain control on regimen or breakthrough pain or sometimes severe or excruciatingly intense pain to a 2% less that statewide	SFY 2019 = [No baseline data reported] SFY 2020* = [18.87%] ☑

Actions/Activities/Interventions:

According to **Region 3B**'s MI Choice Quality Management Plan dated January 15, 2020, **Region 3B** planned to complete the following tasks:

- Initial training will be conducted for staff by QA team to discuss assessing, monitoring, and documentation for this indicator. QA staff to review and audit indicator each month on 2-3 charts per SC. Findings will be tallied, analyzed, and discussed within the QA and management team. If findings are questionable, QA team to discuss with SC also. Quarterly findings to be reported at QA quarterly meeting.

The **Region 3B** MI Choice Quality Management Plan Activities & Outcome Report FY2020 dated January 26, 2021 identified the following:

- Education was provided at Care Management Meeting in February 2020 and a QI tool was created and provided to staff to assist SCs on the requirements of documentation and monitoring of QIs.
- Monthly QI reports are generated, and information for each participant who triggers is entered onto a spreadsheet. The Quality manager reviews documentation in progress notes to identify that there is a complete and accurate description of the pain, pain management techniques and that education was provided. SC interventions must include monitoring of pain. If any of the components are missing SCs and their supervisor are emailed with a request to complete any areas that are lacking. Documentation is reviewed once corrections are completed.

3. *Prevalence of Falls*	Decrease the number of participants who experienced falls excluding those completely dependent in bed mobility to 3% less than statewide	SFY 2019 = [No baseline data reported] SFY 2020* = [4.54%] ☑

Actions/Activities/Interventions:

According to **Region 3B**'s MI Choice Quality Management Plan dated January 15, 2020, **Region 3B** planned to complete the following tasks:

- Initial training will be conducted for staff by QA team to discuss assessing, monitoring, and documentation for this indicator. QA staff to review and audit indicator each month on 2-3 charts per SC. Findings will be tallied, analyzed, and discussed within the QA and management team. If findings are questionable, QA team to discuss with SC also. Quarterly findings to be reported at QA quarterly meeting.

The **Region 3B** MI Choice Quality Management Plan Activities & Outcome Report FY2020 dated January 26, 2021 identified the following:

- Education was provided at Care Management Meeting in February 2020 and a QI tool was created and provided to staff to assist SCs on the requirements of documentation and monitoring of QIs.

QIP Topic	Goal†	Measurement and Outcome
• Monthly QI reports are generated, and information for each participant who triggers is entered onto a spreadsheet. The Quality manager reviews documentation in progress notes to identify that there is a complete and accurate description of falls, fall prevention techniques and that education was provided. SC interventions must include monitoring of falls. If any of the components are missing SCs and their supervisor are emailed with a request to complete any areas that are lacking. Documentation is reviewed once corrections are completed.		
4. *Prevalence of Any Injuries*	Decrease the number of participants with any injuries with fractures or major skin problems by 2% statewide	SFY 2019 = [No baseline data reported] SFY 2020* = [5.41%] ☒
Actions/Activities/Interventions: According to **Region 3B**'s MI Choice Quality Management Plan dated January 15, 2020, **Region 3B** planned to complete the following tasks: • Initial training will be conducted for staff by QA team to discuss assessing, monitoring, and documentation for this indicator. QA staff to review and audit indicator each month on 2-3 charts per SC. Findings will be tallied, analyzed, and discussed within the QA and management team. If findings are questionable, QA team to discuss with SC also. Quarterly findings to be reported at QA quarterly meeting. The **Region 3B** MI Choice Quality Management Plan Activities & Outcome Report FY2020 dated January 26, 2021 identified the following: • Education was provided at Care Management Meeting in February 2020 and a QI tool was created and provided to staff to assist SCs on the requirements of documentation and monitoring of QIs. • Monthly QI reports are generated, and information for each participant who triggers is entered onto a spreadsheet. The Quality manager reviews documentation in progress notes to identify that there is a complete and accurate description of the injury, treatment for injury and that education was provided. SC interventions must include monitoring of injuries. If any of the components are missing SCs and their supervisor are emailed with a request to complete any areas that are lacking. Documentation is reviewed once corrections are completed.		
5. *Prevalence of Dehydration*	Reduce the prevalence of participants who were dehydrated due to insufficient fluid intake to less than 3.5%	SFY 2019 = [No baseline data reported] SFY 2020* = [2.64%] ☑
Actions/Activities/Interventions: According to **Region 3B**'s MI Choice Quality Management Plan dated January 15, 2020, **Region 3B** planned to complete the following tasks: • Initial training will be conducted for staff by QA team to discuss assessing, monitoring, and documentation for this indicator. QA staff to review and audit indicator each month on 2-3 charts per SC. Findings will be tallied, analyzed, and discussed within the QA and management team. If findings are questionable, QA team to discuss with SC also. Quarterly findings to be reported at QA quarterly meeting. The **Region 3B** MI Choice Quality Management Plan Activities & Outcome Report FY2020 dated January 26, 2021 identified the following:		

QIP Topic	Goal†	Measurement and Outcome
• Education was provided at Care Management Meeting in February 2020 and a QI tool was created and provided to staff to assist SCs on the requirements of documentation and monitoring of QIs. • Monthly QI reports are generated, and information for each participant who triggers is entered onto a spreadsheet. The Quality manager reviews documentation in progress notes to identify that there is a complete and accurate description of the dehydration, reason for dehydration and that education was provided. SC interventions must include monitoring of dehydration. If any of the components are missing SCs and their supervisor are emailed with a request to complete any areas that are lacking. Documentation is reviewed once corrections are completed.		

FY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
*HSAG calculated the SFY 2020 performance rates using the numerators and denominators provided by the waiver agency in the annual report.
†HSAG made the assumption that any reference to "statewide" in each goal referred to the statewide rate at the time the QIP quality indicators were selected by MDHHS and the percentage of reduction was based on percentage points less than these statewide rates.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Region 3B met its goals for the *Prevalence of Pain With Inadequate Pain Control*, *Prevalence of Falls*, and *Prevalence of Dehydration* QIPs, indicating that **Region 3B**'s members are experiencing lower incidents of uncontrolled pain, falls, and dehydration.

Weaknesses and Recommendations

Weakness #1: The **Region 3B** goals indicated in the SFY 2020–2021 QMP were not clear and specific. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each measure needs to be clearly and consistently documented.

Why the weakness exists: Each QIP goal identified within the QMP reports was not stated as a specific goal. The goals were presented using "statewide"; however, it was unclear if this referred to the statewide average or the statewide goal, and the point in time to which these percentages applied were not stated.

Recommendation: HSAG recommends that **Region 3B** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals.

Weakness #2: **Region 3B** did not measure improvements to the quality indicators on an ongoing basis. To effectively measure improvement in the quality indicators, it is important to identify and measure a baseline rate.

Why the weakness exists: **Region 3B** did not indicate the baseline rate for each quality indicator within its QMP reports.

Recommendation: HSAG recommends **Region 3B** identify the baseline period and rate for each quality indicator and measure them regularly to determine if interventions implemented are effective.

Weakness #3: In the SFY 2020 annual report, **Region 3B** reported the numerator and denominator for each quarter of SFY 2020 for each quality indicator, but did not calculate the percentages. It is important to monitor not only the numerator and denominator on an ongoing basis, but also the percentage to identify any significant increases or decreases in the rate.

Why the weakness exists: **Region 3B** did not report percentages on their quality indicators in the annual report.

Recommendation: HSAG recommends that **Region 3B** monitor the percentage results for each quality indicator on an ongoing basis to determine if interventions are successful throughout the time period of the QIP.

Weakness #4: The interventions implemented by **Region 3B** did not appear to be effective as **Region 3B** did not meet its goals for the *Prevalence of Neglect/Abuse* and *Prevalence of Any Injuries* QIPs. **Region 3B**'s choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential for the waiver agency's success in achieving the desired outcomes for the QIPs.

Why the weakness exists: **Region 3B** did not meet its goal for two QIPs. Additionally, documentation did not support that a comprehensive causal/barrier analysis was conducted and that an evaluation occurred for each intervention to determine its effectiveness and ensure each intervention was logically linked to any identified barriers.

Recommendation: HSAG recommends that **Region 3B** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes) and innovative (e.g., not an activity already included as part of the expected care management processes). **Region 3B** should also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Region 3B** should analyze and interpret results at multiple points in time and test for statistical significance. **Region 3B** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #5: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **Region 3B**'s QIPs must be designed in a methodically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions.

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2020 annual report included limited details on the design developed and methodology followed by **Region 3B** when implementing its QIPs.

Recommendation: HSAG recommends that **Region 3B** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Region 3B** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2020, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For eight of the 39 performance measures calculated by MDHHS, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Those performance measures with a statewide rate of 100 percent reported through the CMS-372 report were not included as part of the assessment. Table 3-29 displays the eight performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rate as calculated by MDHHS for the CMS-372 report, the statewide percentage rate as calculated by HSAG using the CQAR standard scores associated with each performance measure, and **Region 3B**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Region 3B**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate as calculated by HSAG.

Table 3-29—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* VIII.1, VIII.2, VIII.4, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39	**91.27**	**92.11**	**96.00**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* I.1, I.2, I.3, I.5, II.1, II.2, II.3, II.4, II.5, II.6, II.7, II.8, II.9, IV.1, IV.2, IV.3, IV.5, IV.6, VI.1, VI.2, VI.3, X.1	**96.83**	**98.82**	**100**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* V.3, IX.1, IX.2, IX.3, IX.6	**93.65**	**94.16**	**98.39**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* VIII.7, VIII.8	**98.94**	**99.07**	**100**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* VIII.3, VIII.5, VIII.6, VIII.11	**98.41**	**98.81**	**100**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* V.1, V.2, V.3, V.5, V.10, V.11, V.13, V.15, VI.12, VI.14, VI.16, VIII.1, VIII.2, VIII.3 VIII.4,VIII.5, VIII.6, VIII.11, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39, VIII.40, VIII.41, IX.1, IX.2, IX.3, IX.4, IX.6	**94.97**	**94.13**	**97.82**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* VIII.28, VIII.29, VIII.30, VIII.31, VIII.32, VIII.33, VIII.34, IX.5	**96.03**	**95.54**	**94.12**

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* XI.1, XI.3, XI.4	**89.68**	**93.52**	**100**

* The individual waiver agency performance measure rates were derived from the standards outlined in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report.

**Statewide percentage rates are displayed as reported by MDHHS. HSAG's calculations may differ from MDHHS' calculations as HSAG summed all numerators and denominators related to the CQAR standards included as part of each performance measure, while MDHHS calculated performance measure rates for the CMS-372 report using a total count of CQAR records reviewed across the waiver agencies and removing those records from the numerator when a standard included as part of the performance measure was deficient ("*Non-Evident*").

‡ The statewide percentage rates determined by HSAG were based on results of the SFY 2020 CQAR and the standards associated with each performance measure as indicated in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source." The statewide percentage rates determined by HSAG are displayed for comparison purposes to the MDHHS statewide percentages. Additionally, the HSAG calculated rates were made available for this report to ensure an appropriate representation to the rates calculated for each waiver agency.

Indicates the performance measure rate is higher than the statewide rate as calculated by HSAG.

Indicates the performance measure rate is lower than the statewide rate as calculated by HSAG.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Although MDHHS has not established performance measure benchmarks, **Region 3B**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 7, 8, 12, 22, 24, 27, 28, 29, 31, 33, 34, 37, and 38. Performance Measures 36 and 39 also achieved a rate of 100 percent; however, performance in these measures are driven solely by MDHHS as they relate to capitation payments to the waiver agencies.

Strength #2: **Region 3B** received a 100 percent performance rating for Performance Measures 2, 16, 17, and 20, indicating members were appropriately evaluated and determined to meet the level of care necessary to receive services under the waiver program and, subsequently, were able to access services in the most appropriate care setting as determined by the member, member's guardian, and waiver agency staff members. Additionally, person-centered service plans reviewed as part of the CQAR included appropriate strategies to address members' assessed health and safety risks and individualized goals and preferences; this suggested that **Region 3B** staff members are taking into consideration waiver members' individualized needs, including member-specific health risks, and member preferences when creating service plans, ensuring members are receiving services of the highest quality to meet their own specific and unique needs. Further, person-centered service plans

reviewed as part of the CQAR indicated that members received all of the provided services and supports identified appropriately, which suggested that **Region 3B** staff members followed up to ensure that members continually received the services and supports they needed as identified in their person-centered service plans.

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial trends of weakness. While Performance Measure 19 did not meet the statewide performance rate, it did not fall below the statewide rate by more than 5 percentage points.

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: MDHHS required **Region 3B** to submit a CAP to remediate the deficiencies identified through the CQAR that are used to calculate the performance rates for Performance Measures 19. **Region 3B**'s CAP included, but was not limited to, staff education and training and ongoing auditing of records. HSAG recommends that **Region 3B** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly) as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-30 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-30 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-30—Clinical Quality Assurance Reviews and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus I	Level of Care Determination	100%	100%	**4.00**
Focus I.B	Communication		100%	**4.00**
Focus II	Freedom of Choice	100%		**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus III	Release of Information	85.90%		**4.00**
Focus IV	Status	100%		**4.00**
Focus V	Pre-Planning	97.66%	100%	**4.00**
Focus VI	Assessment	95.00%	100%	**4.00**
Focus VII	Medication Record	96.59%	94.74%	**4.00**
Focus VIII	Person-Centered Service Planning	97.56%	100%	**4.00**
Focus IX	MI Choice Services	96.43%	100%	**4.00**
Focus X	Linking and Coordinating	94.00%	100%	**4.00**
Focus XI	Follow-Up and Monitoring	90.00%	100%	**4.00**
Focus XII	Service Provider	100%		**4.00**
Focus XIII	Contingency Plan	84.62%	100%	**4.00**
Focus XIV	Critical Incidents	80.00%	100%	**2.70**
Focus XV	Adverse Benefit Determination	100%		**4.00**
Focus XVI	Complaints and Grievances	100%		**4.00**
Focus XVII	Home and Community Based		100%	**4.00**
	Totals	**95.86%**	**99.60%**	**3.96**

	Indicates the standard was not reviewed as part of the record review or home visit.
	Indicates substantial compliance: 3.26 or higher.
	Indicates some compliance, needs improvement: 2.51 to 3.25.
	Indicates not full or substantial compliance: 1.76 to 2.50.
	Indicates compliance not demonstrated: 1.00 to 1.75.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: A review of eight home visits was conducted and all reviews achieved full compliance with the exception of one focus area (Medication Record). The purpose of the home visits is to confirm that providers furnish services according to the person-centered service plan and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested that members are receiving services in accordance with their service plans and preferences, and are satisfied with those services.

Strength #2: **Region 3B** achieved a substantial compliance rating in 17 of the 18 standards reviewed as part of the CQAR. The purpose of the record review is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the person-centered service plan and care planning process, reassessment data) and to assess the quality of waiver agency services to each member; therefore, CQAR findings suggested that person-centered service plans and service delivery are being implemented in accordance with many State and federal requirements.

Weaknesses and Recommendations

Weakness #1: **Region 3B** did not receive any compliance determinations that were in the *not full or substantial compliance* or *compliance not demonstrated* rating categories; therefore, no substantial weaknesses were identified.

Why the weakness exists: This section is not applicable as there were no substantial areas of weakness for **Region 3B**.

Recommendation: Although no substantial weaknesses were identified within any of the program areas under review, **Region 3B** had a noted deficiency in the Critical Incidents standard, indicating there are opportunities for improvement related to entering, reporting, and providing updates to the critical incident portal in accordance with MDHHS requirements. Although MDHHS required a CAP for the noted area of deficiency, HSAG also recommends **Region 3B** implement an ongoing and robust internal auditing process to ensure all critical incident program requirements are being met by **Region 3B**.

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

To identify strengths and weaknesses and draw conclusions for **Region 3B**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Region 3B** across all EQR activities. The overarching aggregated findings showed that **Region 3B**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Region 3B** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

HSAG's assessment of **Region 3B** also identified opportunities for **Region 3B** to enhance its quality assessment and performance improvement program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Region 3B** had a QMP that included brief descriptions of its quality management activities, its QMP should be modified to more comprehensively align with the requirements and best practices for a quality assessment and performance improvement program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Region IV Area Agency on Aging

Validation of Performance Improvement Projects

Performance Results

Table 3-31 displays the results for each QIP implemented during SFY 2020. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Region IV Area Agency on Aging** met its internal SFY 2020 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Region IV Area Agency on Aging** did not meet its internal SFY 2020 QIP goal or the statewide goal. Any interventions described within **Region IV Area Agency on Aging**'s QMP reports are also provided in Table 3-31. The results in Table 3-31 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-31—QIP Results

QIP Topic	Goal†	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	State Goal: 3%	SFY 2019 = [No baseline data reported] SFY 2020 = 1.7% ☑
Actions/Activities/Interventions: According to **Region IV Area Agency on Aging**'s MI Choice Quality Management Plan FY' 2020 & FY' 2021, dated January 15, 2020, **Region IV Area Agency on Aging** planned to complete the following tasks: • [None identified] The **Region IV Area Agency on Aging** MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2020 dated January 4, 2021 identified the following: • State Goal Met, no further activities completed.		
2. *Prevalence of Pain With Inadequate Pain Control*	State Goal: 20%	SFY 2019 = [No baseline data reported] SFY 2020 = 33.4% ☒
Actions/Activities/Interventions: According to **Region IV Area Agency on Aging**'s MI Choice Quality Management Plan FY' 2020 & FY' 2021, dated January 15, 2020, **Region IV Area Agency on Aging** planned to complete the following tasks: • [None identified] The **Region IV Area Agency on Aging** MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2020 dated January 4, 2021 identified the following: • State Goal not yet met; however, numbers indicate continued decline from first quarter to fourth quarter. • **Region IV Area Agency on Aging** will continue to work on this indicator in FY21.		

QIP Topic	Goal†	Measurement and Outcome
3. *Prevalence of Falls*	State Goal: 23%	SFY 2019 = [No baseline data reported] SFY 2020 = 29.5% ☒
Actions/Activities/Interventions: According to **Region IV Area Agency on Aging**'s MI Choice Quality Management Plan FY' 2020 & FY' 2021, dated January 15, 2020, **Region IV Area Agency on Aging** planned to complete the following tasks: • [None identified] The **Region IV Area Agency on Aging** MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2020 dated January 4, 2021 identified the following: • State Goal not yet met; however, numbers indicate continued decline from first quarter to fourth quarter. • **Region IV Area Agency on Aging** has implemented a PDSA cycle to test out the STEADI evidence-based intervention created by the CDC to reduce falls in FY 20-21.		
4. *Prevalence of Any Injuries*	State Goal: 3%	SFY 2019 = [No baseline data reported] SFY 2020 = 4.6% ☒
Actions/Activities/Interventions: According to **Region IV Area Agency on Aging**'s MI Choice Quality Management Plan FY' 2020 & FY' 2021, dated January 15, 2020, **Region IV Area Agency on Aging** planned to complete the following tasks: • [None identified] The **Region IV Area Agency on Aging** MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2020 dated January 4, 2021 identified the following: • State Goal not yet met. • **Region IV Area Agency on Aging** has begun focus on this indicator in Dec 2020 by analyzing the detailed QI report. • **Region IV Area Agency on Aging** staff had education provided on proper use of fracture questions on iHC assessment on 12/17/20.		
5. *Prevalence of Dehydration*	State Goal: 1.5%	SFY 2019 = [No baseline data reported] SFY 2020 = 3% ☒
Actions/Activities/Interventions: According to **Region IV Area Agency on Aging**'s MI Choice Quality Management Plan FY' 2020 & FY' 2021, dated January 15, 2020, **Region IV Area Agency on Aging** planned to complete the following tasks: • [None identified] The **Region IV Area Agency on Aging** MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2020 dated January 4, 2021 identified the following:		

QIP Topic	Goal†	Measurement and Outcome
• On August 20, 2020 the **Region IV Area Agency on Aging** MI Choice Quality Committee organized a training with the local hospital Spectrum Health Lakeland to provide an in-service for all staff on dehydration. Although we did not meet our goal of 1.5% we did significantly decrease our percentage of those with dehydration from an high of almost 4% to half that at 1.9% in our fourth quarter.		

FY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
†QIP goals were identified through the annual report as no goals were included as part of the QMP.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Region IV Area Agency on Aging met the state goal for the *Prevalence of Neglect/Abuse* QIP, suggesting that **Region IV Area Agency on Aging**'s members experienced a lower prevalence of incidents of reported neglect/abuse.

Weaknesses and Recommendations

Weakness #1: Region IV Area Agency on Aging did not identify any goals for the QIPs in the SFY 2020–2021 QMP. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each measure needs to be clearly and consistently documented.

Why the weakness exists: Although the statewide goal was identified in the SFY 2020 annual report, **Region IV Area Agency on Aging**'s SFY 2020–2021 QMP did not initially establish any goals for the QIPs. Once a QIP is selected by the QMC, the QMP should be updated with **Region IV Area Agency on Aging**'s internally established goals. Further, the goals only indicated a percentage, but not whether the performance outcome was to be above or below that percentage.

Recommendation: HSAG recommends that **Region IV Area Agency on Aging** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should be documented within its QMP, and an evaluation of these specific goals should be included in the annual report.

Weakness #2: Region IV Area Agency on Aging did not measure improvements to the quality indicators on an ongoing basis. To effectively measure improvement in the quality indicators, it is important to identify and measure a baseline rate.

Why the weakness exists: **Region IV Area Agency on Aging** did not indicate the baseline for each quality indicator within its QMP reports.

Recommendation: HSAG recommends **Region IV Area Agency on Aging** identify the baseline period and rate for each quality indicator and measure them regularly to determine if interventions implemented are effective.

Weakness #3: **Region IV Area Agency on Aging**'s interventions appeared to be ineffective as it did not meet the statewide goals for four QIPs. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly documented.

Why the weakness exists: **Region IV Area Agency on Aging**'s SFY 2020 annual report listed some activities conducted; however, the SFY 2020 annual report did not identify the interventions for all QIPs, or include an assessment of whether a specific intervention(s) was successful or unsuccessful in achieving increased performance. Further, no conclusions were drawn regarding whether the interventions had an impact on the rate.

Recommendation: HSAG recommends that **Region IV Area Agency on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Region IV Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Region IV Area Agency on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #4: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **Region IV Area Agency on Aging**'s QIPs must be designed in a methodically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions.

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2020 annual report included limited details on the design developed and methodology followed by **Region IV Area Agency on Aging** when implementing its QIPs.

Recommendation: HSAG recommends that **Region IV Area Agency on Aging** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Region IV Area Agency on Aging** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2020, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For eight of the 39 performance measures calculated by MDHHS, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Those performance measures with a statewide rate of 100 percent reported through the CMS-372 report were not included as part of the assessment. Table 3-32 displays the eight performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rate as calculated by MDHHS for the CMS-372 report, the statewide percentage rate as calculated by HSAG using the CQAR standard scores associated with each performance measure, and **Region IV Area Agency on Aging**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Region IV Area Agency on Aging**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate as calculated by HSAG, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-32—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* VIII.1, VIII.2, VIII.4, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39	**91.27**	**92.11**	**92.35**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* I.1, I.2, I.3, I.5, II.1, II.2, II.3, II.4, II.5, II.6, II.7, II.8, II.9, IV.1, IV.2, IV.3, IV.5, IV.6, VI.1, VI.2, VI.3, X.1	**96.83**	**98.82**	**98.95**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* V.3, IX.1, IX.2, IX.3, IX.6	**93.65**	**94.16**	**95.65**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* VIII.7, VIII.8	**98.94**	**99.07**	**100**

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* VIII.3, VIII.5, VIII.6, VIII.11	**98.41**	**98.81**	**100**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* V.1, V.2, V.3, V.5, V.10, V.11, V.13, V.15, VI.12, VI.14, VI.16, VIII.1, VIII.2, VIII.3 VIII.4,VIII.5, VIII.6, VIII.11, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39, VIII.40, VIII.41, IX.1, IX.2, IX.3, IX.4, IX.6	**94.97**	**94.13**	**93.26**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* VIII.28, VIII.29, VIII.30, VIII.31, VIII.32, VIII.33, VIII.34, IX.5	**96.03**	**95.54**	**95.24**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* XI.1, XI.3, XI.4	**89.68**	**93.52**	**100**

* The individual waiver agency performance measure rates were derived from the standards outlined in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report.

**Statewide percentage rates are displayed as reported by MDHHS. HSAG's calculations may differ from MDHHS' calculations as HSAG summed all numerators and denominators related to the CQAR standards included as part of each performance measure, while MDHHS calculated performance measure rates for the CMS-372 report using a total count of CQAR records reviewed across the waiver agencies and removing those records from the numerator when a standard included as part of the performance measure was deficient ("*Non-Evident*").

‡ The statewide percentage rates determined by HSAG were based on results of the SFY 2020 CQAR and the standards associated with each performance measure as indicated in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source." The statewide percentage rates determined by HSAG are displayed for comparison purposes to the MDHHS statewide percentages. Additionally, the HSAG calculated rates were made available for this report to ensure an appropriate representation to the rates calculated for each waiver agency.

Indicates the performance measure rate is higher than the statewide rate as calculated by HSAG.

Indicates the performance measure rate is lower than the statewide rate as calculated by HSAG.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Although MDHHS has not established performance measure benchmarks, **Region IV Area Agency on Aging**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 7, 8, 12, 22, 24, 27, 28, 29, 31, 33, 34, 37, and 38. Performance Measures 36 and 39 also achieved a rate of 100 percent; however, performance in these measures are driven solely by MDHHS as they relate to capitation payments to the waiver agencies.

Strength #2: **Region IV Area Agency on Aging** received a 100 percent performance rating for Performance Measures 16, 17, and 20, indicating members were able to access services in the most appropriate care setting as determined by the member, member's guardian, and waiver agency staff members. Additionally, person-centered service plans reviewed as part of the CQAR included appropriate strategies to address members' assessed health and safety risks and individualized goals and preferences; this suggested that **Region IV Area Agency on Aging** staff members are taking into consideration waiver members' individualized needs, including member-specific health risks, and member preferences when creating service plans, ensuring members are receiving services of the highest quality to meet their own specific and unique needs. Further, person-centered service plans reviewed as part of the CQAR indicated that members received all of the provided services and supports identified appropriately, which suggested that **Region IV Area Agency on Aging** staff members followed up to ensure that members continually received the services and supports they needed as identified in their person-centered service plans.

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial trends of weakness. While Performance Measures 18 and 19 did not meet the statewide performance rate, neither performance measure fell below the statewide rate by more than 5 percentage points.

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: MDHHS required **Region IV Area Agency on Aging** to submit a CAP to remediate the deficiencies identified through the CQAR that are used to calculate the performance rates for Performance Measures 18 and 19. **Region IV Area Agency on Aging**'s CAP included, but was not limited to, staff training and implementation of a secondary review process. However, the CAP also indicated internal monitoring is required by **Region IV Area Agency on Aging** until compliance in excess of 85 or 90 percent (depending on the requirement) is achieved. Therefore, HSAG recommends that **Region IV Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-33 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-33 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-33—Clinical Quality Assurance Reviews and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus I	Level of Care Determination	100%	100%	**4.00**
Focus I.B	Communication		100%	**4.00**
Focus II	Freedom of Choice	100%		**4.00**
Focus III	Release of Information	97.73%		**4.00**
Focus IV	Status	95.00%		**4.00**
Focus V	Pre-Planning	88.36%	100%	**4.00**
Focus VI	Assessment	96.32%	100%	**4.00**
Focus VII	Medication Record	90.57%	100%	**4.00**
Focus VIII	Person-Centered Service Planning	96.47%	100%	**4.00**
Focus IX	MI Choice Services	94.79%	100%	**4.00**
Focus X	Linking and Coordinating	98.25%	100%	**4.00**
Focus XI	Follow-Up and Monitoring	91.18%	100%	**4.00**
Focus XII	Service Provider	100%		**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus XIII	Contingency Plan	83.78%	100%	**4.00**
Focus XIV	Critical Incidents	90.00%	100%	**4.00**
Focus XV	Adverse Benefit Determination	94.44%		**4.00**
Focus XVI	Complaints and Grievances	87.50%		**4.00**
Focus XVII	Home and Community Based		100%	**N/A**
	Totals	**94.87%**	**100%**	**4.00**

	Indicates the standard was not reviewed as part of the record review or home visit.
	Indicates substantial compliance: 3.26 or higher.
	Indicates some compliance, needs improvement: 2.51 to 3.25.
	Indicates not full or substantial compliance: 1.76 to 2.50.
	Indicates compliance not demonstrated: 1.00 to 1.75.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: A review of nine home visits was conducted and all reviews achieved full compliance. The purpose of the home visits is to confirm that providers furnish services according to the person-centered service plan and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested that members are receiving services in accordance with their service plans and preferences, and are satisfied with those services.

Strength #2: Region IV Area Agency on Aging achieved a substantial compliance rating in 17 of the 17 applicable standards reviewed as part of the CQAR. The purpose of the record review is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the person-centered service plan and care planning process, reassessment data) and to assess the quality of waiver agency services to each member; therefore, CQAR findings suggested that person-centered service plans and service delivery are being implemented in accordance with many State and federal requirements.

Weaknesses and Recommendations

Weakness #1: Region IV Area Agency on Aging did not receive any compliance determinations that were in the *not full or substantial compliance* or *compliance not demonstrated* rating categories; therefore, no substantial weaknesses were identified.

Why the weakness exists: This section is not applicable as there were no substantial areas of weakness for **Region IV Area Agency on Aging**.

Recommendation: This section is not applicable as there were no substantial areas of weakness for **Region IV Area Agency on Aging**; therefore, HSAG has no recommendations for improvement.

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

To identify strengths and weaknesses and draw conclusions for **Region IV Area Agency on Aging**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Region IV Area Agency on Aging** across all EQR activities. The overarching aggregated findings showed that **Region IV Area Agency on Aging**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Region IV Area Agency on Aging** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

HSAG's assessment of **Region IV Area Agency on Aging** also identified opportunities for **Region IV Area Agency on Aging** to enhance its quality assessment and performance improvement program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Region IV Area Agency on Aging** had a QMP that included brief descriptions of its quality management activities, its QMP should be modified to more comprehensively align with the requirements and best practices for a quality assessment and performance improvement program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Region VII Area Agency on Aging

Validation of Performance Improvement Projects

Performance Results

Table 3-34 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2020. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Region VII Area Agency on Aging** met its internal SFY 2020 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Region VII Area Agency on Aging** did not meet its internal SFY 2020 QIP goal or the statewide goal. Any interventions described within **Region VII Area Agency on Aging**'s QMP reports are also provided in Table 3-34. The results in Table 3-34 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-34—QIP Results

QIP Topic	Goal	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Reduce the percentage of MI Choice Waiver participants who have been neglected/abused, have poor hygiene, are fearful of family member, or have been restrained to a statewide average of 5.0% or less	SFY 2019 = 6.4% SFY 2020 = 4.9% ☑
Actions/Activities/Interventions: According to **Region VII Area Agency on Aging**'s MI Choice Waiver Quality Management Plan (QMP) FY 2020 – FY 2021 dated January 15, 2020, **Region VII Area Agency on Aging** planned to complete the following tasks: • **Region VII Area Agency on Aging** participants are monitored for neglect, abuse, poor hygiene, and fear of family members by the Supports Coordinators (SCs) at the initial assessment, reassessments at least every 180 days, and with monitoring contacts every 90 days or less. • SCs who suspect any incidence of neglect or abuse immediately report the information obtained to their Waiver Manager, Adult Protective Services, and, if the participant is in imminent danger emergency services is contacted. • A Critical Incident is completed for reporting to MDHHS along with a resolution. SCs also follow up with the participant to offer additional services as needed including respite care and future planning to prevent future neglect or abuse. The **Region VII Area Agency on Aging** MI Choice Summary of Quality Management Plan (QMP) Activities & Outcomes Report FY 2020 dated January 27, 2021 identified the following: • **Region VII Area Agency on Aging** met the goal for a statewide average of 5.0% or less for prevalence of neglect/abuse and will continue to strive to reduce this number in FY 2021.		

QIP Topic	Goal	Measurement and Outcome
2. *Prevalence of Pain With Inadequate Pain Control*	Reduce the percentage of MI Choice Waiver participants who experience pain and experience inadequate pain control on regimen or breakthrough pain or sometimes severe or excruciatingly intense pain to a statewide average of 20% or less.	SFY 2019 = 28.1% SFY 2020 = 23.3% ☒
Actions/Activities/Interventions: According to **Region VII Area Agency on Aging**'s MI Choice Waiver Quality Management Plan (QMP) FY 2020 – FY 2021 dated January 15, 2020, **Region VII Area Agency on Aging** planned to complete the following tasks: • **Region VII Area Agency on Aging** SCs assess all MI Choice Waiver Participants for adequate pain control during initial assessment, reassessment at least every 180 days, reassessment within 30 days of a hospitalization, and with monitoring contacts every 90 days or less. • SCs educate participants on pain management and medication regimens with regard to pain medication. • Supports Coordinators offer assistance to participants in contacting their primary care physician for a referral to pain clinics. • **Region VII Area Agency on Aging** also offers participants assistance with medication reconciliation and occupational therapy referrals through a contracted pharmacist and physical therapist to assist with meeting their care needs. The **Region VII Area Agency on Aging** MI Choice Summary of Quality Management Plan (QMP) Activities & Outcomes Report FY 2020 dated January 27, 2021 identified the following: • **Region VII Area Agency on Aging** fell below the goal for a statewide average of 20% or less for prevalence of pain with inadequate pain control. It should be noted, however, that this was an improvement of 4.8% from 28.1% in FY 2019. • **Region VII Area Agency on Aging** will continue to strive to reduce this number and meet the statewide goal in FY 2021.		
3. *Prevalence of Falls*	Reduce the percentage of MI Choice Waiver participants who record a fall on follow-up assessment to a statewide average of 25% or less.	SFY 2019 = 31.7% SFY 2020 = 32.7% ☒
Actions/Activities/Interventions: According to **Region VII Area Agency on Aging**'s MI Choice Waiver Quality Management Plan (QMP) FY 2020 – FY 2021 dated January 15, 2020, **Region VII Area Agency on Aging** planned to complete the following tasks: • **Region VII Area Agency on Aging** SCs assess all MI Choice Waiver Participants for falls during initial assessment, reassessment at least every 180 days, reassessment within 30 days of a hospitalization, and with monitoring contacts every 90 days or less. • SCs educate participants on fall prevention. • SCs offer assistance to participants in contacting their primary care physician for referrals to skilled care for skilled nursing, physical therapy, or occupational therapy.		

QIP Topic	Goal	Measurement and Outcome
• **Region VII Area Agency on Aging** also offers participants assistance with medication reconciliation, occupational therapy, additional RN visits, and additional social worker visits to assist with meeting their care needs through the MICapable Program that is offered to all Waiver participants to improve their physical mobility and quality of life in community based settings. • Any falls that result in injury requiring medical treatment are reported to MDHHS as Critical Incidents including resolution. • Assisted living and AFC providers are required to submit an incident report to Region VII for any falls that Waiver participants experience at their facility along with their resolution for fall prevention. • All in-home community living supports (CLS) providers are also required to notify **Region VII Area Agency on Aging** of any falls or health issues that participants may experience under their care. • **Region VII Area Agency on Aging** also assists with any durable medical equipment needs that a participant may have. The **Region VII Area Agency on Aging** MI Choice Summary of Quality Management Plan (QMP) Activities & Outcomes Report FY 2020 dated January 27, 2021 identified the following: • **Region VII Area Agency on Aging** fell below the goal for a statewide average of 25% or less for prevalence of falls. This may be attributed to difficulties with caregivers not being present at times related to the pandemic in FY 2020. • **Region VII Area Agency on Aging** will work to develop new strategies for fall prevention and monitor reported falls for trends. • **Region VII Area Agency on Aging** will continue to strive to reduce this number in FY 2021.		
4. *Prevalence of Any Injuries*	Reduce the percentage of MI Choice Waiver participants with fractures or major skin problems, excluding current pressure or stasis ulcers to a statewide average of 5.0% or less.	SFY 2019 = 5.2% SFY 2020 = 5.4% ☒
Actions/Activities/Interventions: According to **Region VII Area Agency on Aging**'s MI Choice Waiver Quality Management Plan (QMP) FY 2020 – FY 2021 dated January 15, 2020, **Region VII Area Agency on Aging** planned to complete the following tasks: • **Region VII Area Agency on Aging** SCs assess all MI Choice Waiver Participants for any injuries, including fractures or major skin problems during initial assessment, reassessment at least every 180 days, reassessment within 30 days of a hospitalization, and with monitoring contacts every 90 days or less. • SCs educate participants on fall prevention, skin care, nutrition, incontinence care, and pressure relief. • SCs offer assistance to participants in contacting their primary care physician for referrals to skilled care for skilled nursing, physical therapy, or occupational therapy. • **Region VII Area Agency on Aging** also offers participants assistance with medication reconciliation, occupational therapy, additional RN visits, and additional social worker visits to assist with meeting their care needs through the MICapable Program that is offered to all Waiver participants to improve their physical mobility and quality of life in community based settings. • Any injuries requiring medical treatment are reported to MDHHS as Critical Incidents including resolution.		

QIP Topic	Goal	Measurement and Outcome
• Assisted living and AFC providers are required to submit an incident report to **Region VII Area Agency on Aging** for any injuries that Waiver participants experience at their facility along with their resolution to the incident. • All in-home CLS providers are also required to notify **Region VII Area Agency on Aging** of any injuries or health issues that participants may experience under their care. • **Region VII Area Agency on Aging** also assists with any durable medical equipment needs that a participant may have. The **Region VII Area Agency on Aging** MI Choice Summary of Quality Management Plan (QMP) Activities & Outcomes Report FY 2020 dated January 27, 2021 identified the following: • **Region VII Area Agency on Aging** fell slightly short of the goal for a statewide average of 5.0% or less for prevalence of any injuries. This may be attributed to difficulties with caregivers not being present at times related to the pandemic in FY 2020. • **Region VII Area Agency on Aging** will work to develop new strategies for injury prevention and monitor reported falls for trends. • **Region VII Area Agency on Aging** will continue to strive to reduce this number in FY 2021.		
5. *Prevalence of Dehydration*	Reduce the percentage of MI Choice Waiver participants who have insufficient fluid intake to a statewide average of 2.0% or less.	SFY 2019 = 3.6% SFY 2020 = 3.0% ☒
Actions/Activities/Interventions: According to **Region VII Area Agency on Aging**'s MI Choice Waiver Quality Management Plan (QMP) FY 2020 – FY 2021 dated January 15, 2020, **Region VII Area Agency on Aging** planned to complete the following tasks: • **Region VII Area Agency on Aging** participants are monitored for dehydration (insufficient fluid intake) by the SCs at the initial assessment, and at reassessments at least every 180 days. • When dehydration is identified as an issue, SCs educate participants on fluid intake and signs/symptoms of dehydration and instruct them to contact their primary care physician when signs/symptoms of dehydration are present. • SCs who identify dehydration as a possible issue for participants in an assisted living or AFC also educate the staff at that facility on dehydration and the need to monitor the participant and offer fluids at regular intervals. The **Region VII Area Agency on Aging** MI Choice Summary of Quality Management Plan (QMP) Activities & Outcomes Report FY 2020 dated January 27, 2021 identified the following: • **Region VII Area Agency on Aging** fell below the goal for a statewide average of 2.0% or less for prevalence of dehydration. It should be noted, however, that this was an improvement of 0.6% from 3.6% in FY 2019. • **Region VII Area Agency on Aging** will continue to strive to reduce this number and meet the statewide goal in FY 2021.		

FY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Region VII Area Agency on Aging measured each quality indicator against a baseline rate on an ongoing basis.

Strength #2: Region VII Area Agency on Aging met its internal goal for the *Prevalence of Neglect/Abuse* QIP and demonstrated a reduction in the prevalence rate compared to its baseline rate, indicating that **Region VII Area Agency on Aging**'s members are experiencing less incidents of reported neglect/abuse than the prior year.

Weaknesses and Recommendations

Weakness #1: The **Region VII Area Agency on Aging** goals indicated in the SFY 2020–2021 QMP did not specifically indicate the date by which the goal was to be achieved and did not align with the MDHHS goals associated with the QIPs.

Why the weakness exists: The goals for each quality indicator were stated in the SFY 2020–2021 QMP dated January 15, 2020, under a header titled "FY 2021 Quality Improvement Projects, Goals, Strategies, and Results"; since the QMP was dated January 15, 2020, it was unclear if the goal was for SFY 2020 or if the QMP was updated with a new goal for SFY 2021, but the date on the QMP was not revised. Further, in comparing the rates against the goal, **Region VII Area Agency on Aging** indicated that the rate fell below the goal when trying to convey that the goal was not met. In the case of these quality indicators, a lower score is better, so the evaluation is incorrect.

Recommendation: HSAG recommends that **Region VII Area Agency on Aging** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. Additionally, **Region VII Area Agency on Aging** should ensure that the evaluation of the measured rates against the goals are reported accurately.

Weakness #2: The interventions implemented by **Region VII Area Agency on Aging** did not appear to be effective as prevalence rates increased for the *Prevalence for Falls* and *Prevalence of Any Injuries* QIPs. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly documented.

Why the weakness exists: Region VII Area Agency on Aging demonstrated an increase in prevalence rates for two QIPs. Additionally, documentation did not consistently support that a comprehensive causal/barrier analysis was conducted and that an evaluation occurred for each intervention to determine its effectiveness and ensure each intervention was logically linked to any identified barriers.

Recommendation: HSAG recommends that **Region VII Area Agency on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes) and innovative (e.g., not an activity already included as part of the expected care management

processes). **Region VII Area Agency on Aging** should also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Region VII Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Region VII Area Agency on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #3: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **Region VII Area Agency on Aging**'s QIPs must be designed in a methodically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions.

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2020 annual report included limited details on the design developed and methodology followed by **Region VII Area Agency on Aging** when implementing its QIPs.

Recommendation: HSAG recommends that **Region VII Area Agency on Aging** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Region VII Area Agency on Aging** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2020, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For eight of the 39 performance measures calculated by MDHHS, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Those performance measures with a statewide rate of 100 percent reported through the CMS-372 report were not included as part of the assessment. Table 3-35 displays the eight performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rate as calculated by MDHHS for the CMS-372 report, the statewide percentage rate as calculated by HSAG using the CQAR standards associated with each performance measure, and **Region VII Area Agency on Aging**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Region VII Area Agency on Aging**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate as calculated by HSAG, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-35—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* VIII.1, VIII.2, VIII.4, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39	**91.27**	**92.11**	**98.57**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* I.1, I.2, I.3, I.5, II.1, II.2, II.3, II.4, II.5, II.6, II.7, II.8, II.9, IV.1, IV.2, IV.3, IV.5, IV.6, VI.1, VI.2, VI.3, X.1	**96.83**	**98.82**	**100**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* V.3, IX.1, IX.2, IX.3, IX.6	**93.65**	**94.16**	**92.92**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* VIII.7, VIII.8	**98.94**	**99.07**	**100**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* VIII.3, VIII.5, VIII.6, VIII.11	**98.41**	**98.81**	**100**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* V.1, V.2, V.3, V.5, V.10, V.11, V.13, V.15, VI.12, VI.14, VI.16, VIII.1, VIII.2, VIII.3 VIII.4,VIII.5, VIII.6, VIII.11, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39, VIII.40, VIII.41, IX.1, IX.2, IX.3, IX.4, IX.6	**94.97**	**94.13**	**98.24**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* VIII.28, VIII.29, VIII.30, VIII.31, VIII.32, VIII.33, VIII.34, IX.5	**96.03**	**95.54**	**96.77**

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* XI.1, XI.3, XI.4	**89.68**	**93.52**	**89.66**

* The individual waiver agency performance measure rates were derived from the standards outlined in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report.

**Statewide percentage rates are displayed as reported by MDHHS. HSAG's calculations may differ from MDHHS' calculations as HSAG summed all numerators and denominators related to the CQAR standards included as part of each performance measure, while MDHHS calculated performance measure rates for the CMS-372 report using a total count of CQAR records reviewed across the waiver agencies and removing those records from the numerator when a standard included as part of the performance measure was deficient ("*Non-Evident*").

‡ The statewide percentage rates determined by HSAG were based on results of the SFY 2020 CQAR and the standards associated with each performance measure as indicated in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source." The statewide percentage rates determined by HSAG are displayed for comparison purposes to the MDHHS statewide percentages. Additionally, the HSAG calculated rates were made available for this report to ensure an appropriate representation to the rates calculated for each waiver agency.

Indicates the performance measure rate is higher than the statewide rate as calculated by HSAG.

Indicates the performance measure rate is lower than the statewide rate as calculated by HSAG.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Although MDHHS has not established performance measure benchmarks, **Region VII Area Agency on Aging**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 7, 8, 12, 22, 24, 27, 28, 29, 31, 33, 34, 37, and 38. Performance Measures 36 and 39 also achieved a rate of 100 percent; however, performance in these measures are driven solely by MDHHS as they relate to capitation payments to the waiver agencies.

Strength #2: Region VII Area Agency on Aging received a 100 percent performance rating for Performance Measures 2, 16, and 17, indicating members were appropriately evaluated and determined to meet the level of care necessary to receive services under the waiver program and, subsequently, were able to access services in the most appropriate care setting as determined by the member, member's guardian, and waiver agency staff members. Additionally, person-centered service plans reviewed as part of the CQAR included appropriate strategies to address members' assessed health and safety risks and individualized goals and preferences, which suggested that **Region VII Area Agency on Aging** staff members are taking into consideration waiver members' individualized

needs, including member-specific health risks, and member preferences when creating service plans, ensuring members are receiving services of the highest quality to meet their own specific and unique needs.

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial trends of weakness. While Performance Measures 15 and 20 did not meet the statewide performance rate, neither measure fell below the statewide rate by more than 5 percentage points.

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: MDHHS required **Region VII Area Agency on Aging** to submit a CAP to remediate the deficiencies identified through the CQAR that are used to calculate the performance rates for Performance Measures 15 and 20. **Region VII Area Agency on Aging**'s CAP included, but was not limited to, staff training and a review of at least two chart audits per supports coordinator each quarter. However, the CAP also indicated internal monitoring is required by **Region VII Area Agency on Aging** until compliance in excess of 85 or 90 percent (depending on the requirement) is achieved. Therefore, HSAG recommends that **Region VII Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-36 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-36 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-36—Clinical Quality Assurance Reviews and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus I	Level of Care Determination	100%	100%	**4.00**
Focus I.B	Communication		100%	**4.00**
Focus II	Freedom of Choice	100%		**4.00**
Focus III	Release of Information	100%		**4.00**
Focus IV	Status	100%		**4.00**
Focus V	Pre-Planning	99.17%	100%	**4.00**
Focus VI	Assessment	98.59%	100%	**4.00**
Focus VII	Medication Record	93.99%	100%	**4.00**
Focus VIII	Person-Centered Service Planning	98.81%	100%	**4.00**
Focus IX	MI Choice Services	92.31%	100%	**4.00**
Focus X	Linking and Coordinating	96.43%	100%	**4.00**
Focus XI	Follow-Up and Monitoring	80.70%	100%	**3.33**
Focus XII	Service Provider	94.12%		**4.00**
Focus XIII	Contingency Plan	96.92%	100%	**4.00**
Focus XIV	Critical Incidents	100%	100%	**4.00**
Focus XV	Adverse Benefit Determination	83.33%		**4.00**
Focus XVI	Complaints and Grievances	100%		**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus XVII	Home and Community Based		100%	**4.00**
	Totals	**97.33%**	**100%**	**3.98**

	Indicates the standard was not reviewed as part of the record review or home visit.
	Indicates substantial compliance: 3.26 or higher.
	Indicates some compliance, needs improvement: 2.51 to 3.25.
	Indicates not full or substantial compliance: 1.76 to 2.50.
	Indicates compliance not demonstrated: 1.00 to 1.75.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: A review of 14 home visits was conducted and all reviews achieved full compliance. The purpose of the home visits is to confirm that providers furnish services according to the person-centered service plan and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested that members are receiving services in accordance with their service plans and preferences, and are satisfied with those services.

Strength #2: Region VII Area Agency on Aging achieved a substantial compliance rating in all 18 standards reviewed as part of the CQAR. The purpose of the record review is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the person-centered service plan and care planning process, reassessment data) and to assess the quality of waiver agency services to each member; therefore, CQAR findings suggested that person-centered service plans and service delivery are being implemented in accordance with many State and federal requirements.

Weaknesses and Recommendations

Weakness #1: Region VII Area Agency on Aging did not receive any compliance determinations that were in the *not full or substantial compliance* or *compliance not demonstrated* rating categories; therefore, no substantial weaknesses were identified.

Why the weakness exists: This section is not applicable as there were no substantial areas of weakness for **Region VII Area Agency on Aging**.

Recommendation: This section is not applicable as there were no substantial areas of weakness for **Region VII Area Agency on Aging**; therefore, HSAG has no recommendations for improvement.

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

To identify strengths and weaknesses and draw conclusions for **Region VII Area Agency on Aging**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Region VII Area Agency on Aging** across all EQR activities. The overarching aggregated findings showed that **Region VII Area Agency on Aging**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Region VII Area Agency on Aging** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

HSAG's assessment of **Region VII Area Agency on Aging** also identified opportunities for **Region VII Area Agency on Aging** to enhance its quality assessment and performance improvement program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Region VII Area Agency on Aging** had a QMP that included brief descriptions of its quality management activities, its QMP should be modified to more comprehensively align with the requirements and best practices for a quality assessment and performance improvement program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Region 9 Area Agency on Aging

Validation of Performance Improvement Projects

Performance Results

Table 3-37 displays the results for each QIP implemented during SFY 2020. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Region 9 Area Agency on Aging** met its internal SFY 2020 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Region 9 Area Agency on Aging** did not meet its internal SFY 2020 QIP goal or the statewide goal, as applicable. Any interventions described within **Region 9 Area Agency on Aging**'s QMP reports are also provided in Table 3-37. The results in Table 3-37 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-37—QIP Results

QIP Topic	Goal†	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Prevalence of neglect and abuse: Goal less than 5%	SFY 2019 = [No baseline data reported] SFY 2020* = [1.69%] ☑
Actions/Activities/Interventions: **Region 9 Area Agency on Aging**'s MI Choice Quality Management Plan Fiscal Years 2020 and 2021 dated January 13, 2020, identified that **Region 9 Area Agency on Aging** determined a baseline set for the indicators. From this data, quality indicator goals were determined. The primary goal will be to **Region 9 Area Agency on Aging** achieve better quality indicator scores than FY 2019. A secondary goal will be to ensure that **Region 9 Area Agency on Aging**'s quality scores maintain a rate lower than the statewide average. **Region 9 Area Agency on Aging**'s planned actions to achieve the goal are: • Review data obtained from the quality indicator reports and will act on any category which exceeds the statewide average • Quarterly reviews of quality reports provide a list of individuals that fall within each indicator based on their assessment. The Support Coordinators will be notified of these participants to ensure that ongoing monitoring specifically addresses the identified concern and that all available resources have been offered in attempts to mitigate future occurrences. According to **Region 9 Area Agency on Aging**'s MI Choice Quality Management Plan Activities and Outcomes Report Fiscal Year 2020 report dated January 26, 2021, **Region 9 Area Agency on Aging**'s identified that as a result of the public health emergency related to the COVID-19 Pandemic, barriers have been present in the implementation of the Quality Management Plan. The primary barrier is the result of limited to no in-person communications with participants and providers. Consumer Quality Councils are only hosted virtually. No person received an in-person satisfaction survey. Additionally, the ability to ensure accurate information is limited by over the phone assessments. Under the current pandemic policies for home visits, Supports Coordinators cannot adequately assess the home environments of participants. This inhibits Support Coordinators ability to make		

QIP Topic	Goal†	Measurement and Outcome
recommendations that impact participant health and safety and impact quality goals. **Region 9 Area Agency on Aging** identified the following actions and outcomes for SFY 2020. *Actions* • A robust ongoing education plan for abuse and neglect issues is employed. Additionally, staff monitor participants monthly allowing for potential issues to be addressed quickly. *Outcomes* • **Region 9 Area Agency on Aging** was able to reduce prevalence in quarters three and four.		
2. *Prevalence of Pain With Inadequate Pain Control*	Prevalence of pain with inadequate pain control: Goal less than 20%	SFY 2019 = [No baseline data reported] SFY 2020* = [13.69%] ☑
Actions/Activities/Interventions: **Region 9 Area Agency on Aging**'s Mi Choice Quality Management Plan Fiscal Years 2020 and 2021 dated January 13, 2020, identified that **Region 9 Area Agency on Aging** determined a baseline set for the indicators. From this data, quality indicator goals were determined. The primary goal will be to **Region 9 Area Agency on Aging** achieve better quality indicator scores than FY 2019. A secondary goal will be to ensure that **Region 9 Area Agency on Aging**'s quality scores maintain a rate lower than the statewide average. **Region 9 Area Agency on Aging**'s planned actions to achieve the goal are: • Review data obtained from the quality indicator reports and will act on any category which exceeds the statewide average • Quarterly reviews of quality reports provide a list of individuals that fall within each indicator based on their assessment. The Support Coordinators will be notified of these participants to ensure that ongoing monitoring specifically addresses the identified concern and that all available resources have been offered in attempts to mitigate future occurrences. According to **Region 9 Area Agency on Aging**'s MI Choice Quality Management Plan Activities and Outcomes Report Fiscal Year 2020 report dated January 26, 2021, **Region 9 Area Agency on Aging**'s identified that as a result of the public health emergency related to the COVID-19 Pandemic, barriers have been present in the implementation of the Quality Management Plan. The primary barrier is the result of limited to no in-person communications with participants and providers. Consumer Quality Councils are only hosted virtually. No person received an in-person satisfaction survey. Additionally, the ability to ensure accurate information is limited by over the phone assessments. Under the current pandemic policies for home visits, Supports Coordinators cannot adequately assess the home environments of participants. This inhibits Support Coordinators ability to make recommendations that impact participant health and safety and impact quality goals. **Region 9 Area Agency on Aging** identified the following for SFY 2020: • **Region 9 Area Agency on Aging**'s performance on pain control falls below the statewide goal and statewide average. No further activities than originally outlined were performed. Participants are always encouraged to seek medical care for uncontrolled pain and encouraged to utilize non-pharmalogical pain control methods approved by their primary care providers.		

QIP Topic	Goal†	Measurement and Outcome
3. *Prevalence of Falls*	Prevalence of falls: Goal less than 27%	SFY 2019 = [No baseline data reported] SFY 2020* = [29.24%] ☒

Actions/Activities/Interventions:

Region 9 Area Agency on Aging's Mi Choice Quality Management Plan Fiscal Years 2020 and 2021 dated January 13, 2020, identified that **Region 9 Area Agency on Aging** determined a baseline set for the indicators. From this data, quality indicator goals were determined. The primary goal will be to **Region 9 Area Agency on Aging** achieve better quality indicator scores than FY 2019. A secondary goal will be to ensure that **Region 9 Area Agency on Aging**'s quality scores maintain a rate lower than the statewide average. **Region 9 Area Agency on Aging**'s planned actions to achieve the goal are:

- Review data obtained from the quality indicator reports and will act on any category which exceeds the statewide average
- Quarterly reviews of quality reports provide a list of individuals that fall within each indicator based on their assessment. The Support Coordinators will be notified of these participants to ensure that ongoing monitoring specifically addresses the identified concern and that all available resources have been offered in attempts to mitigate future occurrences.

According to **Region 9 Area Agency on Aging**'s MI Choice Quality Management Plan Activities and Outcomes Report Fiscal Year 2020 report dated January 26, 2021, **Region 9 Area Agency on Aging**'s identified that as a result of the public health emergency related to the COVID-19 Pandemic, barriers have been present in the implementation of the Quality Management Plan. The primary barrier is the result of limited to no in-person communications with participants and providers. Consumer Quality Councils are only hosted virtually. No person received an in-person satisfaction survey. Additionally, the ability to ensure accurate information is limited by over the phone assessments. Under the current pandemic policies for home visits, Supports Coordinators cannot adequately assess the home environments of participants. This inhibits Support Coordinators ability to make recommendations that impact participant health and safety and impact quality goals. **Region 9 Area Agency on Aging** identified the following actions for SFY 2020:

- **Region 9 Area Agency on Aging** had planned to focus significant efforts on reducing falls in FY2020. In 2019, all staff received training through Capable, which addressed the issues of injuries and falls in the home. Further training was planned for FY 2020 utilizing the CDC STEDI program; however, efforts were hampered by the effects of the Pandemic. The inability to perform in person and home environment assessments had hindered any further work on this measure during FY2020.

4. *Prevalence of Any Injuries*	Prevalence of any injuries: Goal less than 5.5%	SFY 2019 = [No baseline data reported] SFY 2020* = [5.16%] ☑

Actions/Activities/Interventions:

Region 9 Area Agency on Aging's Mi Choice Quality Management Plan Fiscal Years 2020 and 2021 dated January 13, 2020, identified that **Region 9 Area Agency on Aging** determined a baseline set for the indicators. From this data, quality indicator goals were determined. The primary goal will be to **Region 9 Area Agency on Aging** achieve better quality indicator scores than FY 2019. A secondary goal will be to ensure that **Region 9 Area Agency on Aging**'s quality scores maintain a rate lower than the statewide average. **Region 9 Area Agency on Aging**'s planned actions to achieve the goal are:

QIP Topic	Goal†	Measurement and Outcome
• Review data obtained from the quality indicator reports and will act on any category which exceeds the statewide average • Quarterly reviews of quality reports provide a list of individuals that fall within each indicator based on their assessment. The Support Coordinators will be notified of these participants to ensure that ongoing monitoring specifically addresses the identified concern and that all available resources have been offered in attempts to mitigate future occurrences. According to **Region 9 Area Agency on Aging**'s MI Choice Quality Management Plan Activities and Outcomes Report Fiscal Year 2020 report dated January 26, 2021, **Region 9 Area Agency on Aging**'s identified that as a result of the public health emergency related to the COVID-19 Pandemic, barriers have been present in the implementation of the Quality Management Plan. The primary barrier is the result of limited to no in-person communications with participants and providers. Consumer Quality Councils are only hosted virtually. No person received an in-person satisfaction survey. Additionally, the ability to ensure accurate information is limited by over the phone assessments. Under the current pandemic policies for home visits, Supports Coordinators cannot adequately assess the home environments of participants. This inhibits Support Coordinators ability to make recommendations that impact participant health and safety and impact quality goals. **Region 9 Area Agency on Aging** identified the following actions for SFY 2020: In FY20, **Region 9 Area Agency on Aging** planned to focus significant efforts on reducing injuries. In 2019, all staff received training through Capable, which addressed the issues of injuries and falls in the home. Further training was planned for FY 2020 utilizing the CDC STEDI program; however, efforts were hampered by the effects of the Pandemic. The inability to perform in person and home environment assessments had hindered any further work on this measure during FY2020.		
5. *Prevalence of Dehydration*	Prevalence of dehydration: Goal less than 2.5%	SFY 2019 = [No baseline data reported] SFY 2020* = [1.94%] ☑
Actions/Activities/Interventions: **Region 9 Area Agency on Aging**'s Mi Choice Quality Management Plan Fiscal Years 2020 and 2021 dated January 13, 2020, identified that **Region 9 Area Agency on Aging** determined a baseline set for the indicators. From this data, quality indicator goals were determined. The primary goal will be to **Region 9 Area Agency on Aging** achieve better quality indicator scores than FY 2019. A secondary goal will be to ensure that **Region 9 Area Agency on Aging**'s quality scores maintain a rate lower than the statewide average. **Region 9 Area Agency on Aging**'s planned actions to achieve the goal are: • Review data obtained from the quality indicator reports and will act on any category which exceeds the statewide average • Quarterly reviews of quality reports provide a list of individuals that fall within each indicator based on their assessment. The Support Coordinators will be notified of these participants to ensure that ongoing monitoring specifically addresses the identified concern and that all available resources have been offered in attempts to mitigate future occurrences. According to **Region 9 Area Agency on Aging**'s MI Choice Quality Management Plan Activities and Outcomes Report Fiscal Year 2020 report dated January 26, 2021, **Region 9 Area Agency on Aging**'s identified that as a result of the public health emergency related to the COVID-19 Pandemic, barriers have been present in the implementation of the Quality Management Plan. The primary barrier is the result of limited to no in-person		

QIP Topic	Goal†	Measurement and Outcome
communications with participants and providers. Consumer Quality Councils are only hosted virtually. No person received an in-person satisfaction survey. Additionally, the ability to ensure accurate information is limited by over the phone assessments. Under the current pandemic policies for home visits, Supports Coordinators cannot adequately assess the home environments of participants. This inhibits Support Coordinators ability to make recommendations that impact participant health and safety and impact quality goals. **Region 9 Area Agency on Aging** identified the following actions and outcomes for SFY 2020: *Actions* • **Region 9 Area Agency on Aging** reviews all individuals on this list and found instances of reporting that did not accurately describe the participant's hydration status. The report does not exclude participants who are on medically prescribed fluid restrictions or end of life care that results in NPO status. *Outcomes* • **Region 9 Area Agency on Aging**'s average consistently remains below the statewide average for this measure.		

FY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
*HSAG calculated the overall SFY 2020 performance rate for each QIP using the numerators and denominators provided by the waiver agency in the annual report.
†QIP goals were identified through the QMP and performance was assessed by HSAG against the percentage rates within these goals.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Region 9 Area Agency on Aging met its goals for four of the five QIPs, suggesting that **Region 9 Area Agency on Aging** had interventions in place to support goal attainment.

Weaknesses and Recommendations

Weakness #1: Although **Region 9 Area Agency on Aging** identified in the SFY 2020–2021 QMP that it had determined a baseline data set for the QIPs, the baseline data set was not included in the SFY 2020–2021 QMP or in the SFY 2020 annual report.

Why the weakness exists: Without baseline rates for the QIPs included in the QMP reports, HSAG was not able to verify improvement from SFY 2019 to SFY 2020.

Recommendation: HSAG recommends that **Region 9 Area Agency on Aging** ensure its QMP and annual report include baseline data and the year-over-year comparative analysis.

Weakness #2: While **Region 9 Area Agency on Aging**'s SFY 2020 annual report was more robust than those submitted by most other waiver agencies, details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the development of relevant interventions to address identified barriers) of the QIPs were limited. **Region 9 Area Agency on Aging**'s QIPs must be designed in a methodically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions.

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2020 annual report included minimal details on QIP design development, the methodology followed, and details into the specific interventions and implementation of those interventions.

Recommendation: HSAG recommends that **Region 9 Area Agency on Aging** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Region 9 Area Agency on Aging** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2020, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For eight of the 39 performance measures calculated by MDHHS, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Those performance measures with a statewide rate of 100 percent reported through the CMS-372 report were not included as part of the assessment. Table 3-38 displays the eight performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rate as calculated by MDHHS for the CMS-372 report, the statewide percentage rate as calculated by HSAG using the CQAR standard scores associated with each performance measure, and **Region 9 Area Agency on Aging**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Region 9 Area Agency on Aging**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate as calculated by HSAG.

Table 3-38—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* VIII.1, VIII.2, VIII.4, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39	**91.27**	**92.11**	**98.57**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* I.1, I.2, I.3, I.5, II.1, II.2, II.3, II.4, II.5, II.6, II.7, II.8, II.9, IV.1, IV.2, IV.3, IV.5, IV.6, VI.1, VI.2, VI.3, X.1	**96.83**	**98.82**	**99.36**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* V.3, IX.1, IX.2, IX.3, IX.6	**93.65**	**94.16**	**98.25**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* VIII.7, VIII.8	**98.94**	**99.07**	**100**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* VIII.3, VIII.5, VIII.6, VIII.11	**98.41**	**98.81**	**100**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* V.1, V.2, V.3, V.5, V.10, V.11, V.13, V.15, VI.12, VI.14, VI.16, VIII.1, VIII.2, VIII.3 VIII.4,VIII.5, VIII.6, VIII.11, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39, VIII.40, VIII.41, IX.1, IX.2, IX.3, IX.4, IX.6	**94.97**	**94.13**	**99.08**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* VIII.28, VIII.29, VIII.30, VIII.31, VIII.32, VIII.33, VIII.34, IX.5	**96.03**	**95.54**	**97.67**

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* XI.1, XI.3, XI.4	**89.68**	**93.52**	**100**

* The individual waiver agency performance measure rates were derived from the standards outlined in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report.

**Statewide percentage rates are displayed as reported by MDHHS. HSAG's calculations may differ from MDHHS' calculations as HSAG summed all numerators and denominators related to the CQAR standards included as part of each performance measure, while MDHHS calculated performance measure rates for the CMS-372 report using a total count of CQAR records reviewed across the waiver agencies and removing those records from the numerator when a standard included as part of the performance measure was deficient ("*Non-Evident*").

‡ The statewide percentage rates determined by HSAG were based on results of the SFY 2020 CQAR and the standards associated with each performance measure as indicated in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source." The statewide percentage rates determined by HSAG are displayed for comparison purposes to the MDHHS statewide percentages. Additionally, the HSAG calculated rates were made available for this report to ensure an appropriate representation to the rates calculated for each waiver agency.

Indicates the performance measure rate is higher than the statewide rate as calculated by HSAG.

Indicates the performance measure rate is lower than the statewide rate as calculated by HSAG.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Although MDHHS has not established performance measure benchmarks, **Region 9 Area Agency on Aging**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 7, 8, 12, 22, 24, 27, 28, 29, 31, 33, 34, 37, and 38. Performance Measures 36 and 39 also achieved a rate of 100 percent; however, performance in these measures are driven solely by MDHHS as they relate to capitation payments to the waiver agencies.

Strength #2: Region 9 Area Agency on Aging received a 100 percent performance rating for Performance Measures 16, 17, and 20, indicating that person-centered service plans reviewed as part of the CQAR included strategies to address member-assessed health and safety risks; included individualized goals and preferences; and that participants were receiving all identified services and supports. This suggested that **Region 9 Area Agency on Aging** staff members are ensuring members/guardians are making informed choices, identifying member-specific health and welfare issues, considering waiver participants' individualized needs, and ensuring participants receive identified services and supports.

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any weaknesses for **Region 9 Area Agency on Aging**. **Region 9 Area Agency on Aging**'s performance rates were above HSAG's calculated statewide performance rates for all performance measures, with Performance Measures 16, 17, and 20 achieving a 100 percent performance rating.

Why the weakness exists: This section is not applicable as no weaknesses were identified.

Recommendation: This section is not applicable as no weaknesses were identified; therefore, HSAG has no recommendations for improvement.

Compliance Review

Performance Results

Table 3-39 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-39 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-39—Clinical Quality Assurance Reviews and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus I	Level of Care Determination	96.55%	100%	**4.00**
Focus I.B	Communication		100%	**4.00**
Focus II	Freedom of Choice	100%		**4.00**
Focus III	Release of Information	100%		**4.00**
Focus IV	Status	100%		**4.00**
Focus V	Pre-Planning	99.20%	100%	**4.00**
Focus VI	Assessment	99.11%	100%	**4.00**
Focus VII	Medication Record	93.81%	100%	**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus VIII	Person-Centered Service Planning	98.45%	100%	**4.00**
Focus IX	MI Choice Services	97.50%	100%	**4.00**
Focus X	Linking and Coordinating	100%	100%	**4.00**
Focus XI	Follow-Up and Monitoring	92.86%	100%	**4.00**
Focus XII	Service Provider	100%		**4.00**
Focus XIII	Contingency Plan	94.29%	100%	**4.00**
Focus XIV	Critical Incidents	80.00%	100%	**2.67**
Focus XV	Adverse Benefit Determination	76.19%		**3.00**
Focus XVI	Complaints and Grievances	100%		**4.00**
Focus XVII	Home and Community Based		N/A	**N/A**
	Totals	**97.71%**	**100%**	**3.93**

N/A indicates this focus area was non-applicable to the review year.

Indicates the standard was not reviewed as part of the record review or home visit.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: A review of seven home visits was conducted and all reviews achieved full compliance. The purpose of the home visits is to confirm that providers furnish services according to the person-centered service plan and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested that providers are consistently adhering to these requirements.

Strength #2: **Region 9 Area Agency on Aging** achieved a substantial compliance rating in 15 out of 17 applicable standards reviewed as part of the CQAR and received a score of 100 percent in six of the focus areas. The purpose of the record review is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the person-centered service plan and care planning process, reassessment data) and to assess the quality of waiver agency services to each member; therefore, CQAR findings suggested that person-centered service plans and service delivery are being implemented in accordance with many State and federal requirements.

Weaknesses and Recommendations

Weakness #1: **Region 9 Area Agency on Aging** did not receive any compliance determinations that were in the *not full or substantial compliance* or *compliance not demonstrated* rating categories; therefore, no substantial weaknesses were identified.

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: Although no substantial weaknesses were identified within any of the program areas under review, **Region 9 Area Agency on Aging** had noted deficiencies in the Critical Incidents and Adverse Benefit Determination standards; this indicated there are opportunities for improvement related to the waiver agency entering, reporting, and providing updates to the critical incident portal as required by MDHHS, and having complete and accurate information in the adverse action and/or ABD notice. MDHHS required a CAP for the noted areas of deficiency. **Region 9 Area Agency on Aging**'s CAP included, but was not limited to, providing staff education and training; conducting quarterly chart reviews; and re-evaluation of monitoring activities if measures fail to meet compliance within two quarters. HSAG recommends **Region 9 Area Agency on Aging** implement an ongoing and robust internal auditing process to ensure **Region 9 Area Agency on Aging** remains compliant with all requirements.

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

To identify strengths and weaknesses and draw conclusions for **Region 9 Area Agency on Aging**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Region 9 Area Agency on Aging** across all EQR activities. The overarching aggregated findings showed that **Region 9 Area Agency on Aging**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Region 9 Area Agency on Aging** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

HSAG's assessment of **Region 9 Area Agency on Aging** also identified opportunities for **Region 9 Area Agency on Aging** to enhance its quality assessment and performance improvement program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Region 9 Area Agency on Aging** had a QMP that included brief descriptions of its quality management activities, its QMP should be modified to more comprehensively align with the requirements and best practices for a quality assessment and performance improvement program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Reliance Community Care Partners

Validation of Performance Improvement Projects

Performance Results

Table 3-40 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2020. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Reliance Community Care Partners** met its internal SFY 2020 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Reliance Community Care Partners** did not meet its internal SFY 2020 QIP goal or the statewide goal, as applicable. Any interventions described within **Reliance Community Care Partners**' QMP reports are also provided in Table 3-40. The results in Table 3-40 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-40—QIP Results

QIP Topic	Goal	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Lower the score by 0.50%	SFY 2019 = 5.07% [5.70%]* SFY 2020 = 4.12% ☑
Actions/Activities/Interventions: According to **Reliance Community Care Partners'** Continuous Quality Improvement Plan MI Choice Medicaid Waiver Program Fiscal Years 2020 & 2021 dated December 18, 2019, **Reliance Community Care Partners** planned to complete the following tasks: • **Reliance Community Care Partners** will evaluate the data and conduct root cause analysis during FY2020. Additional goals and interventions will be established by the local quality councils. The **Reliance Community Care Partners** FY20 MI Choice Quality Management Plan Report dated January 27, 2021 identified the following: • **Reliance Community Care Partners** reviewed the numerator questions to ensure that all their staff ask questions the same and understand the scoring mechanism and attributed this as their greatest impact on FY20 metrics. • **Reliance Community Care Partners** will host webinars on identification and prevention of neglect, abuse and exploitation and reports exploitation as their highest percentage of abuse cases.		
2. *Prevalence of Pain With Inadequate Pain Control*	Lower the score by 1%	SFY 2019 = 21.94% SFY 2020 = 21.53% ☒
Actions/Activities/Interventions: According to **Reliance Community Care Partners'** Continuous Quality Improvement Plan MI Choice Medicaid Waiver Program Fiscal Years 2020 & 2021 dated December 18, 2019, **Reliance Community Care Partners** planned to complete the following tasks: • **Reliance Community Care Partners** will evaluate the data and conduct root cause analysis during FY2020. Additional goals and interventions will be established by the local quality councils.		

QIP Topic	Goal	Measurement and Outcome
The **Reliance Community Care Partners** FY20 MI Choice Quality Management Plan Report dated January 27, 2021 identified the following: • **Reliance Community Care Partners** plans to sponsor a falls prevention day on September 21, 2021 to celebrate the fall season. This will focus on pain management, fall prevention and other injuries.		
3. *Prevalence of Falls*	Lower the score by 1%	SFY 2019 = 28.40% SFY 2020 = 24.59% ☑
Actions/Activities/Interventions: According to **Reliance Community Care Partners'** Continuous Quality Improvement Plan MI Choice Medicaid Waiver Program Fiscal Years 2020 & 2021 dated December 18, 2019, **Reliance Community Care Partners** planned to complete the following tasks: • **Reliance Community Care Partners** will evaluate the data and conduct root cause analysis during FY2020. Additional goals and interventions will be established by the local quality councils. The **Reliance Community Care Partners** FY20 MI Choice Quality Management Plan Report dated January 27, 2021 identified the following: • **Reliance Community Care Partners** worked on newsletters to program participants regarding falls. This was distributed in October 2020 and is hoped to impact results in FY21. • **Reliance Community Care Partners** plans to sponsor a falls prevention day on September 21, 2021 to celebrate the fall season. This will focus on pain management, fall prevention and other injuries.		
4. *Prevalence of Any Injuries*	Lower the score by 0.50%	SFY 2019 = 6.08% SFY 2020 = 4.43% ☑
Actions/Activities/Interventions: According to **Reliance Community Care Partners'** Continuous Quality Improvement Plan MI Choice Medicaid Waiver Program Fiscal Years 2020 & 2021 dated December 18, 2019, **Reliance Community Care Partners** planned to complete the following tasks: • **Reliance Community Care Partners** will evaluate the data and conduct root cause analysis during FY2020. Additional goals and interventions will be established by the local quality councils. The **Reliance Community Care Partners** FY20 MI Choice Quality Management Plan Report dated January 27, 2021 identified the following: • **Reliance Community Care Partners** plans to sponsor a falls prevention day on September 21, 2021 to celebrate the fall season. This will focus on pain management, fall prevention and other injuries.		

QIP Topic	Goal	Measurement and Outcome
5. *Prevalence of Dehydration*	Lower the score by 0.50%	SFY 2019 = 2.30% SFY 2020 = 2.21% ☒

Actions/Activities/Interventions:

According to **Reliance Community Care Partners'** Continuous Quality Improvement Plan MI Choice Medicaid Waiver Program Fiscal Years 2020 & 2021 dated December 18, 2019, **Reliance Community Care Partners** planned to complete the following tasks:

- **Reliance Community Care Partners** will evaluate the data and conduct root cause analysis during FY2020. Additional goals and interventions will be established by the local quality councils.

The **Reliance Community Care Partners** FY20 MI Choice Quality Management Plan Report dated January 27, 2021 identified the following:

- **Reliance Community Care Partners** worked on newsletters to program participants regarding dehydration. This was distributed in October 2020 and is hoped to impact results in FY21.

FY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
*The waiver agency displayed a conflicting SFY 2019 baseline rate in its SFY 2020–2021 QMP and SFY 2020 annual report.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Although not all QIP goals were met, **Reliance Community Care Partners** demonstrated a decrease in the prevalence rates for all five QIPs, suggesting that members are experiencing less incidents of reported neglect/abuse, uncontrolled pain, falls, injuries, and dehydration.

Weaknesses and Recommendations

Weakness #1: Reliance Community Care Partners' QMP did not include any specific planned interventions. The interventions included in the annual report were minimal. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly documented. **Reliance Community Care Partners**' choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential for the waiver agency's success in achieving the desired outcomes for the QIPs.

Why the weakness exists: The QMP did not document the interventions that were initially implemented to reduce prevalence rates for the QIP. Although the annual report briefly connected interventions to results, the documentation was minimal. Additionally, the annual report did not support that a causal/barrier analysis was conducted for all QIPs and that an evaluation occurred for

each intervention to determine its effectiveness and ensure each intervention was logically linked to any identified barriers.

Recommendation: HSAG recommends that **Reliance Community Care Partners** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Reliance Community Care Partners** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Reliance Community Care Partners** should analyze and interpret results at multiple points in time and test for statistical significance. **Reliance Community Care Partners** should also evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #2: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **Reliance Community Care Partners**' QIPs must be designed in a methodically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions.

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2020 annual report included limited details on the design developed and methodology followed by **Reliance Community Care Partners** when implementing its QIPs.

Recommendation: HSAG recommends that **Reliance Community Care Partners** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Reliance Community Care Partners** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2020, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For eight of the 39 performance measures calculated by MDHHS, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Those performance measures with a statewide rate of 100 percent reported through the CMS-372 report were not included as part of the assessment. Table 3-41 displays the eight performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rate as calculated by MDHHS for the CMS-372 report, the statewide percentage rate as calculated by HSAG using the CQAR standard scores associated with each performance measure, and **Reliance Community Care Partners**' percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Reliance Community Care Partners**' impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate as calculated by HSAG, while performance rates shaded in red indicate that performance is worse than the statewide rate as calculated by HSAG.

Table 3-41—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* VIII.1, VIII.2, VIII.4, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39	**91.27**	**92.11**	**85.78**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* I.1, I.2, I.3, I.5, II.1, II.2, II.3, II.4, II.5, II.6, II.7, II.8, II.9, IV.1, IV.2, IV.3, IV.5, IV.6, VI.1, VI.2, VI.3, X.1	**96.83**	**98.82**	**98.04**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* V.3, IX.1, IX.2, IX.3, IX.6	**93.65**	**94.16**	**90.10**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* VIII.7, VIII.8	**98.94**	**99.07**	**97.83**

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* VIII.3, VIII.5, VIII.6, VIII.11	**98.41**	**98.81**	**84.78**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* V.1, V.2, V.3, V.5, V.10, V.11, V.13, V.15, VI.12, VI.14, VI.16, VIII.1, VIII.2, VIII.3 VIII.4,VIII.5, VIII.6, VIII.11, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39, VIII.40, VIII.41, IX.1, IX.2, IX.3, IX.4, IX.6	**94.97**	**94.13**	**90.74**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* VIII.28, VIII.29, VIII.30, VIII.31, VIII.32, VIII.33, VIII.34, IX.5	**96.03**	**95.54**	**93.20**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* XI.1, XI.3, XI.4	**89.68**	**93.52**	**100**

* The individual waiver agency performance measure rates were derived from the standards outlined in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report.

**Statewide percentage rates are displayed as reported by MDHHS. HSAG's calculations may differ from MDHHS' calculations as HSAG summed all numerators and denominators related to the CQAR standards included as part of each performance measure, while MDHHS calculated performance measure rates for the CMS-372 report using a total count of CQAR records reviewed across the waiver agencies and removing those records from the numerator when a standard included as part of the performance measure was deficient ("*Non-Evident*").

‡ The statewide percentage rates determined by HSAG were based on results of the SFY 2020 CQAR and the standards associated with each performance measure as indicated in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source." The statewide percentage rates determined by HSAG are displayed for comparison purposes to the MDHHS statewide percentages. Additionally, the HSAG calculated rates were made available for this report to ensure an appropriate representation to the rates calculated for each waiver agency.

Indicates the performance measure rate is higher than the statewide rate as calculated by HSAG.

Indicates the performance measure rate is lower than the statewide rate as calculated by HSAG.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Although MDHHS has not established performance measure benchmarks, **Reliance Community Care Partners**' overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 7, 8, 12, 22, 24, 27, 28, 29, 31, 33, 34, 37, and 38. Performance Measures 36 and 39 also achieved a rate of 100 percent; however, performance in these measures are driven solely by MDHHS as they relate to capitation payments to the waiver agencies.

Strength #2: Reliance Community Care Partners received a 100 percent performance rating for Performance Measure 20, indicating **Reliance Community Care Partners**' person-centered service plans reviewed as part of the CQAR indicated that members received all of the provided services and supports identified appropriately, suggesting that **Reliance Community Care Partners** staff members followed up to ensure that members continually received the services and supports they needed as identified in their person-centered service plans.

Weaknesses and Recommendations

Weakness #1: Reliance Community Care Partners received a score of 85.78 percent for Performance Measure 1, *number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This indicated that supports coordinators were not completing service plans for members in the time frame required by MDHHS.

Why the weakness exists: Reliance Community Care Partners' performance rate for Performance Measure 1 fell 6.33 percentage points below HSAG's calculated statewide rate. Through the CQAR, of the 23 records reviewed, MPHI determined that four records did not include an acknowledgment that informal supports agreed to provide uncompensated services and supports; three records did not identify and assess the participant's needs and risk factors; three records did not list services and supports that helped the participant achieve goals; and 22 records did not include both waiver and non-waiver services and supports when applicable.

Recommendation: MDHHS required **Reliance Community Care Partners** to develop a CAP to remediate the deficiencies. The completed CAP indicated that **Reliance Community Care Partners** reviews 12 charts per month and conducts retraining of staff as needed. HSAG recommends **Reliance Community Care Partners** continue to conduct audits of individual supports coordinators/care managers on an ongoing basis to ensure person-centered service plans are completed within the required 10 days of enrollment. Additionally, HSAG recommends that **Reliance Community Care Partners** ensure mechanisms are in place that verify timely completion of the person-centered service plan as required.

Weakness #2: Reliance Community Care Partners received a score of 84.78 percent for Performance Measure 17, *number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process,* as indicated by a performance rate of more than 5 percentage points below the statewide rate. This indicated that supports coordinators were not completing service plans for members in the time frame required by MDHHS.

Why the weakness exists: Reliance Community Care Partners' performance rate for Performance Measure 17 fell 14.03 percentage points below HSAG's calculated statewide rate. Through the CQAR, of the 23 records reviewed, MPHI determined that 12 records did not include an acknowledgment that informal supports agreed to provide uncompensated services and supports.

Recommendation: MDHHS required **Reliance Community Care Partners** to develop a CAP to remediate the deficiencies. The completed CAP indicated that **Reliance Community Care Partners** reviews 12 charts per month and retrains staff as necessary. HSAG recommends **Reliance Community Care Partners** continue to conduct audits of individual supports coordinators/care managers on an ongoing basis to ensure person-centered service plans are completed within the required 10 days of enrollment. Additionally, HSAG recommends that **Reliance Community Care Partners** ensure mechanisms are in place that verify timely completion of the person-centered service plan as required.

Compliance Review

Performance Results

Table 3-42 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-42 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-42—Clinical Quality Assurance Reviews and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus I	Level of Care Determination	95.74%	100%	**4.00**
Focus I.B	Communication		100%	**4.00**
Focus II	Freedom of Choice	99.33%		**4.00**
Focus III	Release of Information	98.40%		**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus IV	Status	96.30%		**4.00**
Focus V	Pre-Planning	97.16%	100%	**4.00**
Focus VI	Assessment	94.38%	100%	**4.00**
Focus VII	Medication Record	90.78%	100%	**4.00**
Focus VIII	Person-Centered Service Planning	89.40%	99.00%	**3.34**
Focus IX	MI Choice Services	88.80%	98.15%	**3.34**
Focus X	Linking and Coordinating	96.23%	100%	**4.00**
Focus XI	Follow-Up and Monitoring	68.09%	98.33%	**2.03**
Focus XII	Service Provider	69.23%		**2.00**
Focus XIII	Contingency Plan	96.92%	100%	**4.00**
Focus XIV	Critical Incidents	66.67%	100%	**2.03**
Focus XV	Adverse Benefit Determination	62.50%		**1.00**
Focus XVI	Complaints and Grievances	83.33%		**3.00**
Focus XVII	Home and Community Based		100%	**4.00**
	Totals	**91.89%**	**99.51%**	**3.60**

Indicates the standard was not reviewed as part of the record review or home visit.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: A review of 12 home visits was conducted and all reviews achieved full compliance with the exception of three focus areas (Person-Centered Service Planning, MI Choice Services, and Follow-Up and Monitoring), which received 98.15 percent or above. The purpose of the home visits is to confirm that providers furnish services according to the person-centered service plan and member preferences, and to determine member satisfaction with those services; therefore, the

findings suggested that members are receiving services in accordance with their service plans and preferences, and are satisfied with those services.

Strength #2: Reliance Community Care Partners achieved a substantial compliance rating in 13 of the 18 standards reviewed as part of the CQAR. The purpose of the record review is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the person-centered service plan and care planning process, reassessment data) and to assess the quality of waiver agency services to each member; therefore, CQAR findings suggested that person-centered service plans and service delivery are being implemented in accordance with many State and federal requirements.

Weaknesses and Recommendations

Weakness #1: Reliance Community Care Partners did not consistently follow all Follow-Up and Monitoring requirements; specifically, contacting the member for follow-up and monitoring. Waiver agencies are required to contact each member to ensure services are implemented as planned. When services are not implemented as planned or when the planned services require adjustments, waiver agencies should implement corrective actions to resolve problems and issues.

Why the weakness exists: Through the CQAR, MPHI determined that 15 out of 23 applicable records did not include evidence that the waiver agency contacted the member/guardian for follow-up and monitoring as specified in the person-centered service plan and according to MDHHS policy.

Recommendation: MDHHS required **Reliance Community Care Partners** to submit a CAP to remediate the deficiencies. **Reliance Community Care Partners**' CAP included, but was not limited to, reviewing the FY 2020 CQAR Records as part of a root cause analysis; retraining of staff members regarding communication with guardian or authorized representative, including client and documentation requirements, annually and with staff members that score *Non-Evident* on audits conducted internally and externally; and a review of 12 records per month. However, the CAP also indicated internal monitoring is required until compliance in excess of 90 percent is achieved. Therefore, HSAG recommends that **Reliance Community Care Partners** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #2: Reliance Community Care Partners did not consistently follow all Service Provider requirements; specifically, **Reliance Community Care Partners**' contracted service providers did not contact the waiver agency to inform them of waiver members' health and welfare issues as required.

Why the weakness exists: Through the CQAR, MPHI determined that four out of 11 applicable records did not include evidence that **Reliance Community Care Partners**' service providers contacted the waiver agency to inform it when a member experienced a health and welfare issue.

Recommendation: MDHHS required **Reliance Community Care Partners** to submit a CAP to remediate the deficiencies. **Reliance Community Care Partners'** CAP included, but was not

limited to, reviewing the FY 2020 CQAR Records as part of a root cause analysis; retraining of staff members regarding education on health, welfare, and safety requirements annually and with staff members that score *Non-Evident* on audits conducted internally and externally; annual training with providers on the need to report health, welfare, and safety issues to the case manager; as well as reviewing 12 charts per month until 90 percent compliance is attained. However, HSAG recommends that **Reliance Community Care Partners** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor vendors to ensure performance stays consistent and contract requirements are met.

Weakness #3: Reliance Community Care Partners did not consistently follow the requirements for Critical Incidents. Specifically, **Reliance Community Care Partners**' supports coordinator did not take appropriate action to address an incident with the member; did not discuss methods to prevent the incident with the member; and did not enter, report, and provide updates to the critical incident portal as required by MDHHS.

Why the weakness exists: Through the CQAR, MPHI determined one out of three applicable records did not include evidence that appropriate action was taken to address the incident with the member; one out of three applicable records did not include evidence that methods to prevent further occurrence with the member were discussed; and three out of three records did not include evidence that that **Reliance Community Care Partners** entered, reported, and provided updates to the critical incident portal.

Recommendation: Reliance Community Care Partners was required to submit a CAP to remediate the deficiencies. **Reliance Community Care Partners**' CAP included, but was not limited to, a root cause analysis; retraining staff members; annual training with providers; monthly maintenance of critical incident system; and a review of 12 records per month by the management team. However, **Reliance Community Care Partners** also indicated records will be reviewed until 90 percent compliance is attained. Therefore, HSAG recommends that **Reliance Community Care Partners** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #4: Reliance Community Care Partners did not consistently follow all Adverse Benefit Determination requirements; specifically, **Reliance Community Care Partners** did not consistently provide its members with an ABD notice or with an ABD notice that was complete and accurate. When a member no longer meets NFLOC, the MI Choice Section 1915(c) waiver requires the supports coordinator to initiate program discharge procedures and provide the member with an ABD notice. Complete and accurate ABD notices are necessary to ensure members/guardians understand their appeal rights and how to request an appeal.

Why the weakness exists: Through the CQAR, MPHI determined that six out of nine applicable records did not include evidence that the waiver agency provided the member/guardian with an ABD

notice for disenrollment due to not meeting NFLOC criteria and/or ABD for a service denial, reduction, suspension, and/or termination from the MI Choice Waiver Program. This finding was recurring for the past two years.

Recommendation: MDHHS required **Reliance Community Care Partners** to submit a CAP to remediate the deficiencies. **Reliance Community Care Partners**' CAP included, but was not limited to, retraining of staff members regarding Adverse Beneficiary Determination requirements annually and with staff members that score *Non-Evident* on audits conducted internally and externally; a root cause analysis; and a review of 12 records per month by the management team. However, **Reliance Community Care Partners** also indicated records will be reviewed until 90 percent compliance is attained. Therefore, HSAG recommends that **Reliance Community Care Partners** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

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

To identify strengths and weaknesses and draw conclusions for **Reliance Community Care Partners**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Reliance Community Care Partners** across all EQR activities. The overarching aggregated findings showed that **Reliance Community Care Partners**' quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Reliance Community Care Partners** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

HSAG's assessment of **Reliance Community Care Partners** also identified opportunities for **Reliance Community Care Partners** to enhance its quality assessment and performance improvement program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Reliance Community Care Partners** had a QMP that included brief descriptions of its quality management activities, its QMP should be modified to more comprehensively align with the requirements and best practices for a quality assessment and performance improvement program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Senior Resources

Validation of Performance Improvement Projects

Performance Results

Table 3-43 displays the results for each QIP implemented during SFY 2020. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Senior Resources** met its internal SFY 2020 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Senior Resources** did not meet its internal SFY 2020 QIP goal or the statewide goal, as applicable. Any interventions described within **Senior Resources**' QMP reports are also provided in Table 3-43. The results in Table 3-43 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-43—QIP Results

QIP Topic	Goal†	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Reduce the number of participants who have been neglected/abused, have poor hygiene, are fearful of family member, or have been restrained [3%]	SFY 2019 = [No baseline data reported] SFY 2020 = 2.15% ☑
Actions/Activities/Interventions: According to **Senior Resources**' MI Choice Quality Management Plan Fiscal Years 2020-2021 report dated December 16, 2019, **Senior Resources** planned to complete the following tasks: • **Senior Resources**' QI Committee will review the biannual reports and make recommendations. • Education will continue to be provided to Supports Coordinators regarding this QMP goal, the importance of monitoring these participants and making referrals for services as necessary. If percentages increase further training with SCs will take place. • Supports coordinators will be actively involved in the QMP process during FY20 and 21 to increase buy-in re: the importance of gathering good data and achieving this goal. The **Senior Resources**' Summary of Quality Management Plan Activities & Outcomes for FY 2020 dated December 14, 2020 identified the following: • **Senior Resources** staff was made aware of the signs of neglect and abuse. Staff regularly discuss with the QI Coordinator, supervisors and other Supports Coordinators possible cases of neglect and abuse in all realms-physical, emotional, and financial. **Senior Resources** has an 'At Risk Participants Policy and Procedure' that is reviewed annually and revised, as necessary. A formal training was scheduled for all staff which had to be cancelled due to COVID 19.		

QIP Topic	Goal†	Measurement and Outcome
2. *Prevalence of Pain With Inadequate Pain Control*	Decrease the percent of participants reporting pain with inadequate control [20%]	SFY 2019 = [No baseline data reported] SFY 2020 = 16.4% ☑
Actions/Activities/Interventions: According to **Senior Resources**' MI Choice Quality Management Plan Fiscal Years 2020-2021 report dated December 16, 2019, **Senior Resources** planned to complete the following tasks: • **Senior Resources** will monitor issues, goals and interventions that are identified via the Person-Centered Centered Plan which is completed at every assessment. • Supports Coordinators will be educated annually about the importance of updating this information in COMPASS at every assessment so that accurate data is available for analysis. Additionally, refresher training will be provided to Supports Coordinators regarding the usefulness of "Next Assessment" in COMPASS and appropriately updating the COMPASS assessment. The **Senior Resources**' Summary of Quality Management Plan Activities & Outcomes for FY 2020 dated December 14, 2020 identified the following: • Supports Coordinators will be reminded to discuss pain with inadequate control and encourage participants/representative to address with their physician. • Supports Coordinators will be actively involved in the QMP process during FY20 and 21 to increase buy-in on the importance of gathering good data and achieving this goal. • Effectiveness of interventions will be tracked biannually and revisions made as appropriate. • All Waiver Supports Coordinators are required to receive continuing education in pain. Trainings are offered regularly on site and through web-based programs. The staff educator tracks all trainings for individual Supports Coordinators to be certain education has been completed.		
3. *Prevalence of Falls*	Reduce the percentage of MI Choice participants who have had a fall in the past 6 months (excluding those participants totally dependent with bed mobility) [23%]	SFY 2019 = [No baseline data reported] SFY 2020 = 28.05% ☒
Actions/Activities/Interventions: According to **Senior Resources**' MI Choice Quality Management Plan Fiscal Years 2020-2021 report dated December 16, 2019, **Senior Resources** planned to complete the following tasks: • **Senior Resources** will obtain and analyze data biannually via their QI Committee. Dependent on, and in response to the data obtained, S**enior Resources** will institute processes designed to impact those risk factors. Supports Coordinators will be instructed to ensure that informal and MI Choice supports are adequately meeting the needs of the participant through reassessments and monthly monitoring contacts. Effectiveness of interventions will be tracked biannually and revisions made as appropriate. • Supports Coordinators will be actively involved in the QMP process during FY20 and 21 to increase buy-in on the importance of gathering good data and achieving this goal. The **Senior Resources**' Summary of Quality Management Plan Activities & Outcomes for FY 2020 dated December 14, 2020 identified the following:		

QIP Topic	Goal†	Measurement and Outcome
• **Senior Resources** recognized that this is an area that requires improvement. At the 6/3/20 staff meeting, Supports Coordinators participated in a brainstorming session regarding ideas on how to impact the reduction of falls and reduce the occurrence of injury to generate several ideas. During the second half of FY 20 this Quality Indicator improved by 0.7%.		
4. *Prevalence of Any Injuries*	Decrease the percentage of participants who experience/report an injury [3%]	SFY 2019 = [No baseline data reported] SFY 2020 = 3.65% ☒
Actions/Activities/Interventions: According to **Senior Resources**' MI Choice Quality Management Plan Fiscal Years 2020-2021 report dated December 16, 2019, **Senior Resources** planned to complete the following tasks: • **Senior Resources** will obtain and analyze data biannually via their QI Committee. Dependent on, and in response to the data obtained, **Senior Resources** will institute processes designed to impact those risk factors. Supports Coordinators will be instructed to ensure that informal and MI Choice supports are adequately meeting the needs of the participant through reassessments and monthly monitoring contacts. Effectiveness of interventions will be tracked biannually and revisions made as appropriate. • Supports Coordinators will be actively involved in the QMP process during FY20 and 21 to increase buy-in on the importance of gathering good data and achieving this goal. The **Senior Resources**' Summary of Quality Management Plan Activities & Outcomes for FY 2020 dated December 14, 2020 identified the following: • This Quality Indicator is tied very closely with #3. The discussion that occurred at the 6/3/20 staff meeting was beneficial in reducing the occurrence of injuries by .5%.		
5. *Prevalence of Dehydration*	Reduce the prevalence of participants who were dehydrated due to insufficient fluid intake [1.5%]	SFY 2019 = [No baseline data reported] SFY 2020 = 1.75% ☒
Actions/Activities/Interventions: According to **Senior Resources**' MI Choice Quality Management Plan Fiscal Years 2020-2021 report dated December 16, 2019, **Senior Resources** planned to complete the following tasks: • **Senior Resources** will provide training to Supports Coordinators regarding their responsibilities in this area: determining reason(s) for findings of dehydration and institute appropriate solutions, providing education about community resources, making physician/APS referrals as needed, and collaborating with CLS providers to ensure participant hydration needs are met. • Supports Coordinators will be actively involved in the QMP process during FY20 and 21 to increase buy-in on the importance of gathering good data and achieving this goal. Progress toward reaching this goal will be monitored continuously and processes revised as necessary. The **Senior Resources**' Summary of Quality Management Plan Activities & Outcomes for FY 2020 dated December 14, 2020 identified the following: • **Senior Resources** staff is aware of the need for hydration for all participants. Food boxes are available for any participant that needs help in securing food. Participants are contacted every 2 weeks to determine if they are experiencing any COVID symptoms. During this contact participants are asked if they have any food or		

QIP Topic	Goal†	Measurement and Outcome
supply needs. The topic of dehydration was also discussed at the 11/19/20 Local Collaborative Meeting with participants and staff.		

FY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
†The goals within the QMP did not consistently include a specific percentage rate and, when available, were less stringent than the goals identified in the annual report. Therefore, HSAG assessed performance outcomes using the goals identified in the annual report.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Senior Resources met its goals for the *Prevalence of Neglect/Abuse* and *Prevalence of Pain With Inadequate Pain Control* QIPs, suggesting that **Senior Resources**' members experienced less incidents of reported neglect/abuse and uncontrolled pain.

Weaknesses and Recommendations

Weakness #1: Senior Resources' SFY 2020–2021 QMP and SFY 2020 annual report included conflicting goals, which created confusion as to the true goals established by **Senior Resources** when initiating the QIPs. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each measure needs to be clearly and consistently documented.

Why the weakness exists: Senior Resources' SFY 2020–2021 QMP identified different goals for each QIP than the SFY 2020 annual report. The SFY 2020 goal within the annual report aligned with MDHHS' established statewide goals. Additionally, some goals identified in the SFY 2020–2021 QMP did not include a specific measurable performance goal (i.e., percentage rate).

Recommendation: HSAG recommends that **Senior Resources** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should be consistently documented within its QMP reports. Additionally, **Senior Resources** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers.

Weakness #2: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **Senior Resources**' QIPs must be designed in a methodically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions.

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2020 annual report included limited details on the design developed and the methodology followed by **Senior Resources** when implementing its QIPs.

Recommendation: HSAG recommends that **Senior Resources** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Senior Resources** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2020, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For eight of the 39 performance measures calculated by MDHHS, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Those performance measures with a statewide rate of 100 percent reported through the CMS-372 report were not included as part of the assessment. Table 3-44 displays the eight performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rate as calculated by MDHHS for the CMS-372 report, the statewide percentage rate as calculated by HSAG using the CQAR standard scores associated with each performance measure, and **Senior Resources**' percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Senior Resources**' impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate as calculated by HSAG, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-44—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* VIII.1, VIII.2, VIII.4, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39	**91.27**	**92.11**	**80.95**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* I.1, I.2, I.3, I.5, II.1, II.2, II.3, II.4, II.5, II.6, II.7, II.8, II.9, IV.1, IV.2, IV.3, IV.5, IV.6, VI.1, VI.2, VI.3, X.1	**96.83**	**98.82**	**98.69**

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* V.3, IX.1, IX.2, IX.3, IX.6	93.65	94.16	98.85
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* VIII.7, VIII.8	98.94	99.07	95.24
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* VIII.3, VIII.5, VIII.6, VIII.11	98.41	98.81	100
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* V.1, V.2, V.3, V.5, V.10, V.11, V.13, V.15, VI.12, VI.14, VI.16, VIII.1, VIII.2, VIII.3 VIII.4,VIII.5, VIII.6, VIII.11, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39, VIII.40, VIII.41, IX.1, IX.2, IX.3, IX.4, IX.6	94.97	94.13	89.11
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* VIII.28, VIII.29, VIII.30, VIII.31, VIII.32, VIII.33, VIII.34, IX.5	96.03	95.54	96.70
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* XI.1, XI.3, XI.4	89.68	93.52	90.91

* The individual waiver agency performance measure rates were derived from the standards outlined in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report.

**Statewide percentage rates are displayed as reported by MDHHS. HSAG's calculations may differ from MDHHS' calculations as HSAG summed all numerators and denominators related to the CQAR standards included as part of each performance measure, while MDHHS calculated performance measure rates for the CMS-372 report using a total count of CQAR records reviewed across the waiver agencies and removing those records from the numerator when a standard included as part of the performance measure was deficient ("*Non-Evident*").

ǂ The statewide percentage rates determined by HSAG were based on results of the SFY 2020 CQAR and the standards associated with each performance measure as indicated in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source." The statewide percentage rates determined by HSAG are displayed for comparison purposes to the MDHHS statewide percentages. Additionally, the HSAG calculated rates were made available for this report to ensure an appropriate representation to the rates calculated for each waiver agency.

Indicates the performance measure rate is higher than the statewide rate as calculated by HSAG.

Indicates the performance measure rate is lower than the statewide rate as calculated by HSAG.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Although MDHHS has not established performance measure benchmarks, **Senior Resources**' overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 7, 8, 12, 22, 24, 27, 28, 29, 31, 33, 34, 37, and 38. Performance Measures 36 and 39 also achieved a rate of 100 percent; however, performance in these measures are driven solely by MDHHS as they relate to capitation payments to the waiver agencies.

Strength #2: Senior Resources received a 100 percent performance rating for Performance Measure 17, indicating **Senior Resources** ensured that the person-centered service plans included goals and preferences desired by the members.

Weaknesses and Recommendations

Weakness #1: Senior Resources received a score of 80.95 percent for Performance Measure 1, *number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This indicated that supports coordinators were not completing service plans for members in the time frame required by MDHHS.

Why the weakness exists: Senior Resources' performance rate for Performance Measure 1 fell 11.16 percentage points below HSAG's calculated statewide rate. Through the CQAR, of the 21 records reviewed, MPHI determined that five records did not include an acknowledgment that informal supports agreed to provide uncompensated services and supports; four records did not identify and assess the participant's needs and risk factors; four records did not list services and supports that helped the participant achieve goals; 18 records did not include both waiver and non-waiver services and supports when applicable; and six records did not indicate that the participant or guardian approved the participant's person-centered service plan.

Recommendation: MDHHS required **Senior Resources** to submit a CAP to remediate the deficiencies identified through the CQAR that were used to calculate the performance rate for Performance Measure 1. **Senior Resources**' CAP included, but was not limited to, staff training and review of 12 charts per month. However, the CAP also indicated internal monitoring is required by **Senior Resources** until compliance in excess of 80 to 90 percent (depending on the requirement) is achieved. Therefore, HSAG recommends that **Senior Resources** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #1: Performance Measure 18 received a score of 89.11 percent, which fell more than 5 percentage points below the statewide rate, indicating that service plans were not consistently developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.

Why the weakness exists: Senior Resources' performance rate for Performance Measure 18 fell 5.02 percentage points below HSAG's calculated statewide rate. Through the CQAR, of the 21 records reviewed, MPHI determined that 71 standards associated with the Performance Measure 18 were *Non-Evident*, indicating deficiencies in these related areas.

Recommendation: MDHHS required **Senior Resources** to submit a CAP to remediate the deficiencies identified through the CQAR that were used to calculate the performance rate for Performance Measure 18. **Senior Resources**' CAP included, but was not limited to, staff training and review of 12 charts per month. However, the CAP also indicated internal monitoring is required by **Senior Resources** until compliance in excess of 80 to 90 percent (depending on the requirement) is achieved. Therefore, HSAG recommends that **Senior Resources** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-45 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-45 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-45—Clinical Quality Assurance Reviews and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus I	Level of Care Determination	93.02%	100%	**4.00**
Focus I.B	Communication		100%	**4.00**
Focus II	Freedom of Choice	100%		**4.00**
Focus III	Release of Information	99.10%		**4.00**
Focus IV	Status	100%		**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus V	Pre-Planning	85.26%	100%	**4.00**
Focus VI	Assessment	96.47%	100%	**4.00**
Focus VII	Medication Record	94.81%	98.48%	**4.00**
Focus VIII	Person-Centered Service Planning	91.33%	100%	**4.00**
Focus IX	MI Choice Services	96.72%	100%	**4.00**
Focus X	Linking and Coordinating	98.33%	98.18%	**4.00**
Focus XI	Follow-Up and Monitoring	90.70%	100%	**4.00**
Focus XII	Service Provider	94.44%		**4.00**
Focus XIII	Contingency Plan	91.23%	100%	**4.00**
Focus XIV	Critical Incidents	90.00%	100%	**4.00**
Focus XV	Adverse Benefit Determination	90.48%		**4.00**
Focus XVI	Complaints and Grievances	94.44%		**4.00**
Focus XVII	Home and Community Based		N/A	**N/A**
	Totals	**93.56%**	**99.71%**	**4.00**

Indicates the standard was not reviewed as part of the record review or home visit.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: A review of 11 home visits was conducted and all reviews achieved full compliance with the exception of two focus areas (Medication Record and Linking and Coordinating). The purpose of the home visits is to confirm that providers furnish services according to the person-centered service plan and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested that providers are consistently adhering to these requirements.

Strength #2: Senior Resources achieved a substantial compliance rating in all 17 applicable standards reviewed as part of the CQAR. The purpose of the record review is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the person-centered service plan and care planning process, reassessment data) and to assess the quality of waiver agency services to each member; therefore, CQAR findings suggested that person-centered service plans and service delivery are being implemented in accordance with many State and federal requirements.

Weaknesses and Recommendations

Weakness #1: Senior Resources did not receive any compliance determinations that were in the *not full or substantial compliance* or *compliance not demonstrated* rating categories; therefore, no substantial weaknesses were identified.

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: This section is not applicable as there were no substantial areas of weakness for **Senior Resources**; therefore, HSAG has no recommendations for improvement.

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

To identify strengths and weaknesses and draw conclusions for **Senior Resources**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Senior Resources** across all EQR activities. The overarching aggregated findings showed that **Senior Resources**' quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Senior Resources** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

HSAG's assessment of **Senior Resources** also identified opportunities for **Senior Resources** to enhance its quality assessment and performance improvement program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Senior Resources** had a QMP that included brief descriptions of its quality management activities, its QMP should be modified to more comprehensively align with the requirements and best practices for a quality assessment and performance improvement program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Senior Services

Validation of Performance Improvement Projects

Performance Results

Table 3-46 displays the results for each QIP implemented during SFY 2020. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Senior Services** met its internal SFY 2020 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Senior Services** did not meet its internal SFY 2020 QIP goal or the statewide goal. Any interventions described within **Senior Services**' QMP reports are also provided in Table 3-46. The results in Table 3-46 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-46—QIP Results

QIP Topic	Goal‡	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	[No goal identified]	SFY 2019 = [No baseline data reported] SFY 2020 = 1% ☑
According to **Senior Services**' Quality Management Plan FY 2020-2021 dated January 15, 2020, **Senior Services** planned to complete the following tasks: • [None identified] The **Senior Services** MI Choice Summary of Quality Management Plan (QMP) Activities and Outcomes Report FY 2020 dated January 2021 identified the following: • [None identified]		
2. *Prevalence of Pain With Inadequate Pain Control*	[No goal identified]	SFY 2019 = [No baseline data reported] SFY 2020 = 18% ☑
Actions/Activities/Interventions: According to **Senior Services**' Quality Management Plan FY 2020-2021 dated January 15, 2020, **Senior Services** planned to complete the following tasks: • [None identified] The **Senior Services** MI Choice Summary of Quality Management Plan (QMP) Activities and Outcomes Report FY 2020 dated January 2021 identified the following: • [None identified]		

QIP Topic	Goal‡	Measurement and Outcome
3. *Prevalence of Falls*	[No goal identified]	SFY 2019 = [No baseline data reported] SFY 2020 = 51% ☒
Actions/Activities/Interventions: According to **Senior Services**' Quality Management Plan FY 2020-2021 dated January 15, 2020, **Senior Services** planned to complete the following tasks: • [None identified] The **Senior Services** MI Choice Summary of Quality Management Plan (QMP) Activities and Outcomes Report FY 2020 dated January 2021 identified the following: • [None identified]		
4. *Prevalence of Any Injuries*	[No goal identified]	SFY 2019 = [No baseline data reported] SFY 2020 = 6% ☒
Actions/Activities/Interventions: According to **Senior Services**' Quality Management Plan FY 2020-2021 dated January 15, 2020, **Senior Services** planned to complete the following tasks: • [None identified] The **Senior Services** MI Choice Summary of Quality Management Plan (QMP) Activities and Outcomes Report FY 2020 dated January 2021 identified the following: • [None identified]		
5. *Prevalence of Dehydration*	[No goal identified]	SFY 2019 = [No baseline data reported] SFY 2020 = 1% ☑
Actions/Activities/Interventions: According to **Senior Services**' Quality Management Plan FY 2020-2021 dated January 15, 2020, **Senior Services** planned to complete the following tasks: • [None identified] The **Senior Services** MI Choice Summary of Quality Management Plan (QMP) Activities and Outcomes Report FY 2020 dated January 2021 identified the following: • [None identified]		

FY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
‡Waiver agency did not identify any internal goals in the QMP reports; therefore, HSAG used the statewide rates and the percentage rates identified by the waiver agency in the annual report to determine performance outcomes.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Senior Services met the statewide goal for three QIPs, including *Prevalence of Neglect/Abuse*, *Prevalence of Pain With Inadequate Pain Control*, and *Prevalence of Dehydration*, indicating that **Senior Services**' members experienced less reported neglect/abuse, uncontrolled pain, and dehydration.

Weaknesses and Recommendations

Weakness #1: Senior Services did not identify a goal for any of the five state-required QIPs. Additionally, although **Senior Services**' SFY 2020–2021 QMP included its first quarter metrics for each of the five QIPs, it was not clear if these metrics were intended to be its baseline data to compare against final SFY 2020 performance outcomes. Specific goals (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities; therefore, the goal for each QIP needs to be identified in **Senior Services**' QMP reports.

Why the weakness exists: Neither the SFY 2020–2021 QMP or SFY 2020 annual report identified **Senior Services**' goals for any of the five state-required QIPs. Additionally, the SFY 2020 annual report did not include a comparison of performance to the metrics identified in the SFY 2020–2021 QMP.

Recommendation: HSAG recommends that **Senior Services** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should be consistently documented within its QMP reports (i.e., QMP, annual report). Additionally, **Senior Services** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers. This analysis should be conducted based on **Senior Services**' baseline data included within its QMP.

Weakness #2: Senior Services did not include QIP interventions in its QMP reports. As significant and sustained improvement results from developing and implementing effective improvement strategies, interventions must be documented in **Senior Services**' QMP. **Senior Services**' choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential for the waiver agency's success in achieving the desired outcomes for the QIPs.

Why the weakness exists: Senior Services' SFY 2020–2021 QMP did not list planned interventions for each of the five state-required QIPs, or demonstrate that a causal/barrier analysis was conducted and that an evaluation occurred for each intervention to determine its effectiveness and ensure each intervention was logically linked to any identified barriers.

Recommendation: HSAG recommends that **Senior Services** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Senior Services** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Senior Services** should analyze and interpret results at multiple points in time and test for statistical significance. **Senior Services** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #3: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **Senior Services**' QIPs must be designed in a methodically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions.

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2020 annual report did not include details on the design developed and the methodology followed by **Senior Services** when implementing its QIPs.

Recommendation: HSAG recommends that **Senior Services** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Senior Services** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2020, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For eight of the 39 performance measures calculated by MDHHS, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Those performance measures with a statewide rate of 100 percent reported through the CMS-372 report were not included as part of the assessment. Table 3-47 displays the eight performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rate as calculated by MDHHS for the CMS-372 report, the statewide percentage rate as calculated by HSAG using the CQAR standard scores associated with each performance measure, and **Senior Services**' percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Senior Services**' impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate as calculated by HSAG, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-47—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* VIII.1, VIII.2, VIII.4, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39	91.27	92.11	96.00
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* I.1, I.2, I.3, I.5, II.1, II.2, II.3, II.4, II.5, II.6, II.7, II.8, II.9, IV.1, IV.2, IV.3, IV.5, IV.6, VI.1, VI.2, VI.3, X.1	96.83	98.82	95.15
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* V.3, IX.1, IX.2, IX.3, IX.6	93.65	94.16	83.33
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* VIII.7, VIII.8	98.94	99.07	100
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* VIII.3, VIII.5, VIII.6, VIII.11	98.41	98.81	100
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* V.1, V.2, V.3, V.5, V.10, V.11, V.13, V.15, VI.12, VI.14, VI.16, VIII.1, VIII.2, VIII.3 VIII.4,VIII.5, VIII.6, VIII.11, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39, VIII.40, VIII.41, IX.1, IX.2, IX.3, IX.4, IX.6	94.97	94.13	94.98
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* VIII.28, VIII.29, VIII.30, VIII.31, VIII.32, VIII.33, VIII.34, IX.5	96.03	95.54	82.76

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* XI.1, XI.3, XI.4	**89.68**	**93.52**	**100**

* The individual waiver agency performance measure rates were derived from the standards outlined in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report.

**Statewide percentage rates are displayed as reported by MDHHS. HSAG's calculations may differ from MDHHS' calculations as HSAG summed all numerators and denominators related to the CQAR standards included as part of each performance measure, while MDHHS calculated performance measure rates for the CMS-372 report using a total count of CQAR records reviewed across the waiver agencies and removing those records from the numerator when a standard included as part of the performance measure was deficient ("*Non-Evident*").

‡ The statewide percentage rates determined by HSAG were based on results of the SFY 2020 CQAR and the standards associated with each performance measure as indicated in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source." The statewide percentage rates determined by HSAG are displayed for comparison purposes to the MDHHS statewide percentages. Additionally, the HSAG calculated rates were made available for this report to ensure an appropriate representation to the rates calculated for each waiver agency.

Indicates the performance measure rate is higher than the statewide rate as calculated by HSAG.

Indicates the performance measure rate is lower than the statewide rate as calculated by HSAG.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Although MDHHS has not established performance measure benchmarks, **Senior Services**' overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 7, 8, 12, 22, 24, 27, 28, 29, 31, 33, 34, 37, and 38. Performance Measures 36 and 39 also achieved a rate of 100 percent; however, performance in these measures are driven solely by MDHHS as they relate to capitation payments to the waiver agencies.

Strength #2: Senior Services received a 100 percent performance rating for Performance Measures 16, 17, and 20, indicating **Senior Services** developed person-centered service plans that had strategies to address members' assessed health and safety risks. Additionally, **Senior Services** ensured that the person-centered service plans included goals and preferences desired by the members. Further, person-centered service plans reviewed as part of the CQAR indicated that members received all of the provided services and supports identified appropriately, suggesting that **Senior Services** staff members followed up to ensure that members continually received the services and supports they needed as identified in their person-centered service plans.

Weaknesses and Recommendations

Weakness #1: Senior Services performed substantially worse than other waiver agencies on Performance Measure 15, *number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs*, as indicated by a performance rate of more than 5 percentage points below the statewide rate; this suggested that service summaries did not consistently contain accurate and complete information, and services authorized did not consistently meet service standard requirements.

Why the weakness exists: Senior Services' performance rate for Performance Measure 15 fell 10.83 percentage points below HSAG's calculated statewide rate. Through the CQAR, of 10 records reviewed, two records did not include evidence to support that services were authorized consistent with the members' needs. Additionally, two of 10 records did not include accurate and complete service summaries. Finally, three of 10 records did not include evidence to support that authorized services met service standard requirements.

Recommendation: MDHHS required **Senior Services** to submit a CAP to remediate the deficiencies identified through the CQAR that are used to calculate the performance rate for Performance Measure 15. The CAP indicated **Senior Services** would conduct education and training, and random chart reviews would be conducted until a 95 percent compliance threshold is achieved for three months. However, HSAG recommends that **Senior Services** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements remain compliant.

Weakness #2: Senior Services performed substantially worse than other waiver agencies on Performance Measure 19, *number and percent of participant person-centered service plans that are updated according to requirements by MDHHS*, as indicated by a performance rate of more than 5 percentage points below the statewide rate, indicating supports coordinators were not outreaching to members timely to assess their current health needs and, subsequently, evaluate their goals to determine if existing services and supports were adequate.

Why the weakness exists: Senior Services' performance rate for Performance Measure 19 fell 12.78 percentage points below HSAG's calculated statewide rate. Through the CQAR, of the 10 records reviewed, MPHI determined that four records did not include evidence that the supports coordinator updated the person-centered service plan within 180-day intervals or evaluated the goals timely.

Recommendation: MDHHS required **Senior Services** to develop a CAP to remediate the deficiencies that were associated with Performance Measure 19. The CAP indicated **Senior Services** would conduct education and training, and random chart reviews would be conducted until a 95 percent compliance threshold is achieved for three months. However, HSAG recommends that **Senior Services** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements remain compliant.

Compliance Review

Performance Results

Table 3-48 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-48 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-48—Clinical Quality Assurance Reviews and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus I	Level of Care Determination	95.00%	100%	**4.00**
Focus I.B	Communication		100%	**4.00**
Focus II	Freedom of Choice	96.83%		**4.00**
Focus III	Release of Information	94.34%		**4.00**
Focus IV	Status	90.00%		**4.00**
Focus V	Pre-Planning	97.73%	100%	**4.00**
Focus VI	Assessment	87.69%	100%	**4.00**
Focus VII	Medication Record	93.94%	100%	**4.00**
Focus VIII	Person-Centered Service Planning	93.72%	100%	**4.00**
Focus IX	MI Choice Services	81.48%	95.56%	**2.67**
Focus X	Linking and Coordinating	100%	100%	**4.00**
Focus XI	Follow-Up and Monitoring	70.00%	100%	**2.00**
Focus XII	Service Provider	100%		**4.00**
Focus XIII	Contingency Plan	81.82%	100%	**4.00**
Focus XIV	Critical Incidents	100%	100%	**4.00**
Focus XV	Adverse Benefit Determination	66.67%		**1.00**
Focus XVI	Complaints and Grievances	100%		**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus XVII	Home and Community Based		N/A	**N/A**
	Totals	**92.15%**	**99.32%**	**3.83**

	Indicates the standard was not reviewed as part of the record review or home visit.
	Indicates substantial compliance: 3.26 or higher.
	Indicates some compliance, needs improvement: 2.51 to 3.25.
	Indicates not full or substantial compliance: 1.76 to 2.50.
	Indicates compliance not demonstrated: 1.00 to 1.75.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: A review of five home visits was conducted and all reviews achieved full compliance with the exception of one focus area (MI Choice Services). The purpose of the home visits is to confirm that providers furnish services according to the person-centered service plan and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested that providers are consistently adhering to these requirements.

Strength #2: Senior Services achieved a substantial compliance rating in 14 of the 17 standards reviewed as part of the CQAR. The purpose of the record review is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the person-centered service plan and care planning process, reassessment data) and to assess the quality of waiver agency services to each member; therefore, CQAR findings suggested that person-centered service plans and service delivery are being implemented in accordance with many State and federal requirements.

Weaknesses and Recommendations

Weakness #1: Senior Services did not consistently follow all Follow-Up and Monitoring requirements; specifically, contacting the member for follow-up and monitoring. Waiver agencies are required to contact each member to ensure services are implemented as planned. When services are not implemented as planned or when the planned services require adjustments, waiver agencies should implement corrective actions to resolve problems and issues.

Why the weakness exists: Through the CQAR, MPHI determined that six out of 10 applicable records did not include evidence that **Senior Services** contacted the member/guardian for follow-up and monitoring as specified in the person-centered service plan and according to MDHHS policy. This finding was recurring for the past two years.

Recommendation: MDHHS required **Senior Services** to submit a CAP to remediate the deficiencies. **Senior Services**' CAP included, but was not limited to, education of staff members centered around ensuring the frequency of monitoring and a review of 20 records per month by the quality improvement department until a 90 percent threshold is achieved. HSAG recommends that **Senior Services** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #2: Senior Services did not consistently follow all Adverse Benefit Determination requirements; specifically, **Senior Services** did not consistently provide its members with an ABD notice. When a member no longer meets NFLOC, the MI Choice Section 1915(c) waiver requires the supports coordinator to initiate program discharge procedures and provide the member with an ABD notice. ABD notices are necessary to ensure members/guardians understand their appeal rights and the process to request an appeal.

Why the weakness exists: Through the CQAR, MPHI determined that two out of four applicable records did not include evidence that the waiver agency provided the member/guardian with an ABD notice when required.

Recommendation: MDHHS required **Senior Services** to submit a CAP to remediate the deficiencies. **Senior Services**' CAP included, but was not limited to, education of staff members and a review of 20 records per month by the quality improvement department until a 90 percent threshold is achieved for three consecutive months. HSAG recommends that **Senior Services** continue conducting a specific number of record reviews on an ongoing basis, regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

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

To identify strengths and weaknesses and draw conclusions for **Senior Services**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Senior Services** across all EQR activities. The overarching aggregated findings showed that **Senior Services**' quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Senior Services** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

HSAG's assessment of **Senior Services** also identified opportunities for **Senior Services** to enhance its quality assessment and performance improvement program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Senior Services** had a QMP that included brief descriptions of its quality management activities, its QMP should be modified to more comprehensively align with the requirements and best practices for a quality assessment and

performance improvement program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

The Information Center

Validation of Performance Improvement Projects

Performance Results

Table 3-49 displays the results for each QIP implemented during SFY 2020. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **The Information Center** met its internal SFY 2020 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **The Information Center** did not meet its internal SFY 2020 QIP goal or the statewide goal. Any interventions described within **The Information Center**'s QMP reports are also provided in Table 3-49. The results in Table 3-49 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-49—QIP Results

QIP Topic	Goal‡	Measurement and Outcome‡
1. *Prevalence of Neglect/Abuse*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020* = [0.54%] ☑
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **The Information Center**. **The Information Center** MI Choice Medicaid Waiver Quality Management Plan Activities & Outcomes Report FY 2020 dated January 31, 2021 identified the following: • TIC will continue to work with Participants on reporting neglect/abuse.		
2. *Prevalence of Pain With Inadequate Pain Control*	TIC will to work to decrease the percentage of participant's with inadequate pain control to the statewide goal of 3%	SFY 2019 = [No baseline data reported] SFY 2020* = [35.37%] ☒
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **The Information Center**. **The Information Center** MI Choice Medicaid Waiver Quality Management Plan Activities & Outcomes Report FY 2020 dated January 31, 2021 identified the following: • Supports Coordinators will continue to educate participants who report inadequate pain control and coordinate with the participant's PCSP.		

QIP Topic	Goal‡	Measurement and Outcome‡
3. *Prevalence of Falls*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020* = [28.88%] ☒
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **The Information Center**. **The Information Center** MI Choice Medicaid Waiver Quality Management Plan Activities & Outcomes Report FY 2020 dated January 31, 2021 identified the following: • Supports Coordinators will, on an ongoing basis, educate participants on fall risks/how to avoid falls.		
4. *Prevalence of Any Injuries*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020* = [4.31%] ☒
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **The Information Center**. **The Information Center** MI Choice Medicaid Waiver Quality Management Plan Activities & Outcomes Report FY 2020 dated January 31, 2021 identified the following: • None identified		
5. *Prevalence of Dehydration*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020* = [10.77%] ☒
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **The Information Center**. **The Information Center** MI Choice Medicaid Waiver Quality Management Plan Activities & Outcomes Report FY 2020 dated January 31, 2021 identified the following: • Supports Coordinators will continue to educate and inform Participants on the importance of adequate fluid intake to prevent dehydration.		

FY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
‡MDHHS provided a document labeled "FY 2020 QMP Plan Final" for this waiver agency; however, this document was the SFY 2020 annual report. Therefore, information included as part of the QIP documentation, including the QIP goals and outcomes, were obtained through the SFY 2020 annual report. Where a specific goal was not identified, HSAG evaluated outcomes using the statewide goal percentage rates.
*HSAG calculated the SFY 2020 performance rates using the numerators and denominators provided by the waiver agency in the annual report.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: The Information Center met the statewide goal for the *Prevalence of Neglect/Abuse* QIP, suggesting members are experiencing a low prevalence of neglect/abuse.

Weaknesses and Recommendations

Weakness #1: There was no SFY 2020–2021 QMP available for **The Information Center**.

Why the weakness exists: Although MDHHS provided a document labeled "FY 2020 QMP Plan Final" for **The Information Center**, this document was actually the SFY 2020 annual report. Therefore, it appears that **The Information Center** did not provide MDHHS with a QMP as required by the MDHHS contract requirements.

Recommendation: HSAG recommends that **The Information Center** follow the MDHHS requirement to complete and submit an updated QMP every two years. This QMP should be separate from the annual MI Choice Medicaid Waiver Quality Management Plan Activities & Outcomes Report.

Weakness #2: The Information Center did not indicate goals for most QIPs. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each measure needs to be clearly and consistently documented.

Why the weakness exists: The goals for each QIP quality indicator were not identified in the MI Choice Medicaid Waiver Quality Management Plan Activities & Outcomes Report.

Recommendation: HSAG recommends that **The Information Center** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should be consistently identified within all QMP reports (i.e., QMP, annual report).

Weakness #3: The Information Center did not measure improvements to the quality indicators on an ongoing basis. To effectively measure improvement in the quality indicators, it is important to identify and measure a baseline rate.

Why the weakness exists: The Information Center did not indicate the baseline rate for each quality indicator within its QMP reports.

Recommendation: HSAG recommends **The Information Center** identify the baseline period and rate for each quality indicator and measure them regularly to determine if interventions implemented are effective.

Weakness #4: In the SFY 2020 annual report, **The Information Center** reported the numerator and denominator, and the percentage rates for each half of SFY 2020 for each quality indicator; however, **The Information Center** did not provide an overall performance rate for SFY 2020 or compare performance against a baseline rate to determine performance outcomes. It is important to monitor not only the numerator and denominator on an ongoing basis, but also the annual percentage to identify the performance over time, including any significant improvements or declines in annual outcomes.

Why the weakness exists: **The Information Center** did not calculate a percentage rate for the entire state fiscal year and compare those overall state fiscal year results to an identified baseline rate to determine the QIPs' performance outcomes. Although the percentage rates were determined for a period of two quarters, the percentages were not measured against any performance metrics.

Recommendation: HSAG recommends that **The Information Center** calculate QIP performance rates at the end of the specified measurement period (i.e., conclusion of the state fiscal year) using the numerators and denominators applicable for the entire state fiscal year. These performance rates should then be assessed against a specified baseline rate to determine whether performance in each QIP improved or declined over time. **The Information Center** should use the results of this assessment to determine whether its implemented interventions should continue or be discontinued, be revised, or whether new interventions need to be developed.

Weakness #5: The interventions implemented by **The Information Center** to meet performance goals were very limited and non-specific. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be specific, measurable, and actionable.

Why the weakness exists: **The Information Center**'s SFY 2020 annual report did not include specific and measurable interventions for the state-required QIPs, or include an assessment of whether a specific intervention(s) was successful or unsuccessful in achieving increased performance. Further, no conclusions were drawn regarding whether the interventions had an impact on the rate.

Recommendation: HSAG recommends that **The Information Center** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **The Information Center** should analyze and interpret results at multiple points in time and test for statistical significance. **The Information Center** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #6: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **The Information Center**'s QIPs must be designed in a methodically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions.

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2020 annual report included limited details on the design developed and methodology followed by **The Information Center** when implementing its QIPs.

Recommendation: HSAG recommends that **The Information Center** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **The Information Center** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2020, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For eight of the 39 performance measures calculated by MDHHS, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Those performance measures with a statewide rate of 100 percent reported through the CMS-372 report were not included as part of the assessment. Table 3-50 displays the eight performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rate as calculated by MDHHS for the CMS-372 report, the statewide percentage rate as calculated by HSAG using the CQAR standard scores associated with each performance measure, and **The Information Center**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **The Information Center**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate as calculated by HSAG, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-50—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* VIII.1, VIII.2, VIII.4, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39	91.27	92.11	86.00
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* I.1, I.2, I.3, I.5, II.1, II.2, II.3, II.4, II.5, II.6, II.7, II.8, II.9, IV.1, IV.2, IV.3, IV.5, IV.6, VI.1, VI.2, VI.3, X.1	96.83	98.82	99.10
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* V.3, IX.1, IX.2, IX.3, IX.6	93.65	94.16	90.00
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* VIII.7, VIII.8	98.94	99.07	100
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* VIII.3, VIII.5, VIII.6, VIII.11	98.41	98.81	100
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* V.1, V.2, V.3, V.5, V.10, V.11, V.13, V.15, VI.12, VI.14, VI.16, VIII.1, VIII.2, VIII.3 VIII.4,VIII.5, VIII.6, VIII.11, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39, VIII.40, VIII.41, IX.1, IX.2, IX.3, IX.4, IX.6	94.97	94.13	93.42
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* VIII.28, VIII.29, VIII.30, VIII.31, VIII.32, VIII.33, VIII.34, IX.5	96.03	95.54	93.75

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* XI.1, XI.3, XI.4	**89.68**	**93.52**	**80.00**

* The individual waiver agency performance measure rates were derived from the standards outlined in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report.

**Statewide percentage rates are displayed as reported by MDHHS. HSAG's calculations may differ from MDHHS' calculations as HSAG summed all numerators and denominators related to the CQAR standards included as part of each performance measure, while MDHHS calculated performance measure rates for the CMS-372 report using a total count of CQAR records reviewed across the waiver agencies and removing those records from the numerator when a standard included as part of the performance measure was deficient ("*Non-Evident*").

‡ The statewide percentage rates determined by HSAG were based on results of the SFY 2020 CQAR and the standards associated with each performance measure as indicated in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source." The statewide percentage rates determined by HSAG are displayed for comparison purposes to the MDHHS statewide percentages. Additionally, the HSAG calculated rates were made available for this report to ensure an appropriate representation to the rates calculated for each waiver agency.

Indicates the performance measure rate is higher than the statewide rate as calculated by HSAG.

Indicates the performance measure rate is lower than the statewide rate as calculated by HSAG.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Although MDHHS has not established performance measure benchmarks, **The Information Center**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 7, 8, 12, 22, 24, 27, 28, 29, 31, 33, 34, 37, and 38. Performance Measures 36 and 39 also achieved a rate of 100 percent; however, performance in these measures are driven solely by MDHHS as they relate to capitation payments to the waiver agencies.

Strength #2: The Information Center received a 100 percent performance rating for Performance Measures 16 and 17, indicating the person-centered service plans reviewed as part of the CQAR included appropriate strategies to address members' assessed health and safety risks and individualized goals and preferences. This strong performance in these areas suggested that **The Information Center** staff members are taking into consideration waiver members' individualized needs, including member-specific health risks, and member preferences when creating service plans; and these service plans ensure the individualized goals, preferences, and safety risks are relevant, current, and of the highest quality to meet members' needs.

Weaknesses and Recommendations

Weakness #1: The Information Center received a score of 86 percent for Performance Measure 1, *number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This indicated that supports coordinators were not completing service plans for members in the time frame required by MDHHS.

Why the weakness exists: The Information Center's performance rate for Performance Measure 1 fell 6.11 percentage points below HSAG's calculated statewide rate. Through the CQAR, of the 10 records reviewed, MPHI determined that two records did not identify and assess the participant's needs and risk factors; two records did not list services and supports that helped the participant achieve goals; and 10 records did not include both waiver and non-waiver services and supports when applicable.

Recommendation: MDHHS required **The Information Center** to develop a CAP to remediate the deficiencies. The completed CAP indicated that **The Information Center** would conduct education and training for staff members and the quality department would use reports to audit compliance to determine if individual CAPs need to be developed. HSAG recommends **The Information Center** continue to conduct audits of individual supports coordinators/care managers on an ongoing basis to ensure person-centered service plans contain all required components, and that the person-centered service plans include documentation to support waiver members are receiving all approved services and supports.

Weakness #2: The Information Center performed substantially worse than other waiver agencies on Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan*, as indicated by a performance rate of more than 5 percentage points below the statewide rate, indicating members were not always receiving services timely to maintain optimal health.

Why the weakness exists: Through the record review, MPHI determined two out of seven applicable person-centered service plans did not ensure service delivery according to MDHHS policy, including the use of the waiver member's back-up plan or an out-of-network provider as applicable or necessary.

Recommendation: MDHHS required **The Information Center** to develop a CAP to remediate the deficiencies. The completed CAP indicated that **The Information Center** would conduct education and training for staff members and the quality department would use reports to audit compliance to determine if individual CAPs need to be developed. HSAG recommends **The Information Center** continue to conduct audits of individual supports coordinators/care managers on an ongoing basis to ensure person-centered service plans contain all required components, and that the person-centered service plans include documentation to support waiver members are receiving all approved services and supports. HSAG also recommends that **The Information Center** determine whether the results of the record review were related to staff documentation errors, or whether there was a lack of service providers available to provide the services approved in the person-centered service plan. If the latter, **The Information Center** should analyze its available provider network to determine if additional providers are needed to ensure timely and accessible care.

Compliance Review

Performance Results

Table 3-51 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-51 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-51—Clinical Quality Assurance Reviews and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus I	Level of Care Determination	100%	100%	**4.00**
Focus I.B	Communication		100%	**4.00**
Focus II	Freedom of Choice	100%		**4.00**
Focus III	Release of Information	96.08%		**4.00**
Focus IV	Status	95.65%		**4.00**
Focus V	Pre-Planning	98.86%	100%	**4.00**
Focus VI	Assessment	94.44%	100%	**4.00**
Focus VII	Medication Record	95.08%	100%	**4.00**
Focus VIII	Person-Centered Service Planning	92.68%	100%	**4.00**
Focus IX	MI Choice Services	89.09%	100%	**3.33**
Focus X	Linking and Coordinating	96.55%	100%	**4.00**
Focus XI	Follow-Up and Monitoring	75.00%	100%	**2.67**
Focus XII	Service Provider	100%		**4.00**
Focus XIII	Contingency Plan	92.00%	100%	**4.00**
Focus XIV	Critical Incidents	80.00%	100%	**2.67**
Focus XV	Adverse Benefit Determination	77.78%		**3.00**
Focus XVI	Complaints and Grievances	100%		**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus XVII	Home and Community Based		100%	**4.00**
	Totals	**94.09%**	**100%**	**3.87**

	Indicates the standard was not reviewed as part of the record review or home visit.
	Indicates substantial compliance: 3.26 or higher.
	Indicates some compliance, needs improvement: 2.51 to 3.25.
	Indicates not full or substantial compliance: 1.76 to 2.50.
	Indicates compliance not demonstrated: 1.00 to 1.75.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: A review of five home visits was conducted and all reviews achieved full compliance. The purpose of the home visits is to confirm that providers furnish services according to the person-centered service plan and member preferences, and to determine member satisfaction with those services. These findings suggested that members are accessing services timely in accordance with their service plans and preferences, and are satisfied with those services.

Strength #2: The Information Center achieved a substantial compliance rating in 15 of the 18 standards reviewed as part of the CQAR. The purpose of the record review is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the person-centered service plan and care planning process, reassessment data) and to assess the quality of waiver agency services to each member; therefore, CQAR findings suggested **The Information Center** is conducting the assessment process, developing person-centered service plans, and coordinating service delivery in accordance with many State and federal requirements.

Weaknesses and Recommendations

Weakness #1: The Information Center did not receive any compliance determinations that were in the *not full or substantial compliance* or *compliance not demonstrated* rating categories; therefore, no substantial weaknesses were identified.

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: Although no substantial weaknesses were identified within any of the program areas under review, **The Information Center** had noted deficiencies in the Follow-Up and Monitoring, Critical Incidents, and Adverse Benefit Determination standards. This indicated there

are opportunities for improvement related to the supports coordinators' adherence to processes to follow-up with the member/guardian timely to ensure services are being accessed in accordance with the person-centered service plan; ensure all reported critical incidents are being entered into the critical incident portal for appropriate and timely follow up and resolution; and to ensure members/guardians receive an ABD when being disenrolled from the waiver program for not meeting the NFLOC criteria and/or for any service denial, reduction, suspension, and/or termination. MDHHS required a CAP for the noted areas of deficiency; however, HSAG recommends **The Information Center** implement an ongoing and robust internal auditing process of individual supports coordinators to ensure all program requirements are being met, assuring **The Information Center**'s waiver members are afforded all rights under Medicaid and waiver requirements, and are able to access timely and quality services as indicated in their person-centered service plans.

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

To identify strengths and weaknesses and draw conclusions for **The Information Center**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **The Information Center** across all EQR activities. The overarching aggregated findings showed that **The Information Center**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **The Information Center** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

HSAG's assessment of **The Information Center** also identified opportunities for **The Information Center** to enhance its quality assessment and performance improvement program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **The Information Center** had a QMP that included brief descriptions of its quality management activities, its QMP should be modified to more comprehensively align with the requirements and best practices for a quality assessment and performance improvement program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

The Senior Alliance

Validation of Performance Improvement Projects

Performance Results

Table 3-52 displays the results for each QIP implemented during SFY 2020. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **The Senior Alliance** met its internal SFY 2020 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **The Senior Alliance** did not meet its internal SFY 2020 QIP goal or the statewide goal. Any interventions described within **The Senior Alliance**'s QMP reports are also provided in Table 3-52. The results in Table 3-52 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-52—QIP Results

QIP Topic	Goal‡	Measurement and Outcome‡
1. *Prevalence of Neglect/Abuse*	Reduce the prevalence of participants who have been neglected/abused, have poor hygiene, are fearful of family member, or have been restrained to less than 6.0%.	SFY 2019 = [No baseline data reported] SFY 2020* = [7.20%] ☒
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **The Senior Alliance**. **The Senior Alliance** FY2021 Quality Management Plan: Activities & Outcomes Report For FY 2020 The Senior Alliance 1-C, dated January 19, 2021 identified the following: • **FY2020 Activities:** o Completed scenario/open discussion group training on recognizing abuse and neglect on 12/16/2019. o Completed annual Critical Incident staff training on 12/16/2019. o SCs assessed participant living environment via walk-throughs or comprehensive environmental assessment via phone at each assessment. o Critical Incident training reviewed with TSA contracted vendors on 11/19/2020. • **FY2021 Strategies:** o Add reminder to report any neglect or abuse to a Waiver newsletter and Local Quality Collaborative Group Meetings. o Continue staff education on neglect and abuse, drilling down QI Summary Report results by participant/SC when issues arise. o SCs will assess participant living environment via walk-throughs or comprehensive environmental assessment via phone at each assessment. o Annual Critical Incident training to be completed in FY2021. o Critical Incident training reviewed with TSA contracted vendors annually.		

QIP Topic	Goal‡	Measurement and Outcome‡
2. *Prevalence of Pain With Inadequate Pain Control*	Reduce the prevalence of participants who experience both pain AND inadequate pain control on regimen to less than 24.0%.	SFY 2019 = [No baseline data reported] SFY 2020* = [23.92%] ☑

Actions/Activities/Interventions:

A SFY 2020-2021 QMP was not available for **The Senior Alliance**.

The Senior Alliance FY2021 Quality Management Plan: Activities & Outcomes Report For FY 2020 The Senior Alliance 1-C, dated January 19, 2021 identified the following:

- **FY2020 Activities:**
  - Ongoing education of participants completed on pharmacological and non-pharmacological pain management measures at assessments as necessary.
  - SCs continue to address pain levels, participant's acceptable pain level, and current pain medication regimen during medication review and management. From there, set participant-centered goals and interventions.
  - During RAs, SCs assess participant's ability to manage medications, education about their medications, physical and cognitive abilities to take medications as prescribed, intentional non-adherence, and ongoing monitoring. If needed, nursing services can be ordered via the Waiver program & Waiver staff is encouraged to review attachment H before requesting approval for any Waiver services.
- **FY2021 Strategies:**
  - Include information on PATH classes and pharmacological/non-pharmacological pain management in Waiver newsletter.
  - Continue staff education on pain and pain control, drilling down QI Summary Report results by participant/SC when issues arise.
  - Ongoing education of participants to be completed on pharmacological and non-pharmacological pain management measures at assessments as necessary.
  - SCs will continue to address pain levels, participant's acceptable pain level, and current pain medication regimen during medication review and management. From there, they will set participant-centered goals and interventions.
  - During RAs, SCs assess participant's ability to manage medications, education about their medications, physical and cognitive abilities to take medications as prescribed, intentional non-adherence, and ongoing monitoring. If needed, nursing services can be ordered via the Waiver program & Waiver staff is encouraged to review attachment H before requesting approval for any Waiver services.

3. *Prevalence of Falls*	Reduce the prevalence of participants who experience a fall on a follow-up assessment to less than 20.0%.	SFY 2019 = [No baseline data reported] SFY 2020* = [26.59%] ☒

Actions/Activities/Interventions:

A SFY 2020-2021 QMP was not available for **The Senior Alliance**.

The Senior Alliance FY2021 Quality Management Plan: Activities & Outcomes Report For FY 2020 The Senior Alliance 1-C, dated January 19, 2021 identified the following:

QIP Topic	Goal‡	Measurement and Outcome‡
• **FY2020 Activities:** o SCs assessed participant living environment via walk-throughs or comprehensive environmental assessment via phone at each assessment and assist participant with DME needs (including bathroom DME). o Nursing students completed a sample of medication evaluations using Epocrates and results were communicated to SCs in order to address any issues with participants as necessary. o During assessments SCs completed medication review and assessed medication management, with focus on participant risk reduction including fewer falls, ED visits, and hospitalizations. o Maintained 100% compliance with staff participation in MI Choice Certification Program (CAPABLE). o Included fall prevention information in January 2020 Waiver newsletter. • **FY2021 Strategies:** o Continue staff education on fall prevention, drilling down QI Summary Report results by participant/SC when issues arise. o Include fall prevention information on January 2021 Waiver Newsletter. o Include PATH class information with Waiver Newsletter as available. o SCs will assess participant living environment via walk-throughs or comprehensive environmental assessment via phone at each assessment and assist participant with DME needs (including bathroom DME). o During assessments, SCs will complete medication review and assess medication management, with focus on participant risk reduction including fewer falls, ED visits, and hospitalizations.		
4. *Prevalence of Any Injuries*	Reduce the prevalence of participants who experience fractures or major skin problems (excluding current pressure or stasis ulcers) to less than 5%.	SFY 2019 = [No baseline data reported] SFY 2020* = [4.76%] ☑
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **The Senior Alliance**. **The Senior Alliance** FY2021 Quality Management Plan: Activities & Outcomes Report For FY 2020 The Senior Alliance 1-C, dated January 19, 2021 identified the following: • **FY2020 Activities:** o SCs conduct ongoing evaluation and monitoring at assessments and monitoring contact to ensure that participants are receiving adequate services. o Included appropriate education in January 2020 Waiver newsletter. o SCs assessed participant living environment via walk-throughs or comprehensive environmental assessment via phone at each assessment and assist participant with DME needs (including bathroom DME). o During assessments SCs completed medication review and assessed medication management, with focus on participant risk reduction including fewer falls, ED visits, and hospitalizations. • **FY2021 Strategies:** o Continue staff education on injuries, drilling QI Summary Report results down by participant/SC when issues arise.		

QIP Topic	Goal‡	Measurement and Outcome‡
o SCs will conduct ongoing evaluation and monitoring at assessments and monitoring contact to ensure that participants are receiving adequate services. o SCs will assess participant living environment via walk-throughs or comprehensive environmental assessment via phone at each assessment and assist participant with DME needs (including bathroom DME). o During assessments SCs will complete medication review and assess medication management, with focus on participant risk reduction including fewer falls, ED visits, and hospitalizations.		
5. *Prevalence of Dehydration*	Reduce the prevalence of participants who were dehydrated due to insufficient fluid intake to less than 3.5% statewide.	SFY 2019 = [No baseline data reported] SFY 2020* = [1.00%] ☑
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **The Senior Alliance**. **The Senior Alliance** FY2021 Quality Management Plan: Activities & Outcomes Report For FY 2020 The Senior Alliance 1-C, dated January 19, 2021 identified the following: • **FY2020 Activities:** o SCs continuously assess for adequate hydration during assessments. Nutrition resources are provided as appropriate. • **FY2021 Strategies:** o Continue staff education on dehydration, drilling QI Summary Report results down by participant/SC when issues arise. o Include appropriate education in Waiver newsletter (example: summer heat).		

FY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
‡MDHHS provided a document labeled "FY 2020 QMP Plan Final" for this waiver agency; however, this document was the SFY 2020 annual report. Therefore, information included as part of the QIP documentation, including the QIP goals and outcomes, were obtained through the SFY 2020 annual report. Where a specific goal was not identified, HSAG evaluated outcomes using the statewide goal percentage rates.
*HSAG calculated the SFY 2020 performance rates using the numerators and denominators provided by the waiver agency in the annual report.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: The Senior Alliance met its internal QIP goals for the *Prevalence of Pain With Inadequate Pain Control*, *Prevalence of Any Injuries*, and *Prevalence of Dehydration* QIPs, suggesting **The Senior Alliance** implemented effective interventions.

Strength #2: The Senior Alliance identified clear interventions for SFY 2020, including planned interventions for the next state fiscal year.

Weaknesses and Recommendations

Weakness #1: There was no SFY 2020–2021 QMP available for **The Senior Alliance**.
Why the weakness exists: Although MDHHS provided a document labeled "FY 2020 Quality Management Plan" for **The Senior Alliance**, this document was actually the SFY 2020 annual report. Therefore, it appeared that **The Senior Alliance** did not provide MDHHS with a QMP as required by the MDHHS contract requirements.
Recommendation: HSAG recommends that **The Senior Alliance** follow the MDHHS requirement to complete and submit an updated QMP every two years. This QMP should be separate from the annual MI Choice Medicaid Waiver Quality Management Plan Activities & Outcomes Report.

Weakness #2: The Senior Alliance goals, and specifically the identified percentage rates, did not align with the MDHHS goals associated with the QIPs.
Why the weakness exists: It was unclear how **The Senior Alliance** determined its internal QIP goals.
Recommendation: HSAG recommends that **The Senior Alliance** consult with MDHHS to confirm it is appropriate to establish its own QIP goals that are both attainable and drive improvement, even if those goals do not align with the statewide goals set by MDHHS.

Weakness #3: In the SFY 2020 annual report, **The Senior Alliance** reported the numerator and denominator, and the percentage rates for each quarter of SFY 2020 for each QIP; however, **The Senior Alliance** did not provide an overall performance rate for SFY 2020 or compare performance against a baseline rate to determine performance outcomes. It is important to monitor not only the numerator and denominator on an ongoing basis, but also the annual percentage to identify the performance over time, including any significant improvements or declines in annual outcomes.
Why the weakness exists: The Senior Alliance did not calculate a percentage rate for the entire state fiscal year and compare those overall state fiscal year results to an identified baseline rate to determine the QIPs' performance outcomes.
Recommendation: HSAG recommends that **The Senior Alliance** calculate QIP performance rates at the end of the specified measurement period (i.e., conclusion of the state fiscal year) using the

numerators and denominators applicable for the entire state fiscal year. These performance rates should then be assessed against a specified baseline rate to determine whether performance in each QIP improved or declined over time. **The Senior Alliance** should use the results of this assessment to determine whether its implemented interventions should continue or be discontinued, be revised, or whether new interventions need to be developed.

Weakness #4: The interventions implemented by **The Senior Alliance** to meet performance goals were identified; however, there was no evaluation of each intervention to determine its effectiveness. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly evaluated.

Why the weakness exists: **The Senior Alliance** SFY 2020 annual report did not clearly include an assessment of whether a specific intervention(s) was successful or unsuccessful in achieving increased performance.

Recommendation: HSAG recommends that **The Senior Alliance** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **The Senior Alliance** should analyze and interpret results at multiple points in time and test for statistical significance. **The Senior Alliance** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #5: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **The Senior Alliance**'s QIPs must be designed in a methodically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions.

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2020 annual report included limited details on the design developed and methodology followed by **The Senior Alliance** when implementing its QIPs.

Recommendation: HSAG recommends that **The Senior Alliance** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **The Senior Alliance** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2020, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For eight of the 39 performance measures calculated by MDHHS, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Those performance measures with a statewide rate of 100 percent reported through the CMS-372 report were not included as part of the assessment. Table 3-53 displays the eight performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rate as calculated by MDHHS for the CMS-372 report, the statewide percentage rate as calculated by HSAG using the CQAR standard scores associated with each performance measure, and **The Senior Alliance**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **The Senior Alliance**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate as calculated by HSAG, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-53—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* VIII.1, VIII.2, VIII.4, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39	91.27	92.11	88.24
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* I.1, I.2, I.3, I.5, II.1, II.2, II.3, II.4, II.5, II.6, II.7, II.8, II.9, IV.1, IV.2, IV.3, IV.5, IV.6, VI.1, VI.2, VI.3, X.1	96.83	98.82	100
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* V.3, IX.1, IX.2, IX.3, IX.6	93.65	94.16	97.06
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* VIII.7, VIII.8	98.94	99.07	100

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* VIII.3, VIII.5, VIII.6, VIII.11	**98.41**	**98.81**	**100**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* V.1, V.2, V.3, V.5, V.10, V.11, V.13, V.15, VI.12, VI.14, VI.16, VIII.1, VIII.2, VIII.3 VIII.4,VIII.5, VIII.6, VIII.11, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39, VIII.40, VIII.41, IX.1, IX.2, IX.3, IX.4, IX.6	**94.97**	**94.13**	**92.25**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* VIII.28, VIII.29, VIII.30, VIII.31, VIII.32, VIII.33, VIII.34, IX.5	**96.03**	**95.54**	**92.75**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* XI.1, XI.3, XI.4	**89.68**	**93.52**	**94.12**

* The individual waiver agency performance measure rates were derived from the standards outlined in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report.

**Statewide percentage rates are displayed as reported by MDHHS. HSAG's calculations may differ from MDHHS' calculations as HSAG summed all numerators and denominators related to the CQAR standards included as part of each performance measure, while MDHHS calculated performance measure rates for the CMS-372 report using a total count of CQAR records reviewed across the waiver agencies and removing those records from the numerator when a standard included as part of the performance measure was deficient ("*Non-Evident*").

‡ The statewide percentage rates determined by HSAG were based on results of the SFY 2020 CQAR and the standards associated with each performance measure as indicated in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source." The statewide percentage rates determined by HSAG are displayed for comparison purposes to the MDHHS statewide percentages. Additionally, the HSAG calculated rates were made available for this report to ensure an appropriate representation to the rates calculated for each waiver agency.

Indicates the performance measure rate is higher than the statewide rate as calculated by HSAG.

Indicates the performance measure rate is lower than the statewide rate as calculated by HSAG.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Although MDHHS has not established performance measure benchmarks, **The Senior Alliance**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 7, 8, 12, 22, 24, 27, 28, 29, 31, 33, 34, 37, and 38. Performance Measures 36 and 39 also achieved a rate of 100 percent; however, performance in these measures are driven solely by MDHHS as they relate to capitation payments to the waiver agencies.

Strength #2: The Senior Alliance received a 100 percent performance rating for Performance Measures 2, 16, and 17, indicating members were appropriately evaluated and determined to meet the level of care necessary to receive services under the waiver program and, subsequently, are able to access services in the most appropriate care setting as determined by the member, member's guardian, and waiver agency staff members. Additionally, person-centered service plans reviewed as part of the CQAR included appropriate strategies to address members' assessed health and safety risks and individualized goals and preferences; this suggested that **The Senior Alliance** staff members are taking into consideration waiver members' individualized needs, including member-specific health risks, and member preferences when creating service plans, ensuring members are receiving services of the highest quality to meet their own specific and unique needs.

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial trends of weakness. Although Performance Measures 1, 18, and 19 did not meet the statewide performance rate, none of these performance measures fell below the statewide rate by more than 5 percentage points.

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: MDHHS required **The Senior Alliance** to develop a CAP to remediate the deficiencies associated with Performance Measures 1, 18, and 19. The completed CAP indicated that **The Senior Alliance** would conduct education and training for staff members, and the quality and training manager would continue to monitor compliance. HSAG recommends **The Senior Alliance** continue its monitoring efforts and conduct an audit of a designated number of cases (e.g., 10 per month) for each supports coordinator on an ongoing basis that includes a review of all required components of the person-centered service plan, as well as the processes required to develop the person-centered service plan.

Compliance Review

Performance Results

Table 3-54 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-54 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-54—Clinical Quality Assurance Reviews and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus I	Level of Care Determination	100%	100%	**4.00**
Focus I.B	Communication		100%	**4.00**
Focus II	Freedom of Choice	100%		**4.00**
Focus III	Release of Information	98.91%		**4.00**
Focus IV	Status	100%		**4.00**
Focus V	Pre-Planning	88.51%	100%	**4.00**
Focus VI	Assessment	93.70%	100%	**4.00**
Focus VII	Medication Record	99.04%	100%	**4.00**
Focus VIII	Person-Centered Service Planning	94.15%	100%	**4.00**
Focus IX	MI Choice Services	93.81%	97.44%	**4.00**
Focus X	Linking and Coordinating	94.64%	100%	**4.00**
Focus XI	Follow-Up and Monitoring	76.47%	100%	**2.69**
Focus XII	Service Provider	57.14%		**1.00**
Focus XIII	Contingency Plan	97.73%	100%	**4.00**
Focus XIV	Critical Incidents	90.00%	100%	**4.00**
Focus XV	Adverse Benefit Determination	91.67%		**4.00**
Focus XVI	Complaints and Grievances	100%		**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus XVII	Home and Community Based		100%	**4.00**
	Totals	**94.44%**	**99.67%**	**3.94**

	Indicates the standard was not reviewed as part of the record review or home visit.
	Indicates substantial compliance: 3.26 or higher.
	Indicates some compliance, needs improvement: 2.51 to 3.25.
	Indicates not full or substantial compliance: 1.76 to 2.50.
	Indicates compliance not demonstrated: 1.00 to 1.75.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: A review of nine home visits was conducted with all program areas reviewed scoring higher than 97 percent, including 11 of 12 areas achieving a compliance rate of 100 percent. The purpose of the home visits is to confirm that providers furnish services according to the person-centered service plan and member preferences, and to determine member satisfaction with those services. These findings suggested that most members are accessing services timely in accordance with their service plans and preferences, and are satisfied with those services.

Strength #2: The Senior Alliance achieved a substantial compliance rating in 16 of the 18 standards reviewed as part of the CQAR. The purpose of the record review is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the person-centered service plan and care planning process, reassessment data) and to assess the quality of waiver agency services to each member; therefore, CQAR findings suggested **The Senior Alliance** is conducting the assessment process, developing person-centered service plans, and coordinating service delivery in accordance with most State and federal requirements.

Weaknesses and Recommendations

Weakness #1: The Senior Alliance did not consistently follow all Service Provider requirements; specifically, **The Senior Alliance**'s contracted service providers did not contact the waiver agency to inform it of waiver members' health and welfare issues as required.

Why the weakness exists: Through the CQAR, MPHI determined that three out of four applicable records did not include evidence that **The Senior Alliance**'s service providers contacted the waiver agency to inform them when a member experienced a health and welfare issue.

Recommendation: MDHHS required **The Senior Alliance** to submit a CAP to remediate the deficiencies. **The Senior Alliance**'s CAP indicated staff members would provide education to

service providers through the annual vendor meeting, and ongoing monitoring through monthly chart reviews would occur until a rate of 75 percent compliance is met. However, HSAG recommends that **The Senior Alliance** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor vendors to ensure performance stays consistent and contract requirements are met.

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

To identify strengths and weaknesses and draw conclusions for **The Senior Alliance**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **The Senior Alliance** across all EQR activities. The overarching aggregated findings showed that **The Senior Alliance**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **The Senior Alliance** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

HSAG's assessment of **The Senior Alliance** also identified opportunities for **The Senior Alliance** to enhance its quality assessment and performance improvement program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **The Senior Alliance** had a QMP that included brief descriptions of its quality management activities, its QMP should be modified to more comprehensively align with the requirements and best practices for a quality assessment and performance improvement program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Tri-County Office on Aging

Validation of Performance Improvement Projects

Performance Results

Table 3-55 displays the results for each QIP implemented during SFY 2020. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Tri-County Office on Aging** met its internal SFY 2020 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Tri-County Office on Aging** did not meet its internal SFY 2020 QIP goal or the statewide goal. Any interventions described within **Tri-County Office on Aging**'s QMP reports are also provided in Table 3-55. The results in Table 3-55 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-55—QIP Results

QIP Topic	Goal	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020* = 3.2% ☒
Actions/Activities/Interventions: According to **Tri-County Office on Aging**'s SFY 2020-2021 QMP dated January 8, 2020, **Tri-County Office on Aging** planned to complete the following tasks: • [None identified] **Tri-County Office on Aging**'s Summary of 2020-2021 Quality Management Plan dated January 22, 2021 identified the following: • TCOA implemented a training plan for support coordinators and professional support staff using web-based training platform, Relias. The trainings within the training plan highlight the latest research and evidence-based knowledge related to the prevention and reporting of abuse and neglect. Additionally, TCOA coordinated the implementation of training regarding abuse and neglect at an all staff meeting in FY 2020. TCOA's consumer quality collaborative, CSI, also began the initial planning process for a guide outlining common financial scams targeted at older adults that could be distributed and/or reviewed with participants and community members.		
2. *Prevalence of Pain With Inadequate Pain Control*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020* = 27.3% ☒
Actions/Activities/Interventions: According to **Tri-County Office on Aging**'s Summary of QA Plan Activities and Outcomes dated January 8, 2020, **Tri-County Office on Aging** planned to complete the following tasks: • [None identified]		

QIP Topic	Goal	Measurement and Outcome
Tri-County Office on Aging's Summary of 2020-2021 Quality Management Plan dated January 22, 2021 identified the following: • TCOA implemented a training plan for support coordinators and professional support staff using web-based training platform, Relias. The trainings within the training plan highlight the latest research and evidence-based knowledge related to pain management. Additionally, TCOA utilized the MI Capable Tool-Kit to provide education and resources for SCs related to the efficacy of alternative pain relief strategies. Adequate pain control also continues to be an ongoing topic of discussion at CSI, the local consumer quality collaborative group.		
3. *Prevalence of Falls*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020* = 32% ☒
Actions/Activities/Interventions: According to **Tri-County Office on Aging**'s Summary of QA Plan Activities and Outcomes dated January 8, 2020, **Tri-County Office on Aging** planned to complete the following tasks: • [None identified] **Tri-County Office on Aging**'s Summary of 2020-2021 Quality Management Plan dated January 22, 2021 identified the following: • TCOA implemented a training plan for support coordinators and professional support staff using web-based training platform, Relias. The trainings within the training plan highlight the latest research and evidence-based knowledge related to reducing the risk of falls. Additionally, TCOA utilized the MI Capable Toolkit to provide education and resources for SCs related to the most current evidence-based assessment tools and prevention strategies for falls. The reduction of risk and prevention of falls also continues to be an ongoing topic of discussion at CSI, the local consumer quality collaborative group.		
4. *Prevalence of Any Injuries*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020* = 4.7% ☒
Actions/Activities/Interventions: According to **Tri-County Office on Aging**'s Summary of QA Plan Activities and Outcomes dated January 8, 2020, **Tri-County Office on Aging** planned to complete the following tasks: • [None identified] **Tri-County Office on Aging**'s Summary of 2020-2021 Quality Management Plan dated January 22, 2021 identified the following: • TCOA implemented a training plan for support coordinators and professional support staff using web-based training platform, Relias. The trainings within the training plan highlight the latest research and evidence-based knowledge related to reducing the risk of injury for individuals, including abuse or neglect. Additionally, TCOA utilized the MI Capable Toolkit to provide education and resources for SCs related to the most current evidence-based assessment tools and prevention strategies for risk reduction and intervention		

QIP Topic	Goal	Measurement and Outcome
planning. Reduction of risk and prevention of injury continues to be discussed and addressed by CSI, the local consumer quality collaborative group, who recently updated a document previously developed by the committee to prompt individuals of what may be required or helpful for emergency professionals in case of injury that results in a hospitalization.		
5. *Prevalence of Dehydration*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020* = 1.6% ☒

Actions/Activities/Interventions:

According to **Tri-County Office on Aging**'s Summary of QA Plan Activities and Outcomes dated January 8, 2020, **Tri-County Office on Aging** planned to complete the following tasks:

- [None identified]

Tri-County Office on Aging's Summary of 2020-2021 Quality Management Plan dated January 22, 2021 identified the following:

- TCOA implemented a training plan for support coordinators and professional support staff using web-based training platform, Relias. The trainings within the training plan highlight the latest research and evidence-based knowledge related to proper nutrition and hydration. Additionally, TCOA utilized the MI Capable Toolkit to provide education and resources for SCs related to the most current evidence-based assessment tools and prevention strategies for reducing risk for dehydration. Access to proper nutrition and hydration continues to be discussed and addressed by CSI, the local consumer quality collaborative group, who invited a Registered Dietitian to present on this topic at the February 2021 CSI meeting.

FY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
*HSAG determined performance outcomes using the most current percentage rate identified by the waiver agency within the FY 2020 annual report. HSAG cannot determine whether the most current percentage rates identified by the waiver agency within the report were reflective of the rates at the end of SFY 2020.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: HSAG did not identify any substantial strengths for **Tri-County Office on Aging**.

Weaknesses and Recommendations

Weakness #1: Tri-County Office on Aging did not meet statewide goals for any of the five QIPs and also demonstrated a decrease in four of the five QIPs as indicated in the SFY 2020 annual report.

Why the weakness exists: Based on **Tri-County Office on Aging**'s outcomes analysis within the SFY 2020 annual report, prevalence rates for neglect/abuse, inadequate pain control, falls, and

injuries increased throughout the measurement period, suggesting the implemented activities did not support improvement.

Recommendation: HSAG recommends that **Tri-County Office on Aging** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should be consistently documented within its QMP reports. Additionally, **Tri-County Office on Aging** should ensure that its annual report includes a more comprehensive analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers. Further, HSAG recommends that **Tri-County Office on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Tri-County Office on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Tri-County Office on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #2: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **Tri-County Office on Aging**'s QIPs must be designed in a methodically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions.

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2020 annual report included limited details on the design developed and the methodology followed by **Tri-County Office on Aging** when implementing its QIPs.

Recommendation: HSAG recommends that **Tri-County Office on Aging** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Tri-County Office on Aging** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2020, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For eight of the 39 performance measures calculated by MDHHS, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Those performance measures with a statewide rate of 100 percent reported through the CMS-372 report were not included as part of the assessment. Table 3-56 displays the eight performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage

rate as calculated by MDHHS for the CMS-372 report, the statewide percentage rate as calculated by HSAG using the CQAR standard scores associated with each performance measure, and **Tri-County Office on Aging**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Tri-County Office on Aging**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate as calculated by HSAG.

Table 3-56—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* VIII.1, VIII.2, VIII.4, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39	**91.27**	**92.11**	**95.93**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* I.1, I.2, I.3, I.5, II.1, II.2, II.3, II.4, II.5, II.6, II.7, II.8, II.9, IV.1, IV.2, IV.3, IV.5, IV.6, VI.1, VI.2, VI.3, X.1	**96.83**	**98.82**	**99.28**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* V.3, IX.1, IX.2, IX.3, IX.6	**93.65**	**94.16**	**97.20**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* VIII.7, VIII.8	**98.94**	**99.07**	**100**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* VIII.3, VIII.5, VIII.6, VIII.11	**98.41**	**98.81**	**100**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* V.1, V.2, V.3, V.5, V.10, V.11, V.13, V.15, VI.12, VI.14, VI.16, VIII.1, VIII.2, VIII.3 VIII.4,VIII.5, VIII.6, VIII.11, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39, VIII.40, VIII.41, IX.1, IX.2, IX.3, IX.4, IX.6	**94.97**	**94.13**	**94.55**

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* VIII.28, VIII.29, VIII.30, VIII.31, VIII.32, VIII.33, VIII.34, IX.5	**96.03**	**95.54**	**99.11**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* XI.1, XI.3, XI.4	**89.68**	**93.52**	**100**

* The individual waiver agency performance measure rates were derived from the standards outlined in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report.

**Statewide percentage rates are displayed as reported by MDHHS. HSAG's calculations may differ from MDHHS' calculations as HSAG summed all numerators and denominators related to the CQAR standards included as part of each performance measure, while MDHHS calculated performance measure rates for the CMS-372 report using a total count of CQAR records reviewed across the waiver agencies and removing those records from the numerator when a standard included as part of the performance measure was deficient ("*Non-Evident*").

‡ The statewide percentage rates determined by HSAG were based on results of the SFY 2020 CQAR and the standards associated with each performance measure as indicated in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source." The statewide percentage rates determined by HSAG are displayed for comparison purposes to the MDHHS statewide percentages. Additionally, the HSAG calculated rates were made available for this report to ensure an appropriate representation to the rates calculated for each waiver agency.

Indicates the performance measure rate is higher than the statewide rate as calculated by HSAG.

Indicates the performance measure rate is lower than the statewide rate as calculated by HSAG.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Although MDHHS has not established performance measure benchmarks, **Tri-County Office on Aging**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 7, 8, 12, 22, 24, 27, 28, 29, 31, 33, 34, 37, and 38. Performance Measures 36 and 39 also achieved a rate of 100 percent; however, performance in these measures are driven solely by MDHHS as they relate to capitation payments to the waiver agencies.

Strength #2: Tri-County Office on Aging received a 100 percent performance rating for Performance Measures 16, 17, and 20, indicating **Tri-County Office on Aging** developed person-centered service plans that had strategies to address members' assessed health and safety risks.

Additionally, **Tri-County Office on Aging** ensured that the person-centered service plans included goals and preferences desired by the members. Further, person-centered service plans reviewed as part of the CQAR indicated that members received all of the provided services and supports identified appropriately, suggesting that **Tri-County Office on Aging** staff members followed up to ensure that members continually received the services and supports they needed as identified in their person-centered service plans.

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial trends of weakness.

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: This section is not applicable as no substantial weaknesses were identified; therefore, HSAG has no recommendations for improvement.

Compliance Review

Performance Results

Table 3-57 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-57 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-57—Clinical Quality Assurance Reviews and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus I	Level of Care Determination	100%	100%	**4.00**
Focus I.B	Communication		100%	**4.00**
Focus II	Freedom of Choice	98.75%		**4.00**
Focus III	Release of Information	97.78%		**4.00**
Focus IV	Status	100%		**4.00**
Focus V	Pre-Planning	87.56%	100%	**4.00**
Focus VI	Assessment	98.54%	100%	**4.00**
Focus VII	Medication Record	91.78%	100%	**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus VIII	Person-Centered Service Planning	97.66%	100%	**4.00**
Focus IX	MI Choice Services	97.84%	100%	**4.00**
Focus X	Linking and Coordinating	95.35%	100%	**4.00**
Focus XI	Follow-Up and Monitoring	76.00%	100%	**2.68**
Focus XII	Service Provider	82.35%		**4.00**
Focus XIII	Contingency Plan	92.75%	100%	**4.00**
Focus XIV	Critical Incidents	84.00%	100%	**2.68**
Focus XV	Adverse Benefit Determination	84.00%		**4.00**
Focus XVI	Complaints and Grievances	100%		**4.00**
Focus XVII	Home and Community Based		100%	**4.00**
	Totals	**95.22%**	**100%**	**3.92**

Indicates the standard was not reviewed as part of the record review or home visit.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: A review of 13 home visits was conducted and all reviews achieved full compliance. The purpose of the home visits is to confirm that providers furnish services according to the person-centered service plan and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested that members are receiving services in accordance with their service plans and preferences, and are satisfied with those services.

Strength #2: Tri-County Office on Aging achieved a substantial compliance rating in 16 of the 18 standards reviewed as part of the CQAR. The purpose of the record review is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the person-centered service plan and care planning process, reassessment data) and to assess the quality of waiver agency services to each member; therefore, CQAR findings suggested that person-centered service plans and service delivery are being implemented in accordance with many State and federal requirements.

Weaknesses and Recommendations

Weakness #1: Tri-County Office on Aging did not receive any compliance determinations that were in the *not full or substantial compliance* or *compliance not demonstrated* rating categories; therefore, no substantial weaknesses were identified.

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: Although no substantial weaknesses were identified within any of the program areas under review, **Tri-County Office on Aging** had noted deficiencies in the Follow-Up and Monitoring and Critical Incidents standards. This indicated there are opportunities for improvement related to contacting the member timely for follow-up and monitoring; taking appropriate action to address critical incidents, including discussing strategies to prevent future critical incidents; and ensuring that all critical incidents are appropriately reported through the critical incident database. MDHHS required a CAP for the noted areas of deficiency; however, HSAG recommends **Tri-County Office on Aging** implement an ongoing and robust internal auditing process to ensure **Tri-County Office on Aging** remains compliant with all requirements.

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

To identify strengths and weaknesses and draw conclusions for **Tri-County Office on Aging**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Tri-County Office on Aging** across all EQR activities. The overarching aggregated findings showed that **Tri-County Office on Aging**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Tri-County Office on Aging** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

HSAG's assessment of **Tri-County Office on Aging** also identified opportunities for **Tri-County Office on Aging** to enhance its quality assessment and performance improvement program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Tri-County Office on Aging** had a QMP that included brief descriptions of its quality management activities, its QMP should be modified to more comprehensively align with the requirements and best practices for a quality assessment and performance improvement program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

UPCAP Care Management, Inc.

Validation of Performance Improvement Projects

Performance Results

Table 3-58 displays the results for each QIP implemented during SFY 2020. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **UPCAP Care Management, Inc.** met its internal SFY 2020 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **UPCAP Care Management, Inc.** did not meet its internal SFY 2020 QIP goal or the statewide goal. Any interventions described within **UPCAP Care Management, Inc.**'s QMP reports are also provided in Table 3-58. The results in Table 3-58 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-58—QIP Results

QIP Topic	Goal	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020* = 12.1% ☒
Actions/Activities/Interventions: According to **UPCAP Care Management, Inc.**'s MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2020–FY 2021 dated February 7, 2019[1], **UPCAP Care Management, Inc.** planned to complete the following tasks: • UPCAP will make no significant changes to its current response to incidences of neglect/abuse. • Care managers receive training on this issue that includes signs to look for and reporting responsibilities. • Care managers provide information to clients and families on how to report and make appropriate referrals. The **UPCAP Care Management, Inc.** MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2020 dated January 29, 2021 identified the following: • UPCAP will make no significant changes to its current response to incidences of neglect/abuse. • Supports Coordinators receive training on this issue that includes signs to look for and reporting responsibilities. • Supports Coordinators provide information to participants and families on how to report and make appropriate referrals.		
2. *Prevalence of Pain With Inadequate Pain Control*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020* = 38.8% ☒

QIP Topic	Goal	Measurement and Outcome
Actions/Activities/Interventions: According to **UPCAP Care Management, Inc.**'s MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2020–FY 2021 dated February 7, 2019, **UPCAP Care Management, Inc.** planned to complete the following tasks: • Care managers have reported clients telling them that their physicians are reluctant to prescribe adequate pain medications due to the opioid crisis. • Care managers review medications and try to intervene by talking to physicians but that does not always result in a change to pain medications. • Care managers review medication management plan to assure client is taking meds as prescribed and on time. • Care managers encourage the use of pain clinics, and offer information on alternative pain treatments. The **UPCAP Care Management, Inc.** MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2020 dated January 29, 2021 identified the following: • Supports Coordinators have reported participants telling them that their physicians are reluctant to prescribe adequate pain medications due to the opioid crisis. • Supports Coordinators review medications and try to intervene by talking to physicians but that does not always result in a change to pain medications. • Supports Coordinators review medication management plan to assure participant is taking meds as prescribed and on time. • Supports Coordinators encourage the use of pain clinics, and offer information on alternative pain treatments. • Supports Coordinators also encourage participants to participate in evidence-based programs offered by UPCAP such as "Chronic Pain Self-Management".		
3. *Prevalence of Falls*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020* = 50.9% ☒
Actions/Activities/Interventions: According to **UPCAP Care Management, Inc.**'s MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2020–FY 2021 dated February 7, 2019, **UPCAP Care Management, Inc.** planned to complete the following tasks: • In 2019 all UPCAP Care managers completed the training for the MI CAPABLE model of care. UPCAP is in the process of implementing the model for FY 2020. The **UPCAP Care Management, Inc.** MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2020 dated January 29, 2021 identified the following: • In 2019 all UPCAP Supports Coordinators completed the training for the MI CAPABLE model of care, which educated Supports Coordinators on ways to improve the safety of participants in their home, working with an Occupational Therapist to determine what DME or home modifications are needed. • Supports Coordinators also encourage participants to participate in evidence-based programs offered by UPCAP such as "A Matter of Balance" and "Walk with Ease".		

QIP Topic	Goal	Measurement and Outcome
4. *Prevalence of Any Injuries*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = 6.9% SFY 2020* = 13% ☒
Actions/Activities/Interventions: According to **UPCAP Care Management, Inc.**'s MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2020–FY 2021 dated February 7, 2019, **UPCAP Care Management, Inc.** planned to complete the following tasks: • In 2019 all UPCAP Care mangers completed the training for the MI CAPABLE model of care. • UPCAP is in the process of implementing the model for FY 2020. The **UPCAP Care Management, Inc.** MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2020 dated January 29, 2021 identified the following: • In 2019 all UPCAP Supports Coordinators completed the training for the MI CAPABLE model of care, which educated Supports Coordinators on ways to improve the safety of participants in their home, working with an Occupational Therapist to determine what DME or home modifications are needed. • Supports Coordinators also encourage participants to participate in evidence-based programs offered by UPCAP such as "A Matter of Balance" and "Walk with Ease".		
5. *Prevalence of Dehydration*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020* = 9.5% ☒
Actions/Activities/Interventions: According to **UPCAP Care Management, Inc.**'s MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2020–FY 2021 dated February 7, 2019, **UPCAP Care Management, Inc.** planned to complete the following tasks: • Care managers see clients two times per year and assessing dehydrations in any specific period are difficult. • Provider agencies are reminded on work orders to push fluids and care mangers educate client on the importance of drinking enough fluids. The **UPCAP Care Management, Inc.** MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2020 dated January 29, 2021 identified the following: • Supports Coordinators only see participants two times per year so assessing dehydrations in any specific period are difficult. • Provider agencies are reminded on work orders to push fluids and Supports Coordinators educate participants on the importance of drinking enough fluids.		

FY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
[1]HSAG made the assumption that the QMP dated February 7, 2019, was a typographical error as the QMP included the QIPs required for SFY 2020.
*As reported by the waiver agency, the percentage rates were calculated from numerators and denominators applicable during the time period of April 2020 through September 2020.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: HSAG did not identify any substantial strengths for **UPCAP Care Management, Inc.**

Weaknesses and Recommendations

Weakness #1: The document with the file name "Quality Management Plan 2020" for **UPCAP Care Management, Inc.** had a title of "MI Choice Summary of Quality Management Plan Activities & Outcomes Report"; however, the information in the document appeared to be the SFY 2020–2021 QMP and was dated February 7, 2019.

Why the weakness exists: The title of the document was incorrect.

Recommendation: HSAG recommends **UPCAP Care Management, Inc.** ensure that it completes and submits to MDHHS an updated QMP every two years that includes an appropriate title and date.

Weakness #2: UPCAP Care Management, Inc.'s QIP performance results reported in the SFY 2020 annual report were not comparable across all waiver agencies.

Why the weakness exists: The performance rates, numerators, and denominators in the SFY 2020 annual report identified the data time frame of April 2020 to September 2020 for all QIPs. It is unknown why **UPCAP Care Management, Inc.** only reported data for a six-month period for the SFY 2020 annual results.

Recommendation: HSAG recommends that **UPCAP Care Management, Inc.**'s annual report includes an evaluation of the entire state fiscal year's performance results for each QIP quality indicator.

Weakness #3: UPCAP Care Management, Inc. did not identify goals in the SFY 2020–2021 QMP or in the SFY 2020 annual report. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each measure needs to be clearly and consistently documented.

Why the weakness exists: UPCAP Care Management, Inc. did not identify goals within its SFY 2020–2021 QMP; therefore, there was no analysis indicating whether **UPCAP Care Management** met its goals.

Recommendation: HSAG recommends that **UPCAP Care Management, Inc.** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should align with the goals established by MDHHS. Additionally, **UPCAP Care Management, Inc.** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers.

Weakness #4: The interventions implemented by **UPCAP Care Management, Inc.** to meet performance goals were not specific and measurable. Additionally, there was no evaluation of each intervention to determine its effectiveness. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly evaluated.

Why the weakness exists: **UPCAP Care Management, Inc.**'s FY 2020 annual report did not include a comprehensive assessment of whether a specific intervention(s) was successful or unsuccessful in achieving increased performance.

Recommendation: HSAG recommends that **UPCAP Care Management, Inc.** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **UPCAP Care Management, Inc.** should analyze and interpret results at multiple points in time and test for statistical significance. **UPCAP Care Management, Inc.** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #5: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **UPCAP Care Management, Inc.**'s QIPs must be designed in a methodically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions.

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2020 annual report included limited details on the design developed and methodology followed by **UPCAP Care Management, Inc.** when implementing its QIPs.

Recommendation: HSAG recommends that **UPCAP Care Management, Inc.** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **UPCAP Care Management, Inc.** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2020, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For eight of the 39 performance measures calculated by MDHHS, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Those performance measures with a statewide rate of 100 percent reported through the CMS-372 report were not included as part of the assessment. Table 3-59 displays the eight performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rate as calculated by MDHHS for the CMS-372 report, the statewide percentage rate as calculated by HSAG using the CQAR standard scores associated with each performance measure, and **UPCAP Care Management, Inc.**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **UPCAP Care Management, Inc.**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate as calculated by HSAG, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-59—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* VIII.1, VIII.2, VIII.4, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39	91.27	92.11	94.53
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* I.1, I.2, I.3, I.5, II.1, II.2, II.3, II.4, II.5, II.6, II.7, II.8, II.9, IV.1, IV.2, IV.3, IV.5, IV.6, VI.1, VI.2, VI.3, X.1	96.83	98.82	98.36
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* V.3, IX.1, IX.2, IX.3, IX.6	93.65	94.16	90.38
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* VIII.7, VIII.8	98.94	99.07	100

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* VIII.3, VIII.5, VIII.6, VIII.11	**98.41**	**98.81**	**100**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* V.1, V.2, V.3, V.5, V.10, V.11, V.13, V.15, VI.12, VI.14, VI.16, VIII.1, VIII.2, VIII.3 VIII.4,VIII.5, VIII.6, VIII.11, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39, VIII.40, VIII.41, IX.1, IX.2, IX.3, IX.4, IX.6	**94.97**	**94.13**	**95.40**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* VIII.28, VIII.29, VIII.30, VIII.31, VIII.32, VIII.33, VIII.34, IX.5	**96.03**	**95.54**	**93.98**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* XI.1, XI.3, XI.4	**89.68**	**93.52**	**92.31**

* The individual waiver agency performance measure rates were derived from the standards outlined in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report.

**Statewide percentage rates are displayed as reported by MDHHS. HSAG's calculations may differ from MDHHS' calculations as HSAG summed all numerators and denominators related to the CQAR standards included as part of each performance measure, while MDHHS calculated performance measure rates for the CMS-372 report using a total count of CQAR records reviewed across the waiver agencies and removing those records from the numerator when a standard included as part of the performance measure was deficient ("*Non-Evident*").

‡ The statewide percentage rates determined by HSAG were based on results of the SFY 2020 CQAR and the standards associated with each performance measure as indicated in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source." The statewide percentage rates determined by HSAG are displayed for comparison purposes to the MDHHS statewide percentages. Additionally, the HSAG calculated rates were made available for this report to ensure an appropriate representation to the rates calculated for each waiver agency.

Indicates the performance measure rate is higher than the statewide rate as calculated by HSAG.

Indicates the performance measure rate is lower than the statewide rate as calculated by HSAG.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Although MDHHS has not established performance measure benchmarks, **UPCAP Care Management, Inc.**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 7, 8, 12, 22, 24, 27, 28, 29, 31, 33, 34, 37, and 38. Performance Measures 36 and 39 also achieved a rate of 100 percent; however, performance in these measures are driven solely by MDHHS as they relate to capitation payments to the waiver agencies.

Strength #2: UPCAP Care Management, Inc. received a 100 percent performance rating for Performance Measures 16 and 17, indicating person-centered service plans reviewed as part of the CQAR included appropriate strategies to address members' assessed health and safety risks and individualized goals and preferences; this suggested **UPCAP Care Management, Inc.** staff members are taking into consideration waiver members' individualized needs, including member-specific health risks, and member preferences when creating service plans, ensuring members are receiving services of the highest quality to meet their own specific and unique needs.

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial trends of weakness. While Performance Measures 2, 15, 19, and 20 did not meet the statewide performance rate, none of these performance measures fell below the statewide rate by more than 5 percentage points.

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: MDHHS required **UPCAP Care Management, Inc.** to develop a CAP to remediate the deficiencies. The completed CAP indicated that **UPCAP Care Management, Inc.** would conduct education sessions with the supports coordinators, and departmental leadership would monitor performance monthly and conduct random chart audits to ensure supports coordinators meet compliance. The CAP indicated leadership would conduct monitoring efforts and audits until an assigned percentage of performance is achieved (i.e., 85 and 90 percent depending on the deficient standard); however, HSAG recommends **UPCAP Care Management, Inc.** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the supports coordinator(s) achieves the designated percent of compliance, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-60 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-60 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-60—Clinical Quality Assurance Reviews and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus I	Level of Care Determination	96.30%	100%	4.00
Focus I.B	Communication		100%	4.00
Focus II	Freedom of Choice	98.46%		4.00
Focus III	Release of Information	100%		4.00
Focus IV	Status	100%		4.00
Focus V	Pre-Planning	97.22%	100%	4.00
Focus VI	Assessment	94.23%	100%	4.00
Focus VII	Medication Record	90.59%	100%	4.00
Focus VIII	Person-Centered Service Planning	94.62%	100%	4.00
Focus IX	MI Choice Services	93.33%	100%	4.00
Focus X	Linking and Coordinating	97.56%	100%	4.00
Focus XI	Follow-Up and Monitoring	80.77%	100%	3.35
Focus XII	Service Provider	91.67%		4.00
Focus XIII	Contingency Plan	89.29%	100%	4.00
Focus XIV	Critical Incidents	100%	100%	4.00
Focus XV	Adverse Benefit Determination	68.75%		1.00
Focus XVI	Complaints and Grievances	100%		4.00

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus XVII	Home and Community Based		N/A	N/A
	Totals	**94.51%**	**100%**	**3.92**

N/A indicates this focus area was non-applicable to the review year.

	Indicates the standard was not reviewed as part of the record review or home visit.
	Indicates substantial compliance: 3.26 or higher.
	Indicates some compliance, needs improvement: 2.51 to 3.25.
	Indicates not full or substantial compliance: 1.76 to 2.50.
	Indicates compliance not demonstrated: 1.00 to 1.75.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: A review of seven home visits was conducted with all program areas reviewed achieving a compliance rate of 100 percent. The purpose of the home visits is to confirm that providers furnish services according to the person-centered service plan and member preferences, and to determine member satisfaction with those services. These findings suggested that most members are accessing services timely in accordance with their service plans and preferences, and are satisfied with those services.

Strength #2: UPCAP Care Management, Inc. achieved a substantial compliance rating in 16 of the 17 applicable standards reviewed as part of the CQAR. The purpose of the record review is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the person-centered service plan and care planning process, reassessment data) and to assess the quality of waiver agency services to each member; therefore, CQAR findings suggested **UPCAP Care Management, Inc.** is conducting the assessment process, developing person-centered service plans, and coordinating service delivery in accordance with most State and federal requirements.

Weaknesses and Recommendations

Weakness #1: UPCAP Care Management, Inc. did not consistently follow all Adverse Benefit Determination requirements; specifically, **UPCAP Care Management, Inc.**'s ABD notices did not contain accurate and complete information. Complete and accurate ABD notices are necessary to ensure members/guardians understand their appeal rights and how to request an appeal.

Why the weakness exists: Through the CQAR, MPHI determined that five out of eight applicable records did not include evidence that the waiver agency provided the member/guardian with an

accurate and complete ABD notice for a service denial, reduction, suspension, and/or termination from the MI Choice Waiver Program. Specifically, the waiver services suspended or stopped were not listed within the ABD notices.

Recommendation: MDHHS required **UPCAP Care Management, Inc.** to submit a CAP to remediate the deficiencies. **UPCAP Care Management, Inc.**'s CAP indicated that further education would be provided to all supports coordinators, and supports coordinators would be provided with an example of what is required to be included as part of the ABD notices. Additionally, **UPCAP Care Management, Inc.** leadership would randomly audit charts to ensure supports coordinators' compliance with requirements. **UPCAP Care Management, Inc.** also indicated that monitoring would continue until 80 percent compliance is met. HSAG recommends that **UPCAP Care Management, Inc.** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met. HSAG further recommends that **UPCAP Care Management, Inc.** consider implementing a peer-to-peer ABD review process or have leadership review all ABD notices before notices are sent to members to ensure the notices contain all required federal and state-specific content and comply with the language and format requirements under 42 CFR §438.10(d).

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

To identify strengths and weaknesses and draw conclusions for **UPCAP Care Management, Inc.**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **UPCAP Care Management, Inc.** across all EQR activities. The overarching aggregated findings showed that **UPCAP Care Management, Inc.**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **UPCAP Care Management, Inc.** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

HSAG's assessment of **UPCAP Care Management, Inc.** also identified opportunities for **UPCAP Care Management, Inc.** to enhance its quality assessment and performance improvement program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **UPCAP Care Management, Inc.** had a QMP that included brief descriptions of its quality management activities, its QMP should be modified to more comprehensively align with the requirements and best practices for a quality assessment and performance improvement program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Valley Area Agency on Aging

Validation of Performance Improvement Projects

Performance Results

Table 3-61 displays the results for each QIP implemented during SFY 2020. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Valley Area Agency on Aging** met its internal SFY 2020 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Valley Area Agency on Aging** did not meet its internal SFY 2020 QIP goal or the statewide goal. Any interventions described within **Valley Area Agency on Aging**'s QMP reports are also provided in Table 3-61. The results in Table 3-61 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-61—QIP Results

QIP Topic	Goal	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data not reported] SFY 2020 = 0.9% [1.3]* ☑
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **Valley Area Agency on Aging**[1]. The **Valley Area Agency on Aging** MI Choice Summary of Quality Management Plan (QMP) Activities & Outcomes Report FY 2020 dated January 31, 2021 identified the following: • [None identified]		
2. *Prevalence of Pain With Inadequate Pain Control*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data not reported] SFY 2020 = 15.2% [15.3]* ☑
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **Valley Area Agency on Aging**[1]. The **Valley Area Agency on Aging** MI Choice Summary of Quality Management Plan (QMP) Activities and Outcomes Report FY 2020 dated January 31, 2021 identified the following: • [None identified]		

QIP Topic	Goal	Measurement and Outcome
3. *Prevalence of Falls*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data not reported] SFY 2020 = 29.1% [28.6]* ☒
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **Valley Area Agency on Aging**[1]. The **Valley Area Agency on Aging** MI Choice Summary of Quality Management Plan (QMP) Activities and Outcomes Report FY 2020 dated January 31, 2021 identified the following: • All participants were mailed a Fall Prevention handout that contained detailed education on preventing falls in the home. • Support Coordinators were informed of this finding to provide individual education to participants who report falls during assessments or monitoring contacts.		
4. *Prevalence of Any Injuries*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data not reported] SFY 2020 = 6.1% [5.7]* ☒
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **Valley Area Agency on Aging**[1]. The **Valley Area Agency on Aging** MI Choice Summary of Quality Management Plan (QMP) Activities and Outcomes Report FY 2020 dated January 31, 2021 identified the following: • [None identified]		
5. *Prevalence of Dehydration*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data not reported] SFY 2020 = 0.6% ☑
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **Valley Area Agency on Aging**[1]. The **Valley Area Agency on Aging** MI Choice Summary of Quality Management Plan (QMP) Activities and Outcomes Report FY 2020 dated January 31, 2021 identified the following: • [None identified]		

FY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
[1]The QMP provided by MDHHS for SFY 2020–2021 was not dated by the waiver agency and included QIP results for SFY 2020. Since the QMP for SFY 2020–2021 was due to MDHHS by January 2020, this suggests that the document was not the SFY 2020–2021 QMP. Therefore, the information contained within the document was not reliable for this EQR.
*The SFY 2020 annual report included a performance rate that did not align with the performance rate calculated by HSAG based on the reported numerator and denominator. The HSAG calculated performance rate, when applicable, was used to determine the outcome.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Valley Area Agency on Aging met the statewide goal for three QIPs, including *Prevalence of Neglect/Abuse*, *Prevalence of Pain With Inadequate Pain Control*, and *Prevalence of Dehydration*, suggesting there were less reports of neglect/abuse, uncontrolled pain, and dehydration.

Weaknesses and Recommendations

Weakness #1: There was no SFY 2020–2021 QMP available for **Valley Area Agency on Aging**.

Why the weakness exists: The QMP provided by MDHHS for SFY 2020–2021 was not dated by the waiver agency and included QIP results for SFY 2020. Since the QMP for SFY 2020–2021 was due to MDHHS by January 2020, this suggests that the document was not the SFY 2020–2021 QMP. Therefore, the information contained within the document was not reliable for this EQR.

Recommendation: HSAG recommends that **Valley Area Agency on Aging** follow the MDHHS requirement to complete and submit an updated QMP every two years. This QMP should be separate from the annual MI Choice Medicaid Waiver Quality Management Plan Activities & Outcomes Report.

Weakness #2: Valley Area Agency on Aging did not identify goals in the SFY 2020 annual report. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each measure needs to be clearly and consistently documented.

Why the weakness exists: Valley Area Agency on Aging's SFY 2020 annual report did not include specific and measurable goals for the five state-required QIPs; therefore, there was no analysis indicating whether **Valley Area Agency on Aging** met its goals.

Recommendation: HSAG recommends that **Valley Area Agency on Aging** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should align with the goals established by MDHHS. Additionally, **Valley Area Agency on Aging** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers.

Weakness #3: The interventions implemented by **Valley Area Agency on Aging** to meet performance goals were not specified for four of the five QIPs. Additionally, there was no evaluation of each intervention to determine its effectiveness. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly specified and subsequently evaluated.

Why the weakness exists: **Valley Area Agency on Aging**'s FY 2020 annual report did not include an assessment of whether a specific intervention(s) was successful or unsuccessful in achieving increased performance.

Recommendation: HSAG recommends that **Valley Area Agency on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Valley Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Valley Area Agency on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #4: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **Valley Area Agency on Aging**'s QIPs must be designed in a methodically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions.

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2020 annual report included limited details on the design developed and methodology followed by **Valley Area Agency on Aging** when implementing its QIPs.

Recommendation: HSAG recommends that **Valley Area Agency on Aging** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Valley Area Agency on Aging** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2020, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For eight of the 39 performance measures calculated by MDHHS, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Those performance measures with a statewide rate of 100 percent reported through the CMS-372 report were not included as part of the assessment. Table 3-62 displays the eight performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rate as calculated by MDHHS for the CMS-372 report, the statewide percentage rate as calculated by HSAG using the CQAR standard scores associated with each performance measure, and **Valley Area Agency on Aging**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Valley Area Agency on Aging**'s impact

to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate as calculated by HSAG, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-62—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* VIII.1, VIII.2, VIII.4, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39	**91.27**	**92.11**	**98.36**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* I.1, I.2, I.3, I.5, II.1, II.2, II.3, II.4, II.5, II.6, II.7, II.8, II.9, IV.1, IV.2, IV.3, IV.5, IV.6, VI.1, VI.2, VI.3, X.1	**96.83**	**98.82**	**100**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* V.3, IX.1, IX.2, IX.3, IX.6	**93.65**	**94.16**	**100**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* VIII.7, VIII.8	**98.94**	**99.07**	**100**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* VIII.3, VIII.5, VIII.6, VIII.11	**98.41**	**98.81**	**100**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* V.1, V.2, V.3, V.5, V.10, V.11, V.13, V.15, VI.12, VI.14, VI.16, VIII.1, VIII.2, VIII.3 VIII.4,VIII.5, VIII.6, VIII.11, VIII.12, VIII.13, VIII.16, VIII.17, VIII.18, VIII.20, VIII.26, VIII.38, VIII.39, VIII.40, VIII.41, IX.1, IX.2, IX.3, IX.4, IX.6	**94.97**	**94.13**	**96.51**

Performance Measures and Applicable CQAR Standards*		CMS 372 Statewide % Rate**	HSAG-Calculated Statewide % Rate‡	Waiver Agency % Rate
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* VIII.28, VIII.29, VIII.30, VIII.31, VIII.32, VIII.33, VIII.34, IX.5	96.03	95.54	94.29
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* XI.1, XI.3, XI.4	89.68	93.52	95.00

* The individual waiver agency performance measure rates were derived from the standards outlined in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report.

**Statewide percentage rates are displayed as reported by MDHHS. HSAG's calculations may differ from MDHHS' calculations as HSAG summed all numerators and denominators related to the CQAR standards included as part of each performance measure, while MDHHS calculated performance measure rates for the CMS-372 report using a total count of CQAR records reviewed across the waiver agencies and removing those records from the numerator when a standard included as part of the performance measure was deficient ("*Non-Evident*").

‡ The statewide percentage rates determined by HSAG were based on results of the SFY 2020 CQAR and the standards associated with each performance measure as indicated in the MDHHS-provided Crosswalk SFY 2020 Performance Measures spreadsheet under "Source." The statewide percentage rates determined by HSAG are displayed for comparison purposes to the MDHHS statewide percentages. Additionally, the HSAG calculated rates were made available for this report to ensure an appropriate representation to the rates calculated for each waiver agency.

Indicates the performance measure rate is higher than the statewide rate as calculated by HSAG.

Indicates the performance measure rate is lower than the statewide rate as calculated by HSAG.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Although MDHHS has not established performance measure benchmarks, **Valley Area Agency on Aging**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 7, 8, 12, 22, 24, 27, 28, 29, 31, 33, 34, 37, and 38. Performance Measures 36 and 39 also achieved a rate of 100 percent; however, performance in these measures are driven solely by MDHHS as they relate to capitation payments to the waiver agencies.

Strength #2: Valley Area Agency on Aging received a 100 percent performance rating for Performance Measures 2, 15, 16, and 17 based on the results of the CQAR, indicating **Valley Area Agency on Aging** ensured that participants were enrolled consistent with MDHHS policies and

procedures; the person-centered service plans included services and supports aligned with members' assessed needs; there were appropriate strategies to address assessed health and safety risks; and there were individualized goals and preferences. This demonstrated that **Valley Area Agency on Aging** staff members are developing person-centered service plans that support members are receiving services of the highest quality to meet their own specific and unique needs.

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial trends of weakness. While Performance Measure 19 did not meet the statewide performance rate, it did not fall below the statewide rate by more than 5 percentage points.

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: MDHHS required **Valley Area on Aging** to develop a CAP to remediate the deficiencies. The completed CAP indicated that **Valley Area on Aging** quality staff members would conduct 12 monthly audits on all supports coordinators. HSAG recommends that supports coordinators continue to be audited on an ongoing basis against the requirements of the waiver, including requirements related to the LOCD, assessment process, and person-centered planning process.

Compliance Review

Performance Results

Table 3-63 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-63 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-63—Clinical Quality Assurance Reviews and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus I	Level of Care Determination	100%	100%	**4.00**
Focus I.B	Communication		100%	**4.00**
Focus II	Freedom of Choice	100%		**4.00**
Focus III	Release of Information	100%		**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus IV	Status	100%		4.00
Focus V	Pre-Planning	100%	100%	4.00
Focus VI	Assessment	86.67%	100%	4.00
Focus VII	Medication Record	94.81%	88.89%	4.00
Focus VIII	Person-Centered Service Planning	97.72%	100%	4.00
Focus IX	MI Choice Services	100%	100%	4.00
Focus X	Linking and Coordinating	100%	100%	4.00
Focus XI	Follow-Up and Monitoring	84.38%	100%	3.33
Focus XII	Service Provider	100%		4.00
Focus XIII	Contingency Plan	89.29%	100%	4.00
Focus XIV	Critical Incidents	66.67%	100%	2.00
Focus XV	Adverse Benefit Determination	92.31%		4.00
Focus XVI	Complaints and Grievances	33.33%		1.00
Focus XVII	Home and Community Based		100%	4.00
Totals		**95.98%**	**99.19%**	**3.88**

Indicates the standard was not reviewed as part of the record review or home visit.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: A review of six home visits was conducted with 10 out of 11 program areas reviewed achieving full compliance. The purpose of the home visits is to confirm that providers furnish services according to the person-centered service plan and member preferences, and to determine member satisfaction with those services. These findings suggested that many members are accessing services timely in accordance with their service plans and preferences, and are satisfied with those services. Of note, the Critical Incidents standard through the CQAR record review process provided discrepant results.

Strength #2: Valley Area on Aging achieved a substantial compliance rating in 16 of the 18 standards reviewed as part of the CQAR. The purpose of the record review is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the person-centered service plan and care planning process, reassessment data) and to assess the quality of waiver agency services to each member; therefore, CQAR findings suggested **Valley Area on Aging** is conducting the assessment process, developing person-centered service plans, and coordinating service delivery in accordance with many State and federal requirements.

Weaknesses and Recommendations

Weakness #1: Valley Area on Aging did not consistently follow all Critical Incidents requirements. Specifically, **Valley Area on Aging**'s supports coordinators did not take appropriate action to address reported critical incidents with the waiver member/guardian and discuss methods to prevent further occurrences; and the waiver agency did not enter, report, and provide updates to the critical incident portal as required by MDHHS. Proper reporting of critical incidents is important as it provides **Valley Area on Aging** and the waiver agencies with a mechanism to monitor potential problems and determine the root causes of the problems to prevent future incidents. Appropriate and timely follow-up with members/guardians is also important to ensure members' health, safety, and well-being, and to gain a more comprehensive understanding for why the incident occurred so that preventions can be implemented to mitigate future incidents.

Why the weakness exists: Through the CQAR, MPHI determined that three out of three applicable records did not include evidence that **Valley Area on Aging** adhered to Critical Incidents standards, including taking appropriate action to address the incident with the member/guardian; discuss methods to prevent further occurrence with the member/guardian; and/or enter, report, and provide updates to the critical incident portal as required by MDHHS.

Recommendation: MDHHS required **Valley Area on Aging** to submit a CAP to remediate the deficiencies. **Valley Area on Aging**'s CAP indicated the supervisor provided education on the CQAR findings and quality staff members would conduct 12 monthly audits of all supports coordinators. HSAG recommends that **Valley Area on Aging** continue to audit staff members on an ongoing basis to ensure requirements continue to be met and performance continues to demonstrate improvement. HSAG also recommends **Valley Area on Aging** implement tracking mechanisms to ensure that all incident reports are being appropriately reported through the critical incident reporting database when supports coordinators are notified, and that timely follow-up occurs for all members when a critical incident is reported. **Valley Area on Aging** should use the data available through the Critical Incident Reporting System and its own internal tracking systems to monitor for systemic trends and subsequently implement interventions to mitigate future incidents from occurring.

Weakness #2: Valley Area on Aging did not consistently follow all Complaints and Grievances requirements; specifically, **Valley Area on Aging** did not support members' rights to initiate grievances orally or in writing, and supports coordinators did not adhere to resolution requirements.

Why the weakness exists: Through the CQAR, MPHI determined that two out of two applicable records did not include evidence that **Valley Area on Aging** adhered to Complaints and Grievances

standards, suggesting **Valley Area on Aging** was not adequately documenting issues identified by waiver members and, therefore, staff members were also not responding to these issues and providing members with timely resolution to their identified concerns.

Recommendation: MDHHS required **Valley Area on Aging** to submit a CAP to remediate the deficiencies. **Valley Area on Aging**'s CAP indicated the supervisor provided education on the CQAR findings and quality staff members would conduct 12 monthly audits of all supports coordinators. HSAG recommends that **Valley Area on Aging** continue to audit staff members on an ongoing basis to ensure requirements continue to be met and performance continues to demonstrate improvement. HSAG also recommends **Valley Area on Aging** implement tracking mechanisms to ensure that all grievances are being resolved and notice is provided to members in accordance with resolution timeliness requirements. HSAG further recommends that **Valley Area on Aging** ensure all issues that are brought forth by members and members' legal guardians are treated as grievances and tracked and responded to in accordance with federal and State grievance tracking and resolution requirements.

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

To identify strengths and weaknesses and draw conclusions for **Valley Area Agency on Aging**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Valley Area Agency on Aging** across all EQR activities. The overarching aggregated findings showed that **Valley Area Agency on Aging**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Valley Area Agency on Aging** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

HSAG's assessment of **Valley Area Agency on Aging** also identified opportunities for **Valley Area Agency on Aging** to enhance its quality assessment and performance improvement program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Valley Area Agency on Aging** had a QMP that included brief descriptions of its quality management activities, its QMP should be modified to more comprehensively align with the requirements and best practices for a quality assessment and performance improvement program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

4. Follow-Up on Prior EQR Recommendations for Waiver Agencies

SFY 2020 is the first year that an annual detailed technical report was completed for the MI Choice Waiver Program and the contracted waiver agencies. Therefore, there were no previous quality improvement recommendations made to MDHHS or to the waiver agencies by HSAG or another external quality review organization (EQRO) prior to SFY 2020. Future technical reports will include an assessment of the degree to which each waiver agency addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.

5. Waiver Agency Comparative Information

In addition to performing a comprehensive assessment of the performance of each waiver agency, HSAG compared the findings and conclusions established for each waiver agency to assess the MI Choice Waiver Program. The overall findings of the waiver agencies were used to identify the overall strengths and weaknesses of the MI Choice Waiver Program and to identify areas in which MDHHS could leverage or modify the MDHHS CQS to promote improvement.

Waiver Agency EQR Activity Results

This section provides the summarized results for the mandatory and optional EQR activities across the waiver agencies.

Validation of Performance Improvement Projects

Table 5-1 provides a comparison of the prevalence rates for SFY 2020 for the five state-required QIPs, either as reported to MDHHS or as calculated by HSAG using the numerators and denominators provided by the waiver agencies, which were included in their QMP reports. Lower prevalence rates are indicative of higher performance for all QIPs. Table 5-1 also provides the SFY 2019 statewide baseline rate, the SFY 2020 statewide goal, and the SFY 2020 statewide rate as provided by MDHHS. Bold font indicates the statewide goal was met for SFY 2020.

The data provided to HSAG for the QIP activity included QMPs (as available) and annual reports for each waiver agency. The methodology for developing the QIPs was not described within the waiver agencies' QMPs or the annual reports provided to HSAG for this EQR; therefore, there may be variances in the data collection and rate calculation process. Due to these potential variances in the methodologies, the reader should use caution when interpreting the comparative results of the QIP outcomes. Additionally, HSAG did not validate any of the data provided in the MDHHS-provided QIP documents (i.e., QMPs and annual reports), as HSAG did not conduct the QIP validation activity.

Table 5-1—Comparison of QIP Outcomes*

Waiver Agency	1. Prevalence of Neglect/Abuse	2. Prevalence of Pain With Inadequate Pain Control	3. Prevalence of Falls	4. Prevalence of Any Injuries	5. Prevalence of Dehydration
A&D Home Health Care	3.10%	20.85%	23.16%	8.23%	1.97%
Agency on Aging of Northwest Michigan[1]	—	—	—	—	—
Area Agency on Aging 1B	28.49%	29.96%	**18.16%**	**2.20%**	2.64%
Area Agency on Aging of Western Michigan[2]	**2.4%**	25%	30%	6%	2.5%
Detroit Area Agency on Aging[3]	3.50%	28.29%	**17.33%**	—	5.57%
MORC Home Care[4]	—	—	—	—	—
Northern Healthcare Management[5]	3.2%	31.86	37.78	11.2%	2.94%
Region 2 Area Agency on Aging	**2.5%**	**16.07%**	35.37%	7.04%	**0.53%**
Region 3B	4.22%	**18.87%**	**4.54%**	5.41%	2.64%
Region IV Area Agency on Aging	**1.7%**	33.4%	29.5%	4.6%	3%
Region VII Area Agency on Aging	4.9%	23.3%	32.7%	5.4%	3.0%
Region 9 Area Agency on Aging	**1.69%**	**13.69%**	29.24%	5.16%	1.94%
Reliance Community Care Partners	4.12%	21.53%	24.59%	4.43%	2.21%
Senior Resources	**2.15%**	**16.4%**	28.05%	3.65%	1.75%
Senior Services	**1%**	**18%**	51%	6%	**1%**
The Information Center	**0.54%**	35.37%	28.88%	4.31%	10.77%
The Senior Alliance	7.20%	23.92%	26.59%	4.76%	**1.00%**
Tri-County Office on Aging[6]	3.2%	27.3%	32%	4.7%	1.6%
UPCAP Care Management, Inc.[1]	—	—	—	—	—
Valley Area Agency on Aging	**0.9%**	**15.2%**	29.1%	6.1%	**0.6%**
SFY 2019 Statewide Baseline Rate	**5.1%**	**24.24%**	**27.3%**	**5.6%**	**2.6%**
SFY 2020 Statewide Goal	**3%**	**20%**	**23%**	**3%**	**1.5%**
SFY 2020 Statewide Rate	**5.08%**	**23.35%**	**27.72%**	**5.53%**	**4.04%**
Count of Waiver Agencies that Met SFY 2020 Statewide Goal	**8**	**6**	**3**	**1**	**4**

*Waiver agency results are displayed as reported by the waiver agency and not validated by HSAG. The SFY 2019 and SFY 2020 statewide rates and SFY 2020 statewide goal were provided to HSAG by MDHHS.

Prevalence rates displayed in **bold** font met the SFY 2020 statewide goal.

[1]Prevalence rates provided by the waiver agency were not for the entire SFY 2020 and only included data from April 2020 to September 2020; therefore, the rates are not comparable or displayed.

[2]Waiver agency prevalence rates should be interpreted with caution as all rates provided by the waiver agency did not align with HSAG's calculation of the rate using the numerators and denominators reported by the waiver agency.

[3]Data provided for the *Prevalence of Any Injuries* QIP were unreliable, as the numerators and denominators did not appear to match the stated goal.

[4]Prevalence rates provided by the waiver were for SFY 2020 Quarter 1 only; therefore, the rates are not comparable or displayed.

[5]The waiver agency prevalence rates for QIPs 1 and 4 should be interpreted with caution as rates provided by the waiver agency did not align with HSAG's calculation of the rate using the numerators and denominators reported by the waiver agency.

[6]Performance outcomes were determined using the most current percentage rate identified by the waiver agency within the FY 2020 annual report. HSAG was unable to confirm whether the most current percentage rates identified by the waiver agency within the report were reflective of the rates at the end of SFY 2020; therefore, rates should be interpreted with caution.

—	Rates were not displayed due to incomparability.
	Waiver agency with the lowest reported prevalence rate per QIP.
	Waiver agency with the highest reported prevalence rate per QIP.

Performance Measure Validation

Table 5-2 displays the MI Choice Waiver Program statewide performance measure rates for the SFY 2020 PMV activity as presented through the MI Choice Performance Measure Report FY 2020, which included the data used for the CMS-372 report.

MDHHS calculates all performance measures at the statewide rate; therefore, individual waiver agency performance measure data were not provided to HSAG for review as part of the assessment, except as described in the introduction paragraph for Table 5-3. Additionally, as confirmed by MDHHS, no benchmarks have been established specific to performance measure rates.

Table 5-2—Statewide Performance Measure Rates

Performance Measures		Statewide (%)
Administrative Authority		
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.*	**91.27**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.*	**96.83**
3	*Number and percent of waiver agencies who submit annual Quality Management Plan (QMP) activity and outcome reports that illustrate they are adhering to their QMP.*	**100**
4	*Number and percent of appropriate level of care determinations (LOCDs) found after MDHHS review.*	**97.09**

	Performance Measures	Statewide (%)
5	*Number and percent of corrective action plans that were provided by waiver agencies according to requirements set by the Michigan Department of Health and Human Services (MDHHS) or the External Quality Review Organization (EQRO).*	**100**
	Evaluation/Reevaluation of Level of Care	
6	*Number and percent of new MI Choice waiver participants who meet the NFLOC criteria prior to waiver enrollment.*	**100**
7	*Number and percent of LOCDs made by a qualified evaluator.*	**100**
8	*Number and percent of participants who had initial LOCDs where the NFLOC criteria were accurately applied.*	**100**
9	*Number and percent of MI Choice disenrollments based upon no longer meeting NFLOC criteria that were determined correctly.*	**Not Reported***
10	*Number and percent of providers continuing to meet applicable licensure & certification standards in accordance with state law following initial enrollment.*	**99.64**
11	*Number and percent of new waiver service provider applications that meet initial licensure/certification standards in accordance with state law prior to the provision of waiver services.*	**99.22**
12	*Number and percent of non-licensed or non-certified waiver providers that initially met provider qualifications.*	**100**
13	*Number and percent of non-licensed or non-certified waiver providers that continue to meet provider qualifications.*	**98.87**
14	*Number and percent of providers who meet provider training requirements.*	**98.67**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.*	**93.65**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.*	**98.94**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.*	**98.41**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.*	**94.97**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.*	**96.03**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.*	**89.68**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.*	**96.56**

	Performance Measures	Statewide (%)
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.*	**100**
	Participant Safeguards	
23	*Number and percent of participant critical incidents for which investigations by the waiver agencies were resolved within 60 days.*	**81.96**
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.*	**100**
25	*Number and percent of critical incidents due to unexplained death reported within two business days of notification that the incident occurred.*	**68.57**
26	*Number and percent of all critical incidents EXCEPT unexplained death reported within 30 days of notification that the incident occurred.*	**95.36**
27	*Number and percent of waiver agencies that utilize the critical incident database to track incidents through effective resolution.*	**100**
28	*Number and percent of waiver agencies with staff who have completed required training to prevent incidents.*	**100**
29	*Number and percent of unauthorized use of restraints, restrictive interventions, or seclusions that were reported as a critical incident.*	**100**
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of caregiver).*	**91.01**
31	*Number and percent of participant suicide attempts that resulted in follow up by the waiver agency.*	**100**
32	*Number and percent of participants requiring emergency medical treatment or hospitalization due to medication error.*	**30.77**
33	*Number and percent of critical incidents reporting hospitalization or emergency room visit within 30 days of the previous hospitalization due to neglect or abuse.*	**100**
34	*Number and percent of properly reported suicide attempts in the critical incident database.*	**100**
	Financial Accountability	
35	*Number and percent of encounters submitted to MDHHS with all required data elements.*	**96.78**
36	*Number and percent of capitation payments made to the waiver agencies only for MI Choice participants with active Medicaid eligibility.*	**100**
37	*Number and percent of encounters submitted to MDHHS within required timeframes.*	**100**
38	*Number and percent of service plans that supported paid services.*	**100**

Performance Measures		Statewide (%)
39	*Number and percent of capitation payments that have been paid at rates approved by the Actuary.*	**100**

*MDHHS reported it had data limitations for collecting information using the current performance measure specifications.

For eight of the 39 performance measures using the CQAR record review results, individual waiver agency performance impacted the overall statewide performance measure percentage rate as the percentages sent to CMS in the CMS-372 report were less than 100 percent. Table 5-3 includes the eight performance measures that were impacted by individual waiver agency performance in SFY 2020 and the statewide percentage rates that were calculated by MDHHS for the annual CMS-372 report. Table 5-3 also provides a comparison of waiver agency performance as calculated by HSAG using the CQAR standard scores associated with each performance measure, and the associated HSAG-calculated statewide performance measure percentage rates. Performance rates shaded in red indicate that performance is below the statewide rate as calculated by HSAG.

Table 5-3—Waiver Agency Impact on Statewide Performance Measure Rates and Comparison of Performance

Waiver Agency	Performance Measures							
	1	2	15	16	17	18	19	20
A&D Home Health Care	92.19	98.26	86.57	96.88	99.22	90.31	92.81	91.67
Agency on Aging of Northwest Michigan	88.33	96.85	86.00	91.67	97.92	93.26	94.55	100
Area Agency on Aging 1B	100	99.63	98.00	100	100	99.46	97.30	95.83
Area Agency on Aging of Western Michigan	96.80	97.52	97.41	100	100	98.01	98.11	90.00
Detroit Area Agency on Aging	84.51	98.12	93.75	100	99.34	89.86	90.43	87.18
MORC Home Care	80.00	100	97.56	100	100	91.59	100	90.00
Northern Healthcare Management	92.00	100	93.02	100	100	96.44	100	90.91
Region 2 Area Agency on Aging	95.68	99.52	96.30	100	98.68	93.97	99.08	91.30
Region 3B	96.00	100	98.39	100	100	97.82	94.12	100
Region IV Area Agency on Aging	92.35	98.95	95.65	100	100	93.26	95.24	100
Region VII Area Agency on Aging	98.57	100	92.92	100	100	98.24	96.77	89.66
Region 9 Area Agency on Aging	98.57	99.36	98.25	100	100	99.08	97.67	100
Reliance Community Care Partners	85.78	98.04	90.10	97.83	84.78	90.74	93.20	100
Senior Resources	80.95	98.69	98.85	95.24	100	89.11	96.70	90.91
Senior Services	96.00	95.15	83.33	100	100	94.98	82.76	100

Waiver Agency	Performance Measures							
	1	2	15	16	17	18	19	20
The Information Center	86.00	99.10	90.00	100	100	93.42	93.75	80.00
The Senior Alliance	88.24	100	97.06	100	100	92.25	92.75	94.12
Tri-County Office on Aging	95.93	99.28	97.20	100	100	94.55	99.11	100
UPCAP Care Management, Inc.	94.53	98.36	90.38	100	100	95.40	93.98	92.31
Valley Area Agency on Aging	98.36	100	100	100	100	96.51	94.29	95.00
CMS-372 Report Statewide % Rate*	**91.27**	**96.83**	**93.65**	**98.94**	**98.41**	**94.97**	**96.03**	**89.68**
HSAG-Calculated Statewide % Rate**	**92.11**	**98.82**	**94.16**	**99.07**	**98.81**	**94.13**	**95.54**	**93.52**

*Statewide percentage rates are displayed as reported by MDHHS.

**The statewide percentage rates determined by HSAG were based on results of the SFY 2020 CQAR record review and the standards associated with each performance measure as indicated in the Crosswalk SFY 2020 Performance Measures spreadsheet provided to HSAG from MDHHS. The rate was determined by adding the number of standards that received a score of *Evident* (1 point per each applicable standard associated with the performance measure) then dividing this number by the total number of applicable standards. Total possible points were determined based on the total number of records reviewed multiplied by the number of standards that impacted the performance measure (e.g., 10 record reviews X 4 standards within the performance measure = 40 total points for the performance measure). The non-applicable standards were then subtracted from the total points to obtain the total possible points. The standards receiving a score of *Evident* were summed and then divided by the total possible points to get the performance measure rate. The statewide percentage rates determined by HSAG are displayed for comparison purposes to the MDHHS statewide percentages. Additionally, the HSAG calculated rates were made available for this report to ensure an appropriate representation to the rates calculated for each waiver agency. These rates are not comparable to the MDHHS-determined statewide rates as those rates were calculated using a different methodology, which is described in Appendix A.

Indicates the performance measure rate is lower than the statewide rate as calculated by HSAG.

Compliance Review

Table 5-4 provides the overall percentage of compliance for each waiver agency's SFY 2020 CQAR record review and home visit interview results. Table 5-4 also provides the overall CQAR compliance level as provided by MPHI for MDHHS in each waiver agency's MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination report.

Table 5-4—Summary of SFY 2020 Compliance Review Results–Clinical Quality Assurance Reviews

Waiver Agency	Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
A&D Home Health Care	91.70%	100%	**3.77**
Agency on Aging of Northwest Michigan	93.24%	100%	**3.91**
Area Agency on Aging 1B	97.52%	99.48%	**3.91**
Area Agency on Aging of Western Michigan	96.87%	100%	**3.97**
Detroit Area Agency on Aging	90.52%	99.83%	**3.83**
MORC Home Care	93.11%	99.67%	**3.92**
Region 9 Area Agency on Aging	97.71%	100%	**3.93**
Northern Healthcare Management	96.11%	99.35%	**3.99**
Region 2 Area Agency on Aging	95.25%	100%	**3.97**
Region 3B	95.86%	99.60%	**3.96**
Region IV Area Agency on Aging	94.87%	100%	**4.00**
Region VII Area Agency on Aging	97.33%	100%	**3.98**
Reliance Community Care Partners	91.89%	99.51%	**3.60**
Senior Resources	93.56%	99.71%	**4.00**
Senior Services	92.15%	99.32%	**3.83**
Tri-County Office on Aging	95.22%	100%	**3.92**
The Information Center	94.09%	100%	**3.87**
The Senior Alliance	94.44%	99.67%	**3.94**
UPCAP Care Management, Inc.	94.51%	100%	**3.92**
Valley Area Agency on Aging	95.98%	99.19%	**3.88**

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

Statewide Conclusions and Recommendations

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

Strengths

The overarching aggregated findings from the QIP, PMV, and Compliance Review activities demonstrate that MDHHS has focused its quality improvement efforts on care management processes and person-centered planning to support waiver members' **access** to **timely** services in accordance with their individualized health needs. Additionally, MDHHS and its contracted waiver agencies are focusing strategies on **quality** of care by implementing quality improvement initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes. Further, through the CQAR process, MDHHS mandates immediate corrective action when issues are identified that may impact a member's ability to maintain optimal function; make informed choices; preserve independence and community integration; and/or create barriers to **quality** care or **access** to **timely** and necessary services.

Weaknesses

HSAG's comprehensive assessment of the waiver agencies and the MI Choice Waiver Program also identified areas of focus that represent significant opportunities for improvement within the program. Based on HSAG's assessment of the waiver agencies' QMPs and annual reports, the MI Choice performance measure report, and the CQAR results and succeeding CAPs, the MI Choice Waiver Program has opportunities to enhance its EQR-related processes for overseeing and managing its contracted waiver agencies and subsequently assisting them to improve their performance with respect to **quality**, **timeliness**, and **access to care**, which should support an improvement in the MI Choice Waiver Program's overall performance in these performance domains.

HSAG's assessment identified that the weaknesses within the MI Choice Waiver Program were primarily related to the gaps in MDHHS' processes for conducting EQR-related activities, as there were noted discrepancies within the data reviewed or the data were not available as expected. The discrepant and incomplete data created challenges in evaluating each waiver agency's performance in the domains of **quality**, **timeliness**, and **access** to care as it relates to member outcomes.

Quality Strategy Recommendations for the MI Choice Waiver Program

The MDHHS CQS was designed to improve the health and welfare of the people of the State of Michigan and address the challenges facing the State. Through the MDHHS CQS, MDHHS is focusing on population health improvement on behalf of all of the Medicaid members it serves, while accomplishing its overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality across all Michigan Medicaid managed care programs. MDHHS uses three foundational principles to guide implementation of the MDHHS CQS to improve the quality of care and services. The principles include:

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

In consideration of the goals of the MDHHS CQS and the comparative review of findings for all activities related to quality, timely, and accessible care and services, HSAG recommends the following quality improvement initiatives, which focus on the EQR-related processes designed to provide a sound understanding of the strengths and weaknesses of waiver agencies' performance related to quality, timeliness, and access to care, and primarily target goals #1 and #3 and the associated objectives within the MDHHS CQS.

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

Goal #3: Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external).

Recommendation 1—CMS EQR Protocols

Implementation of EQR-related activities in accordance with 42 CFR §438.358 and in alignment with the CMS EQR protocols will improve MDHHS' ability to oversee and manage the waiver agencies, and should lead to more comprehensive, accurate, and reliable data to assess the MI Choice Waiver Program's performance related to quality, timeliness, and access to care. As such, HSAG recommends MDHHS conduct its EQR-related activities following the Medicaid and CHIP Managed Care Final Rule and the CMS EQR protocols.

- **Validating PIPs**—In accordance with 42 CFR §438.330(d), MDHHS must require that PAHPs conduct PIPs, including any PIPs required by CMS, 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 elements:
  - Measurement of performance using objective quality indicators.
  - Implementation of interventions to achieve improvement in the access to and quality of care.
  - Evaluation of the effectiveness of the interventions based on the performance measures.
  - Planning and initiation of activities for increasing or sustaining improvement.

Issue—Other than the QMPs, HSAG did not receive documentation to support that the waiver agencies maintained documentation specific to the state-required QIPs that include all steps identified in CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.

Recommendation—While MDHHS currently requires the waiver agencies to conduct QIPs for five quality indicators, HSAG recommends that MDHHS select two of the quality indicators, or other quality indicators (one clinical and one nonclinical), of particular interest to MDHHS and the MI Choice Waiver Program and require the waiver agencies to implement these PIPs using a formalized and evidence-based process that aligns with CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019. MDHHS, its agent that is not a PAHP, or an EQRO should conduct the validation in adherence with 42 CFR §438.358(b)(1)(i) and use the documentation provided by the waiver agencies to verify that each waiver agency used sound methodology in its design, implementation, analysis, and reporting of the PIPs.

- **Validating Performance Measures**—In accordance with 42 CFR §438.330(c), MDHHS must specify standard performance measures for PAHPs to include in their comprehensive quality assessment and performance improvement programs. Each year, the PAHPs must measure and report to MDHHS the standard performance measures specified by MDHHS; submit specified data to MDHHS, which enable MDHHS to calculate the standard performance measures; or a combination of these approaches.

  Issue—While MDHHS is calculating performance measures for reporting to CMS in the CMS-372 report, MDHHS is not calculating and subsequently monitoring the performance of individual waiver agencies at a point in time, tracking performance over time, or comparing individual waiver agencies to each other to assess overall performance of the MI Choice Waiver Program. Additionally, some performance measures identified by MDHHS are MDHHS driven and performance is not impacted by individual waiver agencies (e.g., performance related to capitation payments to the waiver agencies). Further, the data sources identified in the CMS approved MI Choice Waiver Program and the CQAR referenced performance measure standards did not align with the data sources and/or the CQAR standards identified in the MI Choice performance measure report.

  Recommendation—HSAG recommends that MDHHS identify a specific number of performance measures that will provide meaningful information on individual waiver agency performance and require the waiver agencies to calculate and report these measures to MDHHS annually. MDHHS should identify the performance measures' specifications for calculating numerators and denominators and the subsequent percentage rates. MDHHS, its agent that is not a PAHP, or an EQRO should conduct the validation of these performance measures in accordance with CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019, and 42 CFR §438.358(b)(1)(ii). The validation activity should assess whether the performance measures calculated by each waiver agency are accurate

based on the measure specifications and State reporting requirements. Once MDHHS has selected a set of performance measures and has collected baseline data, MDHHS should also consider establishing minimum performance standards for each measure to drive continuous improvement.

- **Conducting Compliance Reviews**—In accordance with 42 CFR §438.358(b)(1)(iii), MDHHS, its agent that is not an PAHP, or an EQRO must perform the mandatory compliance review, conducted within the previous three-year period to determine each waiver agency's compliance with the standards set forth in 42 CFR §438 Subpart D, the disenrollment requirements and limitations described in 42 CFR §438.56, the enrollee rights requirements described in 42 CFR §438.100, the emergency and post-stabilization services requirements described in 42 CFR §438.114, and the quality assessment and performance improvement requirements described in 42 CFR §438.330.

  Issue—While MPHI currently conducts an annual CQAR on behalf of MDHHS, it is primarily focused on a review of whether person-centered service plans and service delivery followed State and federal requirements. However, HSAG did not receive documentation to demonstrate that a comprehensive compliance review was conducted in accordance with all standards required by 42 CFR §438.358(b)(1)(iii). While MDHHS confirmed that emergency and post-stabilization services do not apply to waiver agencies due to the scope of services of the MI Choice Waiver Program, most federal Medicaid managed care requirements related to the compliance review activity were not addressed through the CQAR. Additionally, the CMS-approved waiver application for the MI Choice Waiver Program required MDHHS to complete a biennial on-site AQAR to evaluate waiver agency policies and procedure manuals, peer review reports, provider monitoring reports, provider contract templates, financial systems, encounter data accuracy, QMPs, and verification of provider licensure. The scope of the AQAR would appear to address at least some of the federal requirements required to be included in a comprehensive compliance review; however, MDHHS informed HSAG that the AQAR has not been completed in several years due to staffing issues and the coronavirus disease 2019 (COVID-19) pandemic. MDHHS further explained that it is working on a plan to begin the AQAR process.

  Recommendation—HSAG recommends that MDHHS conduct a comprehensive compliance review during each three-year cycle. The review must include all federally mandated standards for managed care plans. The compliance review activity should align with CMS EQR *Protocol 3. Review of Compliance With Medicaid and Chip Managed Care Regulations*: *A Mandatory EQR-Related Activity*, October 2019. MDHHS should begin with developing a crosswalk of the standards currently reviewed as part of the CQAR against the standards required to be part of a compliance review according to 42 CFR §438.358(b)(1)(iii). Any federally required standards that do not apply to the scope of the MI Choice Waiver Program should also be identified within this crosswalk. Based on the findings of the crosswalk, MDHHS should immediately begin preparations to address all gaps identified in its current compliance review process.

Recommendation 2—Quality Assessment and Performance Improvement Program

In accordance with 42 CFR §438.330(d), MDHHS must require through its contracts that each PAHP establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its members. A comprehensive quality assessment and performance improvement program must include at least the following elements:

- PIPs.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness furnished to members with special health care needs.
- For PAHPs providing LTSS:
  - Mechanisms to assess the quality and appropriateness of care furnished to members using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable.
  - Participate in efforts by MDHHS to prevent, detect, and remediate critical incidents for home- and community-based waiver programs.

Issue—The QMPs and annual reports contained minimal information and did not include all components of a comprehensive quality assessment and performance improvement program. Additionally, in general, the QMP reports were conflicting (e.g., QIP goals were not consistent between the QMP and annual report), mislabeled, vague, and included limited performance metrics to assess the success of the program and the barriers that may be contributing to poor performance. Additionally, although the statewide performance measure related to submission of the QMPs was 100 percent, documents submitted as QMPs for some waiver agencies appeared to actually be an annual report as opposed to the QMP.

Recommendation—HSAG recommends MDHHS host a work group with representation of each waiver agency's quality improvement team to enhance the QMPs and the annual QMP evaluation. As part of this work group, the waiver agencies should research best practices for developing a comprehensive quality assessment and performance improvement program and share those practices through the work group. As part of the development process, MDHHS should considering requiring each waiver agency to develop a quality assessment and performance improvement program description, a separate work plan, and a comprehensive annual evaluation.

Each waiver agency should consider addressing the following components, as they apply to the scope of MI Choice Waiver Program, in its program description:

- Vision and mission of the program.
- Organizational/committee structure.
- Key quality staff member roles and responsibilities.
- Resources supporting the quality program.

- Data collection and validation processes.
- Performance measures.
- PIPs.
- Mechanisms to detect under- and overutilization.
- Mechanisms to assessment the effectiveness of services for members with special health care needs.
- Adoption and dissemination of clinical practice guidelines; specifically, those adopted from nationally recognized sources.
- Provider network monitoring, such as access standards.
- Grievances and appeals and identified trends.
- Member outreach and education needs and activities.
- Cultural competency.
- Social determinants of health.
- Credentialing activities.
- Quality of care concerns and peer review.

Each waiver agency should consider addressing the following components, as they apply to the scope of MI Choice Waiver Program, in its work plan:

- Measurable goals and objectives. Goals should be related to the activities identified in its quality assessment and performance improvement program description and priority areas of MDHHS and the waiver agency. The waiver agency should consider using data from the previous year to identify focus areas and subsequent measurable goals.
- Targeted completion dates for each goal.
- Assigned person(s) or department responsible for each goal.
- Interventions and activities to be implemented in an effort to meet each goal.
- Quarterly reviews and documentation of progress or barriers in meeting each goal.

Each waiver agency should consider addressing the following components, as they apply to the scope of MI Choice Waiver Program, in its annual program evaluation:

- Determine whether established measurable goals have been met.
- Identify successes, barriers, and recommendations for improvement, as applicable, for each activity and goal.
- Solicit input from the assigned persons(s) or department responsible for each goal.
- Establish new goals when they have been maintained and sustained or when new focus or priority areas have been identified.
- When goals are not met, complete a barrier analysis and actions steps for the upcoming year.

Appendix A. External Quality Review Activity Methodologies

Methods for Conducting External Quality Review Activities

Validation of Performance Improvement Projects

Activity Objectives

In accordance with 42 CFR §438.330(b)(1), a PAHP's quality assessment and performance improvement program much include PIPs. Additionally, 42 CFR §438.330(d)(2)(i–iv) requires that each PIP include:

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

The goal of each PIP is to assess and improve processes and outcomes of care provided by the waiver agencies in the State of Michigan for the MI Choice Waiver Program.

Technical Methods of Data Collection and Analysis

Each waiver agency develops a QMP every other year that addresses CMS and MDHHS quality requirements. MDHHS also requires each waiver agency to compile an annual report, called the MI Choice Summary of Quality Management Plan Activities & Outcomes Report, which provides a description of the waiver agency's quality management activities and outcomes. Every two years, the QMC members vote on five quality indicators to initiate QIPs, and goals and strategies. Progress of these quality indicators are reported annually to MDHHS through the MI Choice Summary of Quality Management Plan Activities & Outcomes Report. MDHHS reviews and analyzes waiver agency QMPs and the associated annual reports. MDHHS also compiles and compares individual waiver agency quality indicators and statewide averages. Table A-1 outlines the selected five QIP quality indicators for the waiver agencies for the SFY 2020 and SFY 2021 review years.

Table A-1—QIP Indicators

QIP Indicators
1. *Prevalence of Neglect/Abuse*
2. *Prevalence of Pain With Inadequate Pain Control*
3. *Prevalence of Falls*
4. *Prevalence of Any Injuries*
5. *Prevalence of Dehydration*

Description of Data Obtained and Related Time Period

In SFY 2020, each waiver agency submitted detailed information about each of the five QIP indicators to MDHHS through the QMP and MI Choice Summary of Quality Management Plan Activities & Outcomes Report. The waiver agencies were required to submit their completed reports to MDHHS by January 15, 2021, along with detailed data regarding each QIP indicator's goals, strategies, and results during the time period of October 1, 2019, through September 30, 2020. Each waiver agency's QIPs is reported to MDHHS through a yearly activities and outcomes report. These reports provide data about each of the QIPs and the activities completed. The MI Choice Summary of Quality Management Plan Activities & Outcomes Report and each waiver agency's QMP were provided to HSAG by MDHHS for this EQR.

Performance Measure Validation

Activity Objectives

The objective of the PMV activity is to ensure the performance measure rates for the MI Choice waiver agencies are accurately and reliably calculated and reportable.

Annually, MDHHS calculates 39 performance measure rates and subsequently reports the statewide percentage rates for each measure to CMS using the CMS-372 report. MDHHS adheres to the performance measure specifications and methodology described in its CMS-approved Section 1915(c) HCBS waiver for the MI Choice Waiver Program.

Technical Methods of Data Collection and Analysis

MDHHS has systems in place to measure the overall performance of the MI Choice Waiver Program in the following waiver assurance domains: Administrative Authority, Evaluation/Reevaluation of Level of Care, Participant Services, Participant-Centered Planning and Service Delivery, Participant Safeguards, and Financial Accountability. In SFY 2020, MDHHS or its contracted EQRO, MPHI, obtained data through the annual CQAR reviews and MDHHS' online reporting databases, including the Critical Incident Reporting System, NFLOC system, CHAMPS, and the MMIS. The data from these sources were used by MDHHS to calculate and subsequently report statewide performance measure percentage rates to CMS through the CMS-372 report. Table A-2 lists the performance measures calculated by MDHHS and whether the source of the data was from the CQAR, the waiver agency and validated by MDHHS, or a database.

Table A-2—Performance Measures and Source Data

	Performance Measures	Source Data	Sampling Approach
	Administrative Authority		
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.*	CQAR	Representative sample
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.*	CQAR	Representative sample
3	*Number and percent of waiver agencies who submit annual Quality Management Plan (QMP) activity and outcome reports that illustrate they are adhering to their QMP.*	Waiver agency	100% review
4	*Number and percent of appropriate level of care determinations (LOCDs) found after MDHHS review.*	Database	100% review
5	*Number and percent of corrective action plans that were provided by waiver agencies according to requirements set by the Michigan Department of Health and Human Services (MDHHS) or the External Quality Review Organization (EQRO).*	Waiver agency	100% review
	Evaluation/Reevaluation of Level of Care		
6	*Number and percent of new MI Choice waiver participants who meet the NFLOC criteria prior to waiver enrollment.*	Database	100% review
7	*Number and percent of LOCDs made by a qualified evaluator.*	CQAR	Representative sample
8	*Number and percent of participants who had initial LOCDs where the NFLOC criteria were accurately applied.*	CQAR	Representative sample
9	*Number and percent of MI Choice disenrollments based upon no longer meeting NFLOC criteria that were determined correctly.*	Database	100% review
10	*Number and percent of providers continuing to meet applicable licensure & certification standards in accordance with state law following initial enrollment.*	Waiver agency	100% review (Waiver agencies review 20% of records; MDHHS reviews 100% of those records reviewed by waiver agencies)
11	*Number and percent of new waiver service provider applications that meet initial licensure/certification standards in accordance with state law prior to the provision of waiver services.*	CQAR*	100% review
12	*Number and percent of non-licensed or non-certified waiver providers that initially met provider qualifications.*	CQAR*	100% review

	Performance Measures	Source Data	Sampling Approach
13	*Number and percent of non-licensed or non-certified waiver providers that continue to meet provider qualifications.*	Waiver agency	100% review (Waiver agencies review 20% of records; MDHHS reviews 100% of those records reviewed by waiver agencies)
14	*Number and percent of providers who meet provider training requirements.*	Waiver agency	100% review (Waiver agencies review 20% of records; MDHHS reviews 100% of those records reviewed by waiver agencies)
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.*	CQAR	Representative sample
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.*	CQAR	Representative sample
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.*	CQAR	Representative sample
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.*	CQAR	Representative sample
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.*	CQAR	Representative sample
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.*	CQAR	Representative sample
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.*	CQAR	Representative sample
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.*	CQAR	Representative sample
	Participant Safeguards		
23	*Number and percent of participant critical incidents for which investigations by the waiver agencies were resolved within 60 days.*	Database	100% review
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.*	CQAR*	Representative sample
25	*Number and percent of critical incidents due to unexplained death reported within two business days of notification that the incident occurred.*	Database	100% review

	Performance Measures	Source Data	Sampling Approach
26	*Number and percent of all critical incidents EXCEPT unexplained death reported within 30 days of notification that the incident occurred.*	Database	100% review
27	*Number and percent of waiver agencies that utilize the critical incident database to track incidents through effective resolution.*	Database	100% review
28	*Number and percent of waiver agencies with staff who have completed required training to prevent incidents.*	Waiver agency	100% review
29	*Number and percent of unauthorized use of restraints, restrictive interventions, or seclusions that were reported as a critical incident.*	Database	100% review
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of caregiver).*	CQAR	Representative sample
31	*Number and percent of participant suicide attempts that resulted in follow up by the waiver agency.*	Database	100% review
32	*Number and percent of participants requiring emergency medical treatment or hospitalization due to medication error.*	Database	100% review
33	*Number and percent of critical incidents reporting hospitalization or emergency room visit within 30 days of the previous hospitalization due to neglect or abuse.*	Database	100% review
34	*Number and percent of properly reported suicide attempts in the critical incident database.*	Database	100% review (MDHHS) Representative sample (Contracted reviewers)
	Financial Accountability		
35	*Number and percent of encounters submitted to MDHHS with all required data elements.*	Database	100% review
36	*Number and percent of capitation payments made to the waiver agencies only for MI Choice participants with active Medicaid eligibility.*	Database	100% review
37	*Number and percent of encounters submitted to MDHHS within required timeframes.*	Database	100% review
38	*Number and percent of service plans that supported paid services.*	CQAR	Representative sample
39	*Number and percent of capitation payments that have been paid at rates approved by the Actuary.*	Database	100% review

*****Although the MI Choice Waiver Program indicates the data source as the CQAR, the CQAR standards did not include a reference to this performance measure. Therefore, it is unknown where the data came from for performance measure reporting.

For data derived through CQAR results, MDHHS calculated the performance measure rates in accordance with the following steps:

1. On a Microsoft (MS) Excel spreadsheet, MDHHS entered:
   a. The applicable standard from the CQAR
   b. The percent of compliance
   c. The reason for the citations
2. Auto summed the "Percent Compliance" column
3. Divided the Auto Sum calculation by the number of standards included in the applicable Performance Measure to obtain the Percentage of Compliance for the Performance Measure
   a. Example: Performance Measure
      i. 1-12 standards
      ii. 2-22 standards
4. Determined the number of participants that would be applicable for the Performance Measure Percentage of Compliance
   a. The denominator was the number of participants reviewed by CQAR in SFY 2020
   b. The numerator was determined by completing the following:
      i. Performance Measure 1 Example:
         1. SFY 2020 378 participants were reviewed
         2. Overall percentage of compliance of 91.75 percent
         3. After manually changing the numerator, MDHHS determined that 345/378 participants had an overall percentage of compliance of 91.27 percent

For the performance measures that did not use data from the CQAR, MDHHS manually calculated statewide rates using data obtained through reports generated in internal databases or from information collected from the waiver agencies and subsequently validated by MDHHS.

Description of Data Obtained and Related Time Period

MDHHS provided HSAG with each of the 20 waiver agencies' CQAR results and a copy of the MI Choice performance measure report, which included each of the 39 performance measures, the numerator and denominator for each performance measure, and the statewide percentage rate for each performance measure.

The performance measures were calculated by MDHHS using data collected between October 1, 2019, and September 30, 2020 (SFY 2020).

Michigan Public Health Institute Compliance Review

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the MI Choice waiver agencies' compliance with the applicable standards for waiver agencies set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the member rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in 42 CFR §438.330. To meet this requirement, MDHHS performed annual compliance monitoring activities of its 20 contracted PAHP waiver agencies.

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 waiver agencies in developing corrective actions to achieve compliance with State and federal requirements.

Technical Methods of Data Collection and Analysis

MDHHS contracts with its EQRO, MPHI, to complete a CQAR for every waiver agency each state fiscal year that consists of a record review and home visit interview. During the CQAR, reviewers examine case records and other information to gauge the level of compliance with program standards and to assess the quality of waiver agency service to each participant. The CQAR includes a review of whether person-centered service plans and service delivery are in compliance with State and federal requirements. The purpose of the home visits is to verify that what is contained in the record is consistent with what the reviewer observes in the home.

MDHHS selects a random sample of each waiver agency's MI Choice member records. MDHHS determines a statistically significant number of records to review based upon the total number of MI Choice slots used in a given fiscal year. The sampling methodology is less than 100 percent review with a sample confidence interval = +/-5%. MPHI used the Raosoft tool to determine the sample size needed for a 95 percent confidence level with MI Choice population size and allowing for a 5 percent margin of error. The total sample size was portioned over the 20 waiver agencies, depending on their enrollment percentage of the total enrollment to determine the sample needed from each waiver agency. If the waiver agency sample size was less than 10, the sample size was rounded up to 10.

The SFY 2020 CQAR consisted of 18 focus areas identified in Table A-3. Table A-3 also identifies the focus areas included as part of the record review and/or the home visit interview.

Table A-3—CQAR Standards

Standards		Record Review	Home Visit Interview
Focus I	Level of Care Determination	✓	✓
Focus I.B	Communication		✓
Focus II	Freedom of Choice	✓	
Focus III	Release of Information	✓	
Focus IV	Status	✓	
Focus V	Pre-Planning	✓	✓
Focus VI	Assessment	✓	✓
Focus VII	Medication Record	✓	✓
Focus VIII	Person-Centered Service Planning	✓	✓
Focus IX	MI Choice Services	✓	✓
Focus X	Linking and Coordinating	✓	✓
Focus XI	Follow-Up and Monitoring	✓	✓
Focus XII	Service Provider	✓	
Focus XIII	Contingency Plan	✓	✓
Focus XIV	Critical Incidents	✓	✓
Focus XV	Adverse Benefit Determination	✓	
Focus XVI	Complaints and Grievances	✓	
Focus XVII	Home and Community Based		✓

Each review element was assigned a value of *Evident*, *Non-Evident*, or *N/A*. A percentage of *Evident* values for each focus area was derived from the total number of elements assigned a value of *Evident* divided by the number of total applicable elements. MDHHS required a CAP for all cited focus areas/standards.

MDHHS assigned an importance and harm score for each standard reviewed based on the criteria in the table below:

Table A-4—Importance and Harm Score

Score	Importance	Harm
1	**Extremely Important**—standard is a basic CMS assurance	**Definite Risk** to participant's health and welfare and FFP if not present.
2	**Highly Important**—CMS and/or State requirement	**Likely Risk** to participant's health and welfare and/or FFP if not present
3	**Important**—CMS recommendation and/or State contract requirement	**Slight Risk** to participant's health and welfare or FFP if not present.

Following the completion of the CQAR, each standard received a score based on a compliance level (A-B-C-D) and the percentage of compliance shown in Table A-5.

Table A-5—Compliance Level

Total Score	Compliance Level	Citation Threshold	Recommendation Threshold
2	**A**	10.01% or more "Non-Evident" scores	5.01–10% "Non-Evident" scores
3	**B**	15.01% or more "Non-Evident" scores	10.01–15% "Non-Evident" scores
4	**C**	20.01% or more "Non-Evident" scores	15.01–20% "Non-Evident" scores
5 or 6	**D**	25.01% or more "Non-Evident" scores	20.01.–25% "Non-Evident" scores

Table A-6 identifies the four compliance determination categories and the accompanying compliance levels, which MDHHS incorporates into each waiver agency's MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination report.

Table A-6—Compliance Level Determination Matrix

Compliance Level Determination Matrix								
	Overall Compliance Level:		A	B	C	D		Compliance Determination Report
Compliance Determination	Substantial	Waiver Agent substantially meets assurances.	90% Compliant or better	85% Compliant or better	80% Compliant or better	75% Compliant or better		3.26 or higher
	Some, Needs Improvement	Waiver Agent demonstrates assurances, but MDHHS recommends improvements or requires additional information.	85-89% Compliant	80-84% Compliant	75-79% Compliant	70-74% Compliant		2.51 - 3.25
	Not Full or Substantial	Waiver Agent does not fully or substantially demonstrate assurance, though there is evidence that it may be clarified or readily addressed.	80-84% Compliant	75-79% Compliant	70-74% Compliant	65-69% Compliant		1.76 - 2.50
	Not Demonstrated	Waiver Agent does not demonstrate the assurance.	79% Compliant or worse	74% Compliant or worse	69% Compliant or worse	64% Compliant or worse		1 - 1.75

Description of Data Obtained and Related Time Period

Table A-7 lists the major data sources MDHHS used in determining the waiver agencies' performance in complying with requirements and the time period to which the data applied. For this EQR, MDHHS provided HSAG with the completed SFY 2020 CQAR tools and CAPs.

Table A-7—Description of Waiver Agency Data Sources

Data Obtained	Time Period to Which the Data Applied
Record reviews of MDHHS selected members	October 1, 2019–September 30, 2020
Information obtained through member home visit interviews	October 1, 2019–September 30, 2020