Quality Assessment and Performance Improvement Program

Annual Evaluation

2022

CQMC: 4/25/23

HAP Empowered
Quality Assessment and Performance Improvement Program
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Introduction

HAP Empowered Health Plan's Quality Program is supported by the Quality Management Department, the Clinical Quality Management Committee (CQMC) and its subcommittees, the HAP Empowered Board of Directors and HAP staff at large. During the calendar year 2022, HAP Empowered continued to work on making improvements in quality care for the well-being and safety of members. As of December 2022, HAP Empowered Medicaid membership was 37,559. This Program Evaluation is applicable to Medicaid unless otherwise noted.

Highlights of the 2022 Quality Assessment and Performance Improvement Program All-Product (QAPI) includes the following achievements and organizational accomplishments:

- Successful completion of NCQA® MED Module and LTSS Distinction

- HAP won the prestigious Michigan Association of Health Plans Pinnacle award for our palliative care program, taking first place in the 2022 Clinical Service Improvement – Government Programs category. The palliative care program allows members with serious illness to be home with their families, especially during end-of-life care, which increases quality of life. Since 2019, more than 1,000 HAP members have enrolled, with hospitalizations among this group having decreased by up to 58% compared to similar cohort at end of life. HAP continues to be committed to creating programs like this that are designed to ensure every member is treated with dignity and respect at every stage of care.

- HAP partnered with the Detroit Public Schools Community District (DPSCD) to support a program that provides coats and personal care items to students throughout the district who need them. HAP's $75,000 donation to the DPSCD Foundation will purchase all-weather coats and personal care items that students can "shop" for at DPSCD schools. The program is designed to support students and their families, eliminating barriers to attendance and attention while at school.

- The Institute of Medicaid Innovation (IMI) selected HAP's COVID-19 Response: Pre- and Post-Vaccine as one of twenty-five outstanding programs nationally that will be highlighted in a compendium of exemplary initiatives.

- All HAP team members completed training on Unconscious Bias.

- Online Chronic Disease Self-Management Program: Implemented Better Choices, Better Health (BCBH) in partnership with the National Kidney Foundation of Michigan which is a six-week online program developed by Stanford University. Members learn to manage a variety chronic conditions like diabetes, high blood pressure, heart disease, sleep apnea, depression, arthritis, and improve healthy behaviors. Outreach was sent to 2,452 members that met the following criteria: Medicaid, ≤3 chronic conditions, and between the ages of 25-64. Since the initial outreach in September, 23 members enrolled through a mailer (6) or text campaign (17). Targeted enrollment is 20-25 members.

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- New HAP Empowered contract with McLaren Health System Effective Oct. 1, 2022, McLaren Greater Lansing Hospital and its 125 providers have joined the HAP network. This means that all McLaren facilities and providers in Michigan are now in-network for Medicaid plans.

- Launched New Provider Excellence team to support contracting expansion activities

- Implemented new Provider reports to assist FQHC providers groups in scheduling annual wellness visits

- Enhanced SMS outreach to add new care gap messages including annual wellness visits, dental care reminders, and flu vaccine reminders

Goals and Objectives

Each year HAP Empowered sets goals and objectives for its Quality Improvement (QI) activities designed to improve the level of care and service provided to its members. Annually, HAP Empowered reviews the QAPI to evaluate the value and effectiveness of activities implemented throughout the year and to determine if goals and objectives are met. Program revisions are dependent on clinical outcomes, effectiveness of interventions, contractual agreements, accreditation standards requirements, budget, and overall satisfaction with meeting goals of the QAPI.

Quality Program Evaluation

The Quality Program was developed to ensure alignment with the HAP Unifying Concept strategies, stakeholder/purchaser and regulatory requirements, and accreditation standards. The program document is enhanced annually and as necessary to capture the increased focus on patient safety and behavioral health initiatives. We will continue to evaluate plan-wide achievement of organizational goals on a quarterly basis. The quarterly review ensures adherence to the organizational vision, goals, strategies, and the opportunity to evaluate effectiveness of the interventions in a timely manner.

The Quality Program annual evaluation provides both qualitative and quantitative evaluations of plan-wide performance. HAP Empowered provides information on the effectiveness of the Quality Program annually to network providers. Evaluations are available on the plan website annually; providers are notified of the availability of program documents.

The Quality Program Work Plan evaluation tool is a quarterly review of the plan's ability to accomplish organizational goals and objectives as well as an evaluation of the accomplishments, limitations, and recommendations for future goals and objectives. The QI Workplan evaluation is shared with MDHHS on an annual basis.

- QI activities and objectives for improving the quality & safety of clinical care, quality of service and members' experience
- Time frame for each activity's completion
- Staff members responsible for each activity
- Monitoring of progress and/or barriers

HAP Empowered's Quality Program encompasses strategies to design programs that are population

based and provide for identification of high-risk members with chronic conditions for enrollment into health coaching and case management programs; measure performance outcomes; and support systematic follow-up on the effectiveness of interventions. Additionally, the quality improvement projects address clinical and non-clinical activities and are based on measurable, evidence-based, achievable outcomes that are analyzed annually. The outcomes are reported to the CQMC and Board of Directors.

HEDIS® Performance Outcomes Measures Results

Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA®) to objectively measure, report, and compare quality across health plans. NCQA® develops HEDIS measures through a committee represented by purchasers, consumers, health plans, health care providers, and policy makers. As state and federal governments move toward a quality-driven healthcare industry, HEDIS scores are becoming more important for both health plans and individual providers.

HAP Empowered recognizes the importance of assisting the Medicaid population in obtaining preventive care which improves health outcomes and can prevent diseases. HAP Empowered has utilized the HEDIS® in conjunction with breakdowns in member's demographics and social determinants of health to identify members in need of preventive services, their barriers, and opportunities for improvement to create programs/interventions that aim to encourage Medicaid members to complete those needed preventive services.

The intent of this evaluation is to provide a brief, high-level summary of HAP Empowered's MY 2021 HEDIS® performance compared to its goals and to highlight any improvements made over the past year. The analysis includes information related to three-year trending of measures and compares the final HEDIS® MY 2021 rates against the NCQA® National Benchmarks and Thresholds.

For MY 2021, HAP Empowered achieved the following NCQA® benchmarks:

- 75th NCQA® Percentile:
  - Breast Cancer Screening
  - Adults' Access to Preventive/Ambulatory Health Services (65+ Years)
- 50th NCQA® Percentile:
  - Chlamydia Screening in Women (Total)
  - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (BMI Percentile)
  - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Counseling for Nutrition)
  - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Counseling for Physical Activity)

The following analyzes HEDIS® measures for member access, prevention, child prevention and immunizations and diabetes care. In addition, a summary of HAP Empowered's efforts to improve HEDIS® measures is included.

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Children and Adolescent Preventive Care

EPSDT

Federal regulations require state Medicaid programs to offer early and periodic screening, diagnosis, and treatment (EPSDT) services to Medicaid eligible beneficiaries younger than 21 years of age; however, beneficiary participation is voluntary. The intent of EPSDT is to correct or ameliorate defects in physical and mental illnesses and conditions discovered by screening services.

Providers are responsible for providing Well-Child Visits, including immunizations and developmental screening, at specified intervals as defined in the periodicity schedule by the American Academy of Pediatrics (AAP). To encourage providers to perform member outreach and provide age-appropriate services, HAP Empowered offers Primary Care Physicians and members EPSDT financial incentives.

Well-Child Visits

Well-Child Visits provide an opportunity for the Primary Care Physician to obtain an initial history or interval history, promote healthy lifestyle choices, monitor children's physical and behavioral health, and provide age-appropriate anticipatory guidance and education. It is during these Well-Child Visits that potential health problems may be detected and prevented or treated in the early stages, thereby reducing the negative effects of these problems. Components of a Well-Child Visit include a physical examination, counseling in nutrition and physical activity, various immunizations, and various screenings such as sensory, developmental, behavioral, and lead screenings.

HAP Empowered focused on Well-Child Visits in MY 2021 for several important reasons including that the state of Michigan recognizes a decrease in immunizations, lead screenings, and other preventive screenings. Therefore, it is essential that HAP Empowered monitors progress for these measures through annual HEDIS® and monthly gaps in care reports through the software vendor. The following are results for several childhood preventive health measures.

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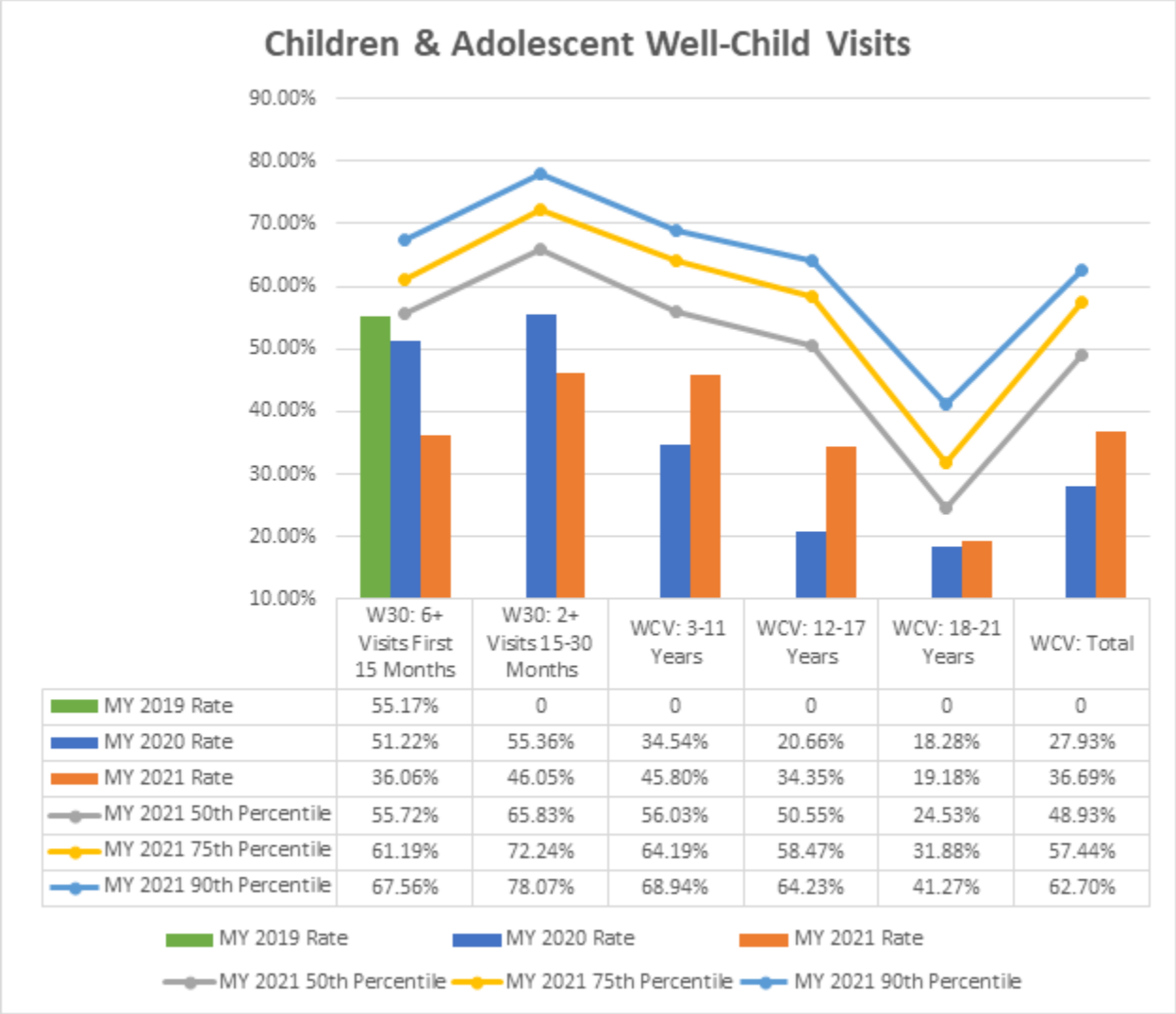
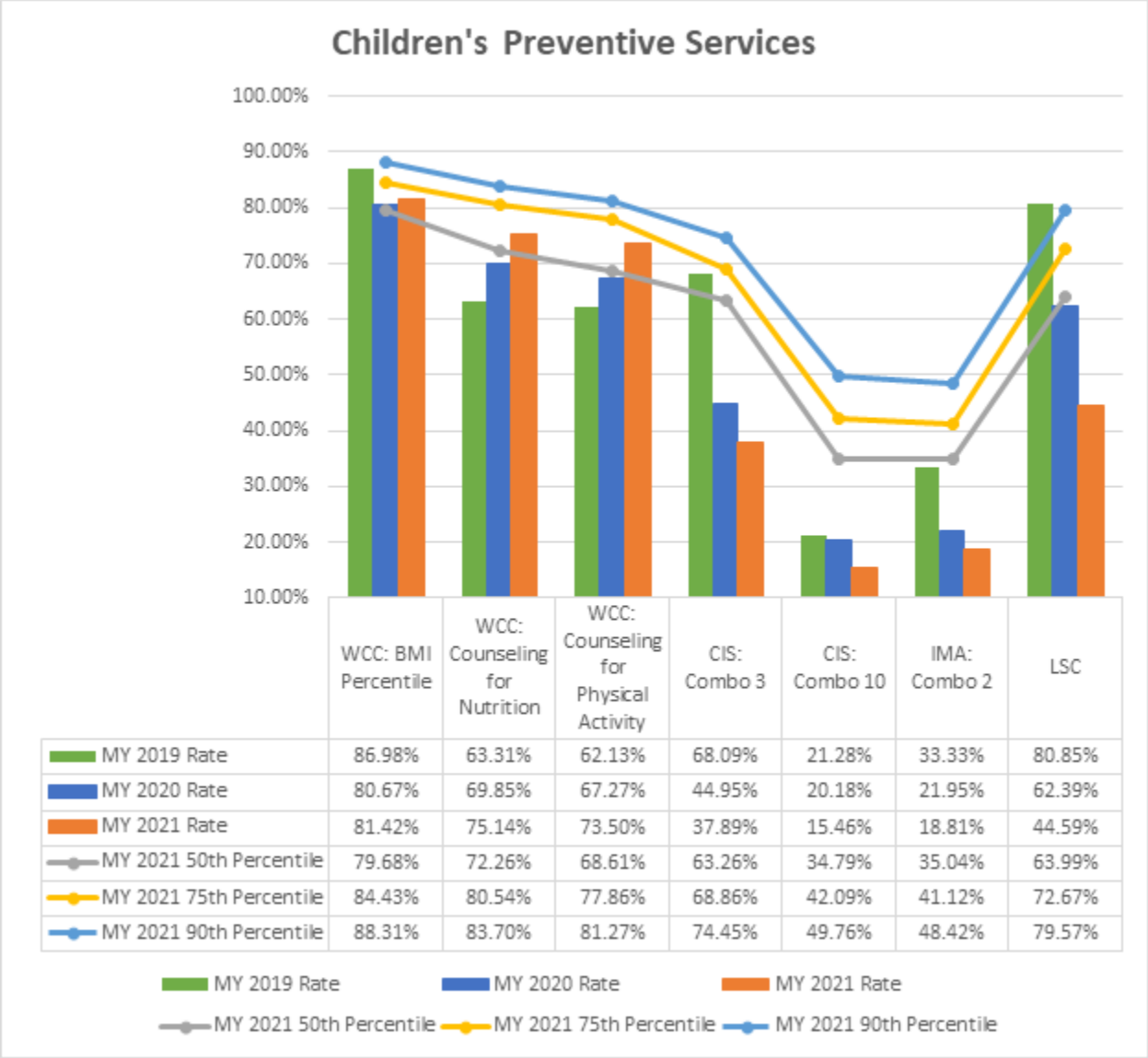
Graph 1



	W30: 6+ Visits First 15 Months	W30: 2+ Visits 15-30 Months	WCV: 3-11 Years	WCV: 12-17 Years	WCV: 18-21 Years	WCV: Total
MY 2019 Rate	55.17%	0	0	0	0	0
MY 2020 Rate	51.22%	55.36%	34.54%	20.66%	18.28%	27.93%
MY 2021 Rate	36.06%	46.05%	45.80%	34.35%	19.18%	36.69%
MY 2021 50th Percentile	55.72%	65.83%	56.03%	50.55%	24.53%	48.93%
MY 2021 75th Percentile	61.19%	72.24%	64.19%	58.47%	31.88%	57.44%
MY 2021 90th Percentile	67.56%	78.07%	68.94%	64.23%	41.27%	62.70%

Graph 2



	WCC: BMI Percentile	WCC: Counseling for Nutrition	WCC: Counseling for Physical Activity	CIS: Combo 3	CIS: Combo 10	IMA: Combo 2	LSC
MY 2019 Rate	86.98%	63.31%	62.13%	68.09%	21.28%	33.33%	80.85%
MY 2020 Rate	80.67%	69.85%	67.27%	44.95%	20.18%	21.95%	62.39%
MY 2021 Rate	81.42%	75.14%	73.50%	37.89%	15.46%	18.81%	44.59%
MY 2021 50th Percentile	79.68%	72.26%	68.61%	63.26%	34.79%	35.04%	63.99%
MY 2021 75th Percentile	84.43%	80.54%	77.86%	68.86%	42.09%	41.12%	72.67%
MY 2021 90th Percentile	88.31%	83.70%	81.27%	74.45%	49.76%	48.42%	79.57%

Qualitative Analysis

HAP Empowered had a goal of achieving the 50th percentile for Well-Child Visits and other childhood preventive health measures for MY 2021. HAP Empowered met the 50th percentile for some of the preventive health measures including Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC): BMI Percentile, WCC: Counseling for Nutrition, and WCC: Counseling for Physical Activity. Unfortunately, HAP Empowered did not reach this goal for some of the other measures. A part of this is due to a substantial increase in the denominators which made it more difficult for HAP Empowered to reach the goal of the 50th percentile. For example, Well-Child Visits in the First 30 Months of Life (W30): 6+ Visits First 15 Months denominator increased by 407.32% from MY

2020 to MY 2021 (41 members to 208 members). Additionally, the Lead Screening in Children (LSC) denominator increased by 255.96% from MY 2020 to MY 2021 (109 members to 388 members). While HAP Empowered did not reach its goal of the 50th percentile, four (4) out of six (6) Well-Child Visit (WCV) measures increased from the previous year – WCV: 3-11 Years, WCV: 12-17 Years, WCV:18-21 Years, and WCV: Total. Not only did these measures improve from year to year but had statistically significant improvement. HAP Empowered used the Chi-Square Calculation to determine if these measures had statistically significant improvement (where if the p-value <0.05 indicates statistically significant improvement). For instance, WCV: 12-17 Years had 13.69% difference in rates and had a p-value = 6.7E-12 indicating statistically significant improvement.
It was also identified that while the WCV:12-17 Years had statistically significant improvement, Immunizations for Adolescents (IMA): Combo 2 had a 14.31% decrease from MY 2020 (43.56% decrease from MY 2019). Per HEDIS®, children should be completing IMA: Combo 2 by their 13th birthday. The decrease in immunizations in conjunction with an increase in Well-Child Visits has led to the hypothesis that while parents/guardians have become more comfortable since the pandemic started to take their child(ren) to their primary care physicians for their WCV, there may be a large barrier around vaccine hesitancy preventing these children from completing the immunization series. As a result, HAP Empowered will need to work with its provider and community partners to help educate the community on the importance of adolescent and children's immunizations and address concerns that parents/guardians may have around vaccines.

In August of 2021, HAP Empowered hired three (3) contractors who telephonically outreached to members that were due for a WCV by the end of the year. During these outreaches, the contractors would remind members of the preventive care that they were due to complete, provide education around these services, identify, and address social determinants of health barriers, and assist in scheduling doctor appointments and transportation (as needed).

Barriers

- HAP Empowered continued to experience member disengagement with healthcare due to the COVID-19 pandemic. Therefore, some members were not going into their doctor offices, specifically children who are deemed healthy.
- Some services were unavailable via telehealth such as immunizations which are displayed with the Childhood Immunizations (CIS) and IMA decreased rates.
- Although the WCV rates are increasing, preventive services are not being completed during the doctor's visit such as immunizations and lead screenings. There was a recall on lead screening tools, therefore doctors are recently receiving strips that are required to complete lead screenings.
- In 2021, members were asked to prioritize the COVID-19 vaccination over other childhood and adolescent vaccinations while allowing enough time between the immunizations according to the relative regulations.

Opportunities for Improvement

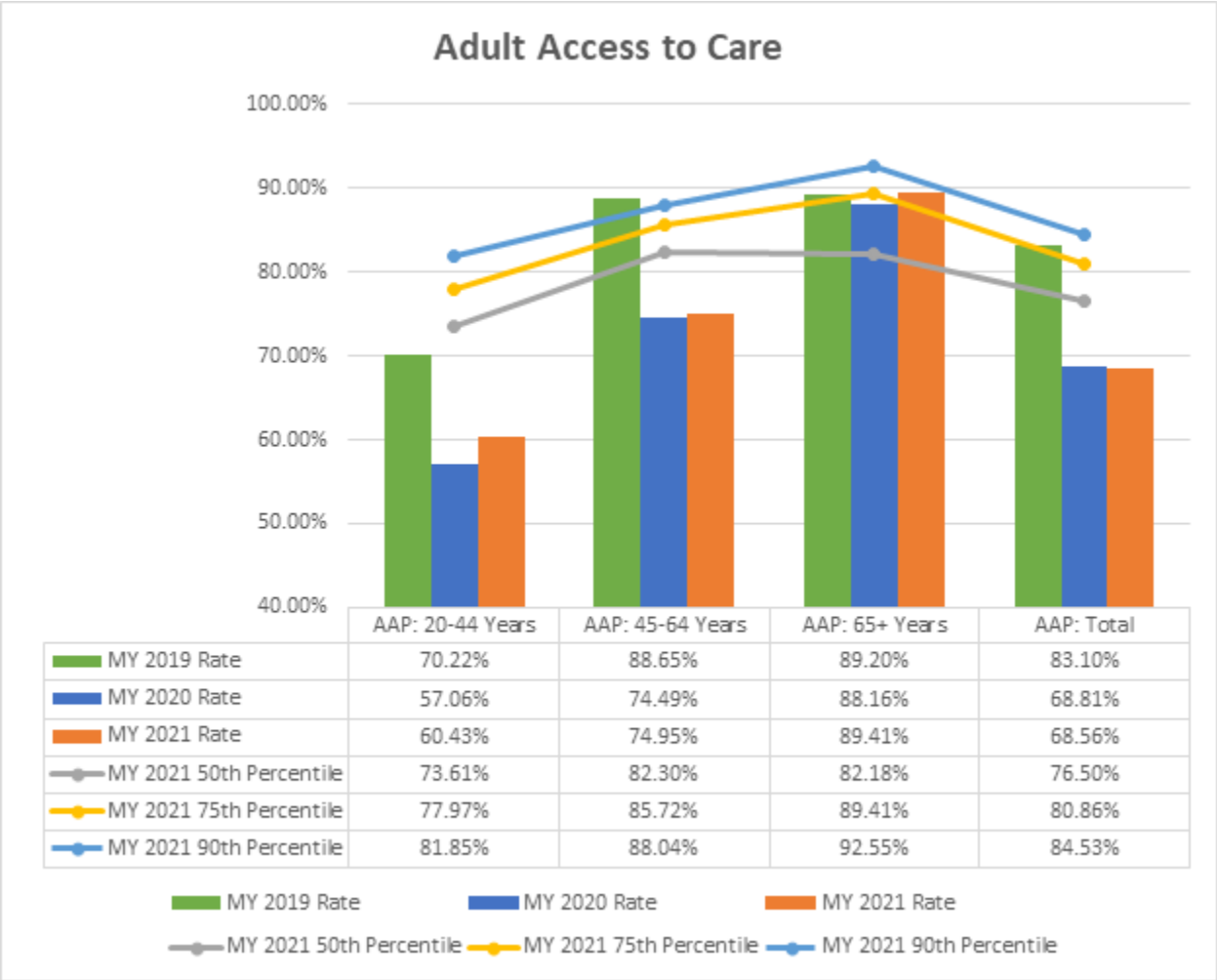
HAP Empowered will revisit implementation of previous initiatives and has implemented new strategies to address the above barriers, including:

- Continue focused member telephonic outreach and text messaging including educational materials for members to inform them of the importance of preventive screenings and to remind them of incentives and transportation opportunities.

- Create a health outreach team that will focus on getting 0–21-year-old members into the doctor's office.
- Revamp the reward program with the goal of increasing doctor office visits and increasing the chance that preventive screenings are completed during the doctor office visit.
- Continue to identify racial and ethnic disparities through data analysis and focus efforts (programs, initiatives) to address the disparities.
- Provide gaps in care information to providers to assist them in performing outreach to their members and implementing member gaps in care via the provider portal.
- Continue to plan and develop child focused clinic events (which can provide COVID-19 vaccinations and lead screenings).
- Continue to employ Alternative Payment Models and Value Based Payments.
- Closely partner with targeted provider groups and Federally Qualified Health Centers (FQHCs) to improve their compliance rates.

Adult Access to Care

It is important for adults ages 20 years and older to see their provider at least once a year. These annual visits allow the members to have their vitals checked, discuss topics and concerns such as preventive care needs (examples include cervical cancer screenings) and to manage those chronic conditions. HAP Empowered has been focused on improving performance for Adults' Access to Preventive/Ambulatory Services (AAP) as members get more comfortable obtaining preventive care services after the pandemic. Additionally, AAP is a measure that impacts several quality programs such as Medicaid Auto-Assignment, Consumer Guide, and Bonus Template.



	AAP: 20-44 Years	AAP: 45-64 Years	AAP: 65+ Years	AAP: Total
MY 2019 Rate	70.22%	88.65%	89.20%	83.10%
MY 2020 Rate	57.06%	74.49%	88.16%	68.81%
MY 2021 Rate	60.43%	74.95%	89.41%	68.56%
MY 2021 50th Percentile	73.61%	82.30%	82.18%	76.50%
MY 2021 75th Percentile	77.97%	85.72%	89.41%	80.86%
MY 2021 90th Percentile	81.85%	88.04%	92.55%	84.53%

Graph 3

Qualitative Analysis

HAP Empowered had a goal of the 50th percentile for AAP 20-44 Years, 45-64 Years, and the Total sub-measures in MY 2021. Unfortunately, HAP Empowered has struggled to meet this goal for these sub-measures. HAP Empowered missed the goal for the 20–44-Years population by 13.18 percentage points or by 1,334 numerator hits. While this measure did not meet the goal, it did have statistically significant improvement in the rate with a p-value = 4E-05. It should be noted that the 20-44 Years denominator also grew by 81.69% from MY 2020 to MY 2021. Unlike the AAP: 20-44 Years, AAP: 45-64 Years, and AAP: Total population, HAP Empowered had a goal of the 75th percentile for MY 2021 for AAP: 65+ Years since this measure has historically hit the 50th percentile. HAP Empowered just met this goal in MY 2021 with a rate of 89.41% (the exact rate of the 75th percentile).

Several interventions were implemented in MY 2021 that were aimed at improving Adults' Access to Care. HAP Empowered continued its member rewards program where members were eligible to receive a $25 gift voucher for seeing their provider. Improvements have been identified to improve the effectiveness of this program, as it is currently a member reported program, making it burdensome to

the members. Additional interventions included a mass mailing in Q3 2021 where over 8,000 HAP Empowered members were mailed a care gap reminder letter. These members were all due for Adult's Access to Care. These letters included information to help motivate members to close their gaps such as information on the member reward program and how to obtain free transportation.

Barriers

- In MY 2021, HAP Empowered continued to experience member disengagement with healthcare due to the COVID-19 pandemic.
- Additional factors affecting preventive care and access to care rates include missing, incorrect, or incomplete contact information that results in unsuccessful member contact and members having transportation issues.
- Additional barriers include racial and ethnic disparities, and social determinants of health – housing and food insecurity, income, type of employment, poverty, and education.

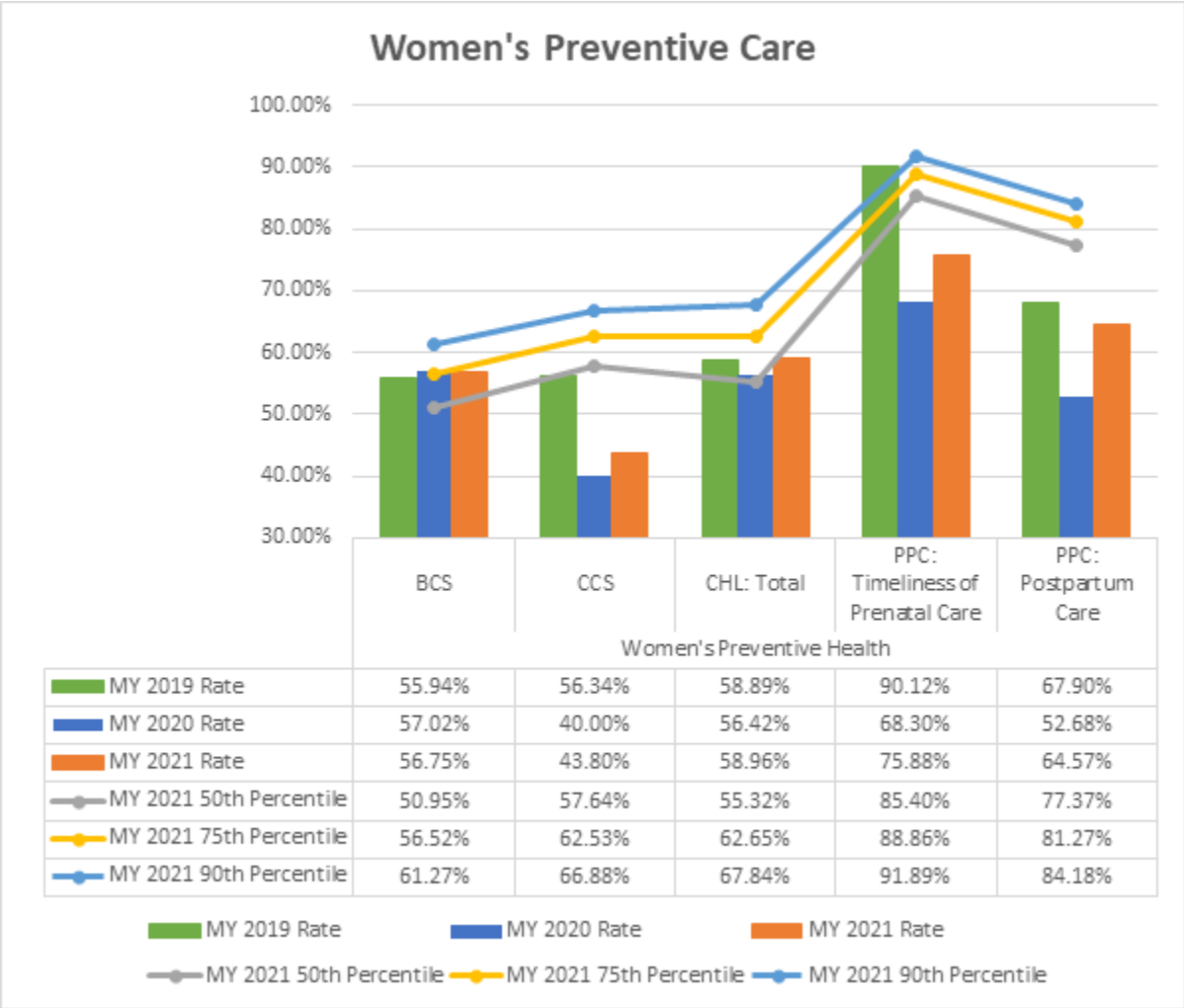
Opportunities for Improvement

HAP Empowered will revisit implementation of previous initiatives and has implemented new strategies to address the above barriers, including:

- Revamp the reward program to improve incentives for members with the goal of increasing doctor office visits and preventive screenings.
- Continue incentivizing members for annual primary care provider visits.
- Develop high touch gaps in care outreach campaign that includes texting, telephonic outreach, and mail.
- Continue to identify racial and ethnic disparities through data analysis and focus efforts (programs, initiatives) to address the disparities.
- Provide gaps in care information to providers to assist them in performing outreach to their members and implementing member care gaps via the provider portal.
- Continue to employ Alternative Payment Models and Value Based Payments.

<u>Women's Preventive Care</u>

Women's Preventive Care includes preventive screenings such as Cervical Cancer Screening (CCS), Breast Cancer Screening (BCS), Chlamydia Testing in Women (CHL), as well as Timeliness in Prenatal Care and Postpartum Care Visits. In 2021, HAP Empowered was focused on improving the rates for Women's Preventive Care through internal interventions as well as partnerships with provider offices. It is important for women to complete these services when recommended so that diseases and illnesses can be detected early and therefore lead to better outcomes.



	BCS	CCS	CHL: Total	PPC: Timeliness of Prenatal Care	PPC: Postpartum Care
MY 2019 Rate	55.94%	56.34%	58.89%	90.12%	67.90%
MY 2020 Rate	57.02%	40.00%	56.42%	68.30%	52.68%
MY 2021 Rate	56.75%	43.80%	58.96%	75.88%	64.57%
MY 2021 50th Percentile	50.95%	57.64%	55.32%	85.40%	77.37%
MY 2021 75th Percentile	56.52%	62.53%	62.65%	88.86%	81.27%
MY 2021 90th Percentile	61.27%	66.88%	67.84%	91.89%	84.18%

Graph 4

Qualitative Analysis

HAP Empowered had a goal of the 50th percentile for the Women's Preventive Health measures. CHL met the 50th NCQA® Quality Compass (QC) benchmark with a rate of 58.96% and this measure continued to improve from MY 2020 as well as improved from MY 2019. BCS exceeded the goal of the 50th percentile and met the 75th percentile with a rate of 56.75%. While BCS surpassed the goal, there was a slight decline in performance from MY 2020 with a decrease of 0.27 percentage points. Considering the HAP MI Health Link (MMP) impact, the population may still be hesitant to go into the doctor office for preventive care as they are a higher risk population for COVID-19.

In addition, there are other areas of improvement in performance from MY 2020 to MY 2021. Although CCS, Timeliness of Prenatal Care (PPC), and Postpartum Care (PPC) did not reach the goal of the 50th percentile, HAP Empowered saw improvement in the rates. For example, PPC: Postpartum Care had 11.89% difference in rates and had statistically significant improvement (p-value = 0.00361).

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HAP Empowered partnered with Community Health and Social Services (CHASS), a FQHC in Detroit where the focus of the partnership was to assist Medicaid members in receiving women's preventive health care screenings. Clinic days were hosted at CHASS on a quarterly basis and HAP Empowered conducted outreach to women who needed a preventive screening to invite them to the clinic day and schedule an appointment. Henry Ford Health provided a mobile mammogram unit where members could have their breast cancer screening completed because CHASS did not have the equipment necessary to complete this screening. Members who attended would receive their gift voucher for the services that are included in the member rewards program on-site instead of requiring the members to submit their request for the reward. All the women's preventive screenings were included in the member reward program for MY 2021 with varying reward amounts. For example, BCS and CCS Screening both had a $50 reward.

Barriers

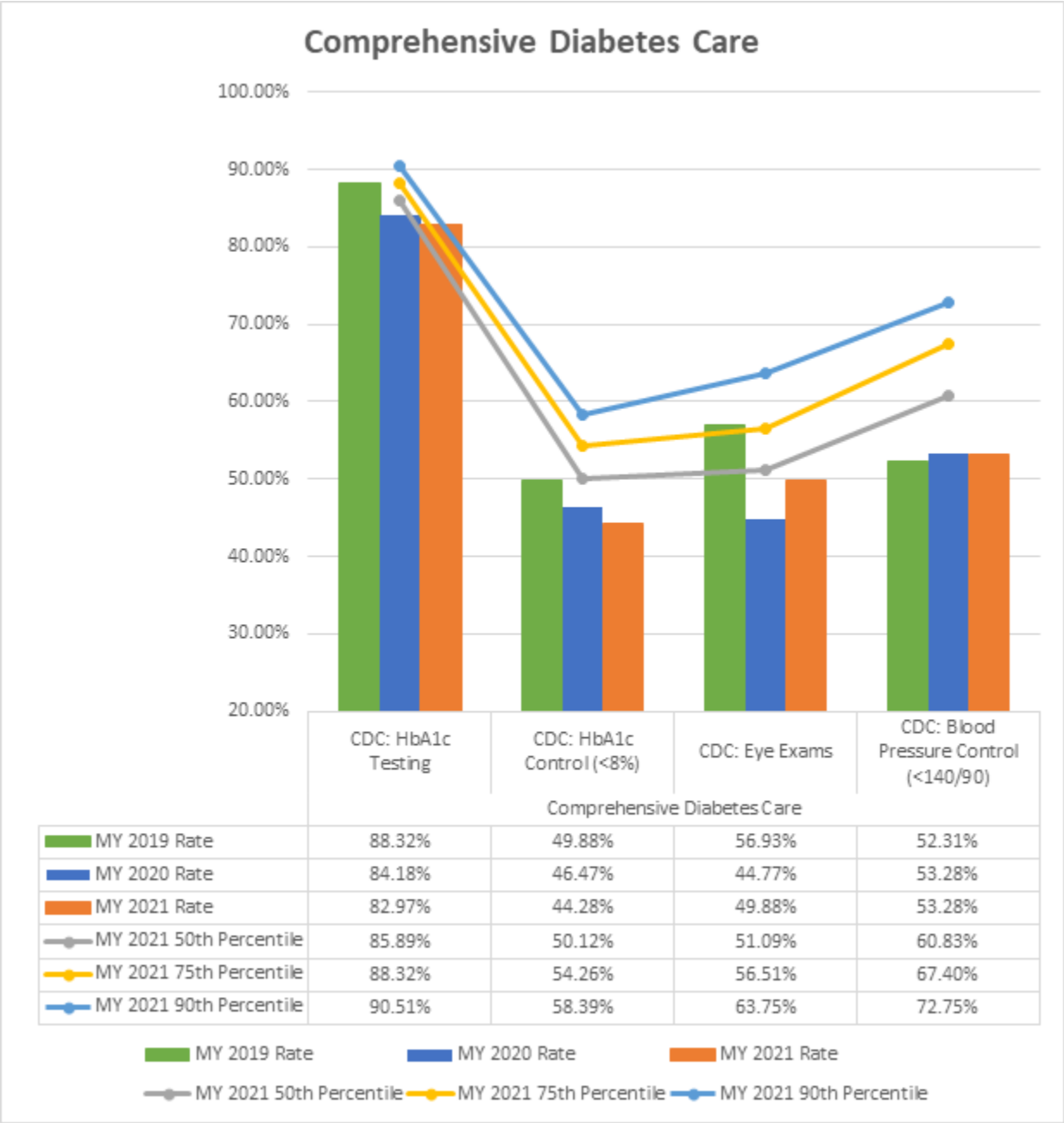
- In MY 2021, HAP Empowered continued to experience member disengagement with healthcare due to the COVID-19 pandemic. Therefore, members have postponed preventive screenings that require in-person visits.
- Missing, incorrect, or incomplete contact information that results in unsuccessful member contact and members having transportation issues.
- Social determinants of health barriers such as housing and food insecurity, income, type of employment, poverty, and education prevent members from seeking needed care.

Opportunities for Improvement

- Continue to implement women's events focused on providing needed screenings while growing partnerships with providers which can assist in closing gaps.
- Develop a high-touch gaps in care outreach program that includes texting, telephonic, email, and mail to remind members of the gaps they are due for and services available to them.
- Provide providers with performance metrics around these measures so they can monitor their gap closure progress and improve performance.
- Partner with provider groups and FQHCs in closing gaps in care.

<u>Comprehensive Diabetes Care</u>

It is important for members who have been diagnosed with diabetes to complete several additional services that help the member and their provider manage the member's condition. These services allow members to track their diabetes and may improve health outcomes such as controlling high blood pressure and hemoglobin A1c control. HAP Empowered has been focused on improving performance for comprehensive diabetes care as members get more comfortable obtaining preventive care services after the pandemic.



Comprehensive Diabetes Care	CDC: HbA1c Testing	CDC: HbA1c Control (<8%)	CDC: Eye Exams	CDC: Blood Pressure Control (<140/90)
MY 2019 Rate	88.32%	49.88%	56.93%	52.31%
MY 2020 Rate	84.18%	46.47%	44.77%	53.28%
MY 2021 Rate	82.97%	44.28%	49.88%	53.28%
MY 2021 50th Percentile	85.89%	50.12%	51.09%	60.83%
MY 2021 75th Percentile	88.32%	54.26%	56.51%	67.40%
MY 2021 90th Percentile	90.51%	58.39%	63.75%	72.75%

Graph 5

Qualitative Analysis

HAP Empowered had a goal of the 50th percentile for diabetes care measures. HAP Empowered struggled to meet benchmarks for the Comprehensive Diabetes Care (CDC) measures including CDC: Poor HbA1c Control, which is not displayed in the graph since this measure is reported as an inverse measure. For MY 2021, the CDC: Poor HbA1c Control rate was 50.12% while the 50th percentile benchmark is 39.90% and a lower rate displays a better performance for this measure. Although CDC: Eye Exams did not meet

the 50th percentile, there was an increase in performance from MY 2020 to MY 2021 and HAP Empowered was only five (5) numerator hits from meeting the goal of the 50th percentile. However, there was not statistically significant improvement amongst the CDC measures.
Interventions were implemented in MY 2021 that were aimed at making diabetes care more accessible to diabetic Medicaid members. This included partnering with a vendor Matrix. Matrix conducted telephonic outreach to members who were due for a CDC: Eye Exam to schedule an in-home CDC: Eye Exam. If these members were also due to have their HbA1c tested, then Matrix would send the member a home testing kit that could be mailed back for analysis. Additionally, HAP Empowered partnered with Home Access on a kit campaign, where members who were due for a HbA1c Test or had a poor controlled HbA1c rate were mailed a home HbA1c testing kit. These kits were easy to use and were free to the members. Additionally, the member's results through these programs were also shared with the member's doctor.

Barriers

- In MY 2021, HAP Empowered continued to experience member disengagement with healthcare due to the COVID-19 pandemic. In addition, member disengagement included members may not seek preventive care services to avoid or reduce complications of diabetes.
- Additional factors affecting the comprehensive diabetes care rates include member transportation issues and missing, incorrect, or incomplete contact information that results in unsuccessful member contact.
- Additional barriers include racial and ethnic disparities, and social determinants of health – housing and food insecurity, income, type of employment, poverty, and education.

Opportunities for Improvement

HAP Empowered will revisit implementation of previous initiatives and has implemented new strategies to address the above barriers, including:

- Enhance the Matrix in-home kit program as several kits that are mailed out are not returned.
- Revamp the rewards program to improve incentives for members to encourage members to complete the necessary diabetes care.
- Develop a high-touch gaps in care outreach program that includes texting, telephonic, email, and mail to remind members of the gaps they are due for and services available to them.
- Continue to identify racial and ethnic disparities through data analysis and focus efforts (programs, initiatives) to address the disparities and identify locations for targeted interventions.

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HAP Empowered HEDIS Table – Measurement Years 2019 – 2021

Measure/Data Element	HAP Empowered's Rates			NCQA® Quality Compass 2021		
	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate	50th Percentile	75th Percentile	90th Percentile
Child and Adolescent Prevention						
Child and Adolescent Well-Care Visits (WCV: (3-11)	NA	34.54%	45.80%	56.03%	64.19%	68.94%
Child and Adolescent Well-Care Visits (WCV): 12-17 Years	NA	20.66%	34.35%	50.55%	58.47%	64.23%
Child and Adolescent Well-Care Visits (WCV): 18-21 Years	NA	18.28%	19.18%	24.53%	31.88%	41.27%
Child and Adolescent Well-Care Visits (WCV): Total	NA	27.93%	36.69%	48.93%	57.44%	62.70%
Well-Child Visits in the First 30 Months of Life (W30): First 15 Months	55.17%	51.22%	36.06%	55.72%	61.19%	67.56%
Well-Child Visits in the First 30 Months of Life (W30): 15 Months-30 Months	NA	55.36%	46.05%	65.83%	72.24%	78.07%
Lead Screening in Children (LSC)	80.85%	62.39%	44.59%	63.99%	72.67%	79.57%
Childhood Immunization Status (CIS): Combination #3	68.09%	44.95%	37.89%	63.26%	68.86%	74.45%
Childhood Immunization Status (CIS): Combination #10	21.28%	20.18%	15.46%	34.79%	42.09%	49.76%
Immunizations of Adolescents (IMA): Combination #2	33.33%	21.95%	18.81%	35.04%	41.12%	48.42%
WCC: BMI Percentile	86.98%	80.67%	81.42%	79.68%	84.43%	88.31%
WCC: Counseling for Nutrition	63.31%	69.85%	75.14%	72.26%	80.54%	83.70%
WCC: Counseling for Physical Activity	62.13%	67.27%	73.50%	68.61%	77.86%	81.27%
Adult Prevention/Wellness						
Adults' Access to Preventive/Ambulatory Health Services (AAP): 20-44 Years	70.22%	57.06%	60.43%	73.61%	77.97%	81.85%
Adults' Access to Preventive/Ambulatory Health Services (AAP): 45-64 Years	88.65%	74.49%	74.95%	82.30%	85.72%	88.04%
Adults' Access to Preventive/Ambulatory Health Services (AAP): 65+ Years	89.20%	88.16%	**89.41%**	82.18%	89.41%	92.55%
Adults' Access to Preventive/Ambulatory Health Services (AAP): Total	83.10%	68.81%	68.56%	76.50%	80.86%	84.53%
Women's Health						
Prenatal and Postpartum Care - Timeliness of Prenatal Care	90.12%	68.30%	75.88%	85.40%	88.86%	91.89%
Prenatal and Postpartum Care - Postpartum Care	67.90%	52.68%	64.57%	77.37%	81.27%	84.18%
Breast Cancer Screening (BCS)	55.94%	57.02%	**56.75%**	50.95%	56.52%	61.27%
Cervical Cancer Screening (CCS)	56.34%	40.00%	43.80%	57.64%	62.53%	66.88%

CQMC: 4/25/2023

Chlamydia Screening in Women (CHL): Total	58.89%	56.42%	**58.96%**	55.32%	62.65%	67.84%
Comprehensive Diabetes Care (CDC)						
Comprehensive Diabetes Care - HbA1c Testing	88.32%	84.18%	82.97%	85.89%	88.32%	90.51%
Comprehensive Diabetes Care - Poor HbA1c Control	44.04%	46.96%	50.12%	39.90%	35.52%	30.90%
Comprehensive Diabetes Care - HbA1c Control (<8%)	49.88%	46.47%	44.28%	50.12%	54.26%	58.39%
Comprehensive Diabetes Care - Eye Exams	56.93%	44.77%	49.88%	51.09%	56.51%	63.75%
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	52.31%	53.28%	53.28%	60.83%	67.40%	72.75%
Pharmacy						
Controlling High Blood Pressure (CBP)	57.18%	52.55%	57.32%	59.85%	65.10%	69.19%
Asthma Medication Ratio (AMR): Total	55.93%	46.27%	48.30%	64.26%	69.67%	74.21%

Improvement Activities

HAP Empowered will revisit implementation of previous initiatives and has implemented new strategies to address the above barriers, including:

- Continue incentivizing members and providers for annual Primary Care Provider Visits and women's preventive screenings.
- Continue focused member telephonic outreach, text messaging and email reminders.
- Identify racial and ethnic disparity through data analysis and focus efforts (programs, initiatives) to address the disparities.
- Continue Women's Events focused on providing needed screenings.
- Providing gaps in care information to providers to assist them in performing outreach to their members and implementing member gaps in care via the provider portal
- Continue to employ Alternative Payment Models and Value Based Payments.

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Maternity Management Program

HAP Empowered's Maternity Management program powered by ProgenyHealth ensures members have a health pregnancy by:

- Connecting members with an OB or OB/GYN
- Providing reminders for prenatal and postpartum visits, and assisting with scheduling if needed
- Conducting maternity-specific assessments in order to ensure members are receiving the care they need
- Educating on benefits available while pregnant, including dental services
- Connecting members to nurses or behavioral health services if needed
- Referring members to a Maternal Infant Health Program (MIHP). MIHPs offer in-home visits by qualified nurses or social workers to provide education and support
- Checking in with members after delivery to make sure everyone is doing well
- Ongoing education, and support through the Ovia Health™ mobile application

Maternal Infant Health Program (MIHP)

The Maternal Infant Health Program (MIHP) is a home-visiting program for Medicaid-eligible women and infants to promote healthy pregnancies, positive birth outcomes, identify risk, deliver interventions, measure outcomes, and promote healthy infant growth and development. Health plans are required to have a signed care coordination agreement and contract with each MIHP Provider in their service areas. The purpose of the care coordination agreement and contract is to define the responsibilities and relationship between the MIHP Provider and HAP Empowered.

HAP Empowered continues to refer all pregnant members and infants to MIHP. HAP continued contracting activities in 2022 with all MIHP providers operating in the service area. MIHP helps pregnant members and infants get the proper food, support, and transportation for all health services. It also helps emphasize the importance of getting prenatal care, childcare, and shots when they are scheduled. MIHP services include prenatal teaching, childbirth education classes, nutritional support and education, newborn baby assessments, referrals to community resources and help in finding baby cribs, car seats, and clothing, help with transportation to pregnancy related appointments, and support to stop smoking.

MIHP Interventions

Date	Frequency	Intervention
Ongoing	As needed	Continued oversight of contracts and care coordination agreements with MIHP Provider's in HAP service area
Ongoing	Monthly	Identify Pregnant women and infants; send referral to MIHP in member's county
Ongoing	As needed	Contact MIHP Provider regarding status of care coordination agreement

Ongoing	As needed	Follow up with MIHP Providers regarding status of referrals
Ongoing	Monthly	Use the pregnancy indicator and claims reports to identify members for the Maternal Infant Health Program on a monthly basis

On a monthly basis, HAP utilizes the pregnancy indicator to identify members for the Maternal Infant Health Program. Referrals are made by email, phone, or fax. Referrals made by email are in Microsoft excel format and are secured through password protection. HAP collaborates and maintains care coordination agreements with MIHP providers in HAP service areas. The MIHP Provider is responsible for sending reports of HAP members enrolled in MIHP services. HAP MHP maintains registries of those members enrolled in MIHP services. HAP understands the importance of educating members about MIHP services and will continue to provide referrals for MIHP to its Medicaid pregnant women and infant members. Data related to HEDIS 2022 (Measurement Year 2021) is below.

- 79/217 (36.4%) members enrolled in the maternity case management program.
- Of those enrolled, 61/79 (77.2%) received timely prenatal care
- 194/217 (89.4%) received member incentive mailing
- 12/194 (6.18%) members earned the prenatal incentive.

Low Birth Weight (LBW)

In FY22, MDHHS utilized a quantitative measure to monitor performance of LBW. The CMS Child Core Set Measure "Live Births Weighing Less Than 2,500 Grams," based on MDHHS administrative data, will be utilized in the FY22 performance bonus incentive program. Below are the FY22 objectives for LBW:

- Maintain regional collaboration efforts
- MDHHS will incentivize reductions in LBW racial disparities for African Americans and minority populations

HAP Empowered continued to implement collaborative interventions with the Region 6 and Region 10 health plans. Monthly workgroup meetings with plans were established to review action plans and discuss ongoing low birth weight improvement strategies. A high-level summary of initiatives is below:

- MC3 Promotion to OB/Gyn Offices
- Partnership with Black Mother Breastfeeding Clubs
- Continue collaboration efforts with MIHPs

Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ+) Care Quality Improvement Project

The purpose of the LGBTQ+ Care Quality Improvement project is to gain further understanding of the clinical and care management landscape in terms of care coordination and provider competency to address health disparities particular to the LGBTQ+ population. In FY22, HAP Empowered submitted the MDHHS template to describe plan projects and activities that address the needs of LGBTQ+ members. HAP will continue to identify specific quality improvement metrics and activities to continually improve care for LGBTQ+ population. Below is a summary of focus areas for the project:

- Non-Discrimination Policies
- Increasing access to Gender-Affirming Services
- Improving screening, prescribing, and utilization rates for Pre-Exposure Prophylaxis (PrEP)
- Sexual Health Care Management

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Performance Improvement Projects
HAP Empowered conducts performance improvement projects (PIP) that focus on clinical and non-clinical areas. Below is a summary of project interventions in 2022.

Improving The Timeliness of Prenatal Care
HAP Empowered continued participation in the MDHHS PIP. The study indictor for the project is improving the Timeliness of Prenatal Care in the Black/African American Population. HAP Empowered will be measuring if targeted interventions increase the percentage of Black/African American women who receive a prenatal care visit in the first trimester, on the enrollment date, or within 42 days of enrollment into the MHP. HAP Empowered analyzes HEDIS results to measure the effectiveness of interventions and to identify additional opportunities for improvement.

PIP Results Baseline

The Baseline period is the Measurement Year 2021 HEDIS® rate. The overall MY2021 HEDIS® prenatal care rate is 75.8%. HAP Empowered further compared the study indicator of the Black/African American rate to the overall rate. The Black/African American rate is 72.3% which is below the overall rate but does not indicate a statistically significant disparity. HAP Empowered continues to identify opportunities for improvement and collaborate on plan interventions.

HAP Empowered has a prenatal care workgroup consisting of representatives from the Quality Management, Performance Improvement/HEDIS and Care Management departments. This workgroup meets monthly to discuss ongoing barriers, interventions, and strategies to improve prenatal care. To identify initial barriers, the workgroup created and continues to utilize a fishbone diagram as a QI tool. This helped to document barriers and initiate discussions for improvement. Furthermore, workplans are maintained to track progress. Sessions were also held to brainstorm and prioritize barriers. Barriers were prioritized into focus areas. The workgroup completed the following activities throughout 2021:

- Reviewing HEDIS® performance data
- Identifying key drivers and areas in need of improvement utilizing the fishbone diagram
- Identifying interventions to implement
- Developing action and work plans
- Monitoring intervention performance and outcomes
- Revise or discontinue interventions when necessary

Improving Comprehensive Diabetes Care-Eye Exam
The following Performance Improvement Project serves as the foundation of HAP Empowered's commitment to continuously improve the quality of the treatment and services it provides. HAP Empowered is committed to the ongoing improvement of services that are provided in a safe, effective, patient-centered, timely recovery-oriented fashion. HAP Empowered is committed to the ongoing improvement of the quality of care its consumers receive, as evidenced by the outcomes of that care. The organization continuously strives to ensure:

- The treatment provided incorporates evidence based, effective practices
- Providers are educated on the importance of preventive visits

- The treatment and services are appropriate to each consumer's needs, and available when needed
- Risk to consumers, providers and others is minimized, and errors in the delivery of services are prevented
- Procedures, treatments, and services are provided in a timely and efficient manner, with appropriate coordination and continuity across all phases of care and all providers of care

Diabetes can profoundly impact a person's eye by causing an increase in eye conditions such as glaucoma and cataracts. Therefore, it is important for those who have a diagnosis of diabetes (type 1 and type 2) to obtain routine diabetic retinal eye exams, so that these conditions can be identified early and treated. While there are no cures for diabetic retinopathy, treatment can reduce complications. In addition to the clinical impact that diabetic retinopathy has, this measure also has significant impact on quality programs. The diabetic retinal eye exam is included in the following:

- Auto-Assignment
- Bonus Template
- Consumer Guide
- NCQA Accreditation

Measure Definition: Diabetic Eye Exam focuses on members 18-75 years of age with diabetes (type 1 and type 2) who had a retinal eye exam.

Qualitative Analysis

HAP Empowered did not meet the MY 2020 NQCA Quality Compass 50th percentile goal of 51.36% with a rate of 49.88%. HAP Empowered has seen an improvement of 5.11 percentage points from MY 2020 to MY 2021; however, the MY 2021 rate remains below the baseline year rate. A couple of major factors were identified that contributed to the statistically significant decline from MY 2018 to MY 2020 rate. First, the HAP Empowered MY 2018 and MY 2019 rate only included members in region 6. HAP Empowered acquired Trusted Health Plan (who operated in region 10) at the end of 2019. Those members became HAP Empowered members on January 1st, 2020, and therefore fell into the MY 2020 denominator. Additionally, the COVID-19 Pandemic started in 2020, resulting in in-person preventive care being halted from March 2020 through July 2020. Even with services starting back up, a number of members where still uncomfortable and afraid to leave quarantine, making it difficult to close diabetic retinal eye exam gaps. The impact of the pandemic is also reflected in the NCQA Quality Compass 50th Percentile as there was a 7.28 percentage point decline in the benchmark from MY 2019 to MY 2020.

Interventions were implemented in MY 2021 that were aimed at making diabetes care more accessible to diabetic Medicaid members. This included partnering with a vendor Matrix. Matrix conducted telephonic outreach to members who were due for a CDC: Eye Exam to schedule an in-home CDC: Eye Exam. If these members were also due to have their HbA1c tested, then Matrix would send the member a home testing kit that could be mailed back for analysis. Additionally, HAP Empowered partnered with Home Access on a kit campaign, where members who were due for a HbA1c Test or had a poor controlled HbA1c rate were mailed a home HbA1c testing kit. These kits were easy to use and were free to the members. Additionally, the member's results through these programs were also shared with the member's doctor.

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Quality Improvement Activities and Opportunities

- Partner with providers to host Clinic Days that focus on diabetic retinal eye exams in the Detroit area
- HAP Empowered has continued to include the diabetic retinal eye exam in the Empower Your Health Member Rewards Program
- Continue to promote and use the HEDIS Member Outreach Tool. HAP Empowered customer service representatives can utilize this tool to look up gaps in care that the member is due for (such as diabetic retinal eye exam) and then provide a friendly reminder to complete that preventive service
- Create member communication (telephonic, texting, and/or mail) around diabetes care
- Perform a geographic zip code analysis to identify hot spots for targeted interventions
- Identify locations and systems that are not submitting the diabetic retinal eye exam results on the submitted claim

Adult Access to Preventive/Ambulatory Health Services (AAP) and Improving Prenatal and Postpartum Care

The Adult Access to Preventive/Ambulatory Health Services (AAP) and Prenatal/Postpartum Performance Improvement Projects serve as the foundation of HAP Empowered's commitment to continuously improve the quality of the treatment and services it provides. Throughout 2022, a number of different activities were conducted to improve member access to well visits and maternity services.

HAP Empowered enhanced the Member Rewards Program to make it less burdensome, moving it from a form-based program to a claim-based program. The exception to this enhancement was prenatal rewards. Due to the nature of the Prenatal Visit HEDIS® Measure, HAP Empowered did continue the form-based process for the prenatal reward. Efforts are currently underway to change the Prenatal Care Visit Reward to a claims-based process. Below is a table on the Rewards for 2022 and 2023.

Service Rewarded	2022 Incentive	2023 Incentive
Adult Access to Care*	$25	$50
Prenatal Visit	$75	$50
Postpartum Visit	$25	$50

*In 2022, the incentive was only available for 20–44-year-olds. This has been expanded to 22 years and older for 2023.

Throughout 2022, ProgenyHealth has outreached to the pregnant population via telephone, with the focus to educate the members on the prenatal and postpartum services that are needed. The Postpartum Hotlist was transitioned to ProgenyHealth in August 2022. This hotlist shows the members that recently had a live-birth and need their postpartum visit. The hotlist includes information on when the member needs to complete the postpartum visit in order to be HEDIS® compliant. ProgenyHealth then outreaches to the members on this list to help them schedule their postpartum visits prior to their Postpartum Visit due date. HAP Empowered and ProgenyHealth are currently in the process of consolidating the Postpartum Hotlist with the Behavioral Health Survey Outreach List to improve the member experience.

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HAP Empowered's reviewed and updated its Customer Service Resource (CSR) Tool. The CSR Tool is an internally developed tool that member-facing staff can use to help provider reminders to members that they are due for preventive services such as Adult Access to Care. After its update, internal member facing departments were retrained on the measures, their importance and how to utilize the tool.

For 2023, capabilities to communicate with the member via their communication preference (email, texting, mail, telephonic) are being investigated. The goal is that this will lead to increased member engagement and increased preventive annual exams. In addition to this, HAP Empowered has identified high-volume provider organizations and FQHCs to partner with.

Activities Summary
A HEDIS® Outreach Team was established in August 2021 and conducted telephonic outreach to Medicaid and MI Health Link members who needed preventive services. In Q1 2022, this team solely focused on outreaching to children who were aging out of Lead Screening (LSC), Childhood Immunizations (CIS), Immunizations for Adolescents (IMA) and/or Well-Child Visits within the First 30 Months of Life (W30) by August 2022. These measures were the focus as they saw significant decline throughout the pandemic. Throughout the outreach, the team also addressed social determinants of health barriers that were identified.

In addition to telephonic outreach, HAP Empowered implemented quarterly text messaging campaigns for Women's Preventive Health and Child/Adolescent Well Visits. Measures that were specifically targeted included: Chlamydia Screening in Women (CHL), Breast Cancer Screening (BCS), Cervical Cancer Screening (CCS) as well as Child and Adolescent Well-Care Visits (WCV).

HAP Empowered also enhanced the Member Rewards Program to make it less burdensome, moving it from a form-based program to a claim-based program. The 2022 Member Reward Program did reward members for completing a number of preventive services, which are listed below:

- Childhood Immunizations – Combo 3 (CIS)
- Immunizations for Adolescents – Combo 2 (IMA)
- Lead Screening in Children (LSC)
- Child and Adolescent Well-Care Visits (WCV)
- Well-Child Visits within the First 15 Months of Life (W30)
- Breast Cancer Screening (BCS)
- Chlamydia Screening in Women (CHL)
- Prenatal Visit (PPC)
- Postpartum Visit (PPC)
- Diabetic Eye Exam (CDC)
- Adult Access to Care: 20-44 Year (AAP)
- Healthy Michigan Dental Visit

HAP Empowered's Community Outreach Team established a close partnership with the Detroit Health Department where a number of clinical events were conducted throughout the summer of 2022 with the sponsorship and assistance of the Detroit Public Schools. The focus was to provide both HAP Empowered Medicaid Members as well as community members with various immunizations (i.e.,

childhood immunizations, immunizations for adolescents, and COVID-19 immunizations) as well as lead screenings.

Barriers
Some barriers that were identified throughout 2022 include:

- A lack of a strategic and consistent communication plan that encompassed all member communications (email, text, mail, telephonic). This also led to concerns around burdening the member with a number of repetitive or conflicting messages, which could negatively impact member experience and lead to disengagement.
- HAP Empowered has not been able to send out text messages for members that are 0-17 years old as that data is still being mastered.
- 2022 was a transition year for the Rewards Program, meaning some rewards still follow the manual reporting process and the automation process is split across multiple teams.
- For 2022, some of the member rewards were not incentivizing members to complete the service as the incentive amount did not match the amount of visits that the member was required to complete. (For example, members had to complete 6 well-child visits by their 15th month birthday in order to get their $50 incentive)
- HAP Empowered saw low show rates at the clinic events, even with reminder calls and appointment confirmation letters

We Treat Hepatitis C Initiative
HAP Empowered partners with the MDHHS public health campaign called *We Treat Hep C*, aimed at eliminating Hepatitis C Virus (HCV) in Michigan. The initiative involves increasing the number of people who are tested for HCV, increasing the number of providers who treat HCV, and expanding access to HCV curative treatments. Below are the care coordination activities focused on HCV during 2022.

- A workgroup meets monthly to review the internal workplan, implement interventions from the *We Treat Hep C* Care Coordination Memo and discuss any barriers as needed. The workgroup is comprised of stakeholders from Care Coordination, Quality Management, Pharmacy, and Provider Network Management teams.
- ***Member Outreach***
    - HCV letter template and fact sheet sent to all members ages 18 and older with quarterly mailings scheduled for new members
    - Utilizing CHWs, Community Based Organizations and homeless shelters to conduct outreach to beneficiaries that are transient/difficult to reach, including those who are homeless, disabled or those living with substance use disorders
    - Developing a report of members with an HCV diagnosis and without a record of treatment to conduct ongoing outreach
    - Follow-up with members who have a positive HCV test as well as their providers to initiate treatment with Mavyret
    - Utilizing the Daily Carve-Out Utilization File (5165), regarding members who are receiving Mavyret or another DAA to conduct outreach to members receiving treatment and provide education on medication adherence
- ***Provider Outreach***
    - A Hepatitis C provider resource page was added to the HAP Empowered website
        - Education materials to network providers on the CDC's new universal testing

guidelines
        - Promoting the resources listed on Michigan.gov/WeTreatHepC.
    - Work with providers to incorporate orders for HCV tests in routine primary care for all members
    - Ensure that CDC HCV testing algorithms are followed (running an HCV virus detection test or PCR for any persons who tests positive for HCV antibody)
    - Conduct targeted outreach and support to network providers in areas where HCV is prevalent as well as to network providers who treat opioid use disorder
    - Promote medication adherence to network providers and pharmacies to ensure that Mavyret is dispensed in an 8-week supply (or 12-week supply when appropriate)
    - Encourage providers to enroll patients receiving treatment in the Mavyret Nurse Ambassador program.
- ***Pharmacy Outreach***
    - Provide ongoing education to network pharmacies s including the removal of prior authorization requirement for Mavyret

Pediatric Sickle Cell Quality Collaborative
HAP Empowered partners with MDHHS on a pediatric sickle cell quality improvement project to improve care by preventing serious infections, stroke, and pain crises among children with sickle cell anemia. The quality collaborative will combine the collective knowledge and lived experiences of parents and individuals with sickle cell disease, in partnership with the University of Michigan, the state of Michigan, and Medicaid Health Plans in Region 10 to implement a pilot Pediatric Sickle Cell Improvement Program in Southeast Michigan.

This program aims to achieve improvement in preventive care delivery for this high-risk and vulnerable population through the development of an innovative quality collaborative that will have Medicaid Health Plans working together as one team to improve the care of all children with sickle cell in the region, not just those enrolled in their individual plans. This initiative will develop a robust platform for interaction to share ideas and provide support as the health plans work together to improve the performance rates of antibiotic prophylaxis, transcranial Doppler screening, and hydroxyurea use.

***Preventive Care Outcomes Measures for Children with Sickle Cell Anemia*:** The following quality measures will be utilized and have been endorsed by the National Quality Forum.

- **Daily Antibiotics Dispensed**: Increase the percentage of children ages 3 months to 5 years who are dispensed appropriate antibiotic prophylaxis for at least 300 of 365 days per year.
- **Annual Transcranial Doppler Ultrasonography (TCD) Screening**: Increase the percentage of children ages 2 through 15 years old who receive at least one TCD screening per year.
- **Daily Hydroxyurea Dispensed**: Increase the percentage of children ages 1 to 18 years who are dispensed hydroxyurea for at least 300 of 365 days per year.

Below data shows measurement period performance for 7/1/21 – 6/30/22 for Region 10. In FY23, benchmarks will be set for the measures.

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REGION 10 Only Pediatric Members with SCA	Numerator (N)	Denominator (D)	Rate (N/D)
Proportion of pediatric members (ages 2 through 15 years) with sickle cell anemia with a completed transcranial Doppler (TCD) screening	1	10	10%
Proportion of pediatric members with sickle cell anemia (ages 3 months to 5 years) with at least 300 days of dispensed antibiotics	0	3	0
Proportion of pediatric members (ages 1 to 18 years) with sickle cell anemia with at least 300 days of dispensed hydroxyurea	1	15	6.67%

Population Health Management
The Population Health Management (PHM) Strategy outlines HAP Empowered's comprehensive and integrated programs that address population health management. HAP's approach to managing population health ensures that members' needs are being met across the continuum of care to ensure that they have access to high-quality, cost-effective health care. The strategy is a framework that defines how health services are offered and delivered to meet the needs of HAP's members across the four focus areas of population health, including:

- Keeping Members Healthy
- Managing Members with Emerging Risk
- Patient Safety or Outcomes across Settings
- Managing Multiple Chronic Illness

Annually, HAP Empowered reviews member population data through a combination of reports on characteristics, including demographics of HAP Empowered membership. This analysis of data includes a review of:

- Characteristics and needs, including social determinants of health
- Relevant subpopulations and subpopulation needs, examples:
    - Multiple chronic conditions
    - At-risk ethnic, language and/or ethnic groups
- The needs of children and adolescents
- The needs of individuals with disabilities
- The needs of individuals with serious and persistent mental illness

A regional and statewide population review is also performed to determine health disparities and other potential population issues that may need to be addressed for the HAP Empowered membership. Following this analysis, findings are used to:

- Identify changes to business rules which will better identify individuals for PHM programs, including but not limited to, the number of events (hospitalizations and ER visits) used to flag potential PHM program candidates; the cost threshold levels; which diagnosis or procedure codes are used to target members; and the risk score ranges or other new methods to consider when identifying potential PHM candidates

- Review and identify changes to PHM processes to best address member needs. The business drivers for these changes include but are not limited to, compliance with mandatory regulations, reduction of redundant member outreach; continuous improvements including clinical effectiveness, outcomes and quality, and increased coordination across programs
- Review PHM resources and modify them, if necessary, to address member needs

Annually, a comprehensive analysis inclusive of clinical, cost/utilization and experience measures are completed to evaluate the effectiveness of the PHM programs and the overall impact of the PHM strategy. Specific measurements included in the annual analysis are included in the *Annual Population Health Management Impact Measures*. This analysis was conducted by the supporting departments and reviewed and approved by the CQMC. After the completion of the analysis, the PHM workgroups will modify the strategy document, as necessary, to reflect any changes that need to be made based on the evaluation and the population assessment

Once the population analysis is complete, the results of the population assessment analysis are used to determine whether the PHM Strategy meets member needs. The following components are evaluated for necessary updates:

- PHM programs, services and activities
- PHM staff resources and training
- Community resources

Data/Risk Stratification

Data integration allows for member identification as well as determining and supports their ongoing care needs. HAP may evaluate a number of integrated data sources to determine the appropriate risk stratification of members including those that offer predictive modeling to ensure that me members receive the appropriate support and interventions in the right setting at the right time. HAP's segmentation and stratification process utilizes the ACG process to group and segment the entire membership appropriately utilizing a predictive risk stratification modeling system. This system assigns each member into one of six segments and then calculates member risk scores within each segment. The tool provides in-depth data analytics, interpretation and customization of population health data paired with design and implementation of care management plans and clinical interventions programs to meet the unique needs of varying populations.

Care Coordination

HAP Empowered continues to assist those members with the most acute physical and socioeconomic needs through their Complex Case Management program. This program is available to members with multiple chronic illnesses, chronic illnesses that result in high utilization, or a new diagnosis of certain diseases. The nurse case manager completes a comprehensive assessment on the member's conditions, medical history, and medications in order to better determine how to assist the member in regaining optimum health. All members enrolled in Complex Case Management are also referred to a social worker for further evaluation and discussion of their needs.

The purpose of HAP's Care Management program is to improve the health and well-being of its membership by addressing the medical, pharmacy and psychosocial needs of members. Care Management team members optimize the use of community resources and work to strengthen the

member's relationship with the practitioner and care teams. Care management programs are integrated with Utilization Management through a concurrent review process which results in a referral to Care Management for members who meet program criteria

The Care Management programs provide care coordination across all settings, including acute outpatient and inpatient. HAP provides Care Management services both within the service area and to members who are traveling or residing out of area. Members identified as at risk for safety and symptom management related to medication are referred to HAP's Pharmacy department for a medication management evaluation.

An important part of each program is the ability to share information electronically. CareRadius functions as both a care coordination platform and a communication mechanism that enables staff to see all the programs and services a member receives. CareRadius is designed with a member centric approach that allows each discipline to review other disciplines' documentation and updates. Tasking and other forms of communication within the platform complement face to face and email communication between staff members. Within the 360-view in CareRadius, all programs are listed for all Care Radius users. Within the conditions/risks screen, all conditions are listed from claims and the ACG tool. The CareRadius Manual identifies each category in the 360 View: Participation & Recruitment, Risks and Conditions, Care Alerts, Metrics and Labs, Medications, Utilization Management (UM) Summary and Eligible Services. A Care Alert is created for members with the following conditions: HTN, COPD, DM, and CHF to coordinate care. With the multi-disciplinary approach CareRadius provides each team, it allows each discipline to review all documentation and updates and allows for enhanced communication of member conditions.

The SDoH/Population Health Strategy Plan for all members is focused on our responsibilities to integrate clinical and social health. We are committed to assessment of members, connecting them to community resources and implementation of clinical and community wide projects and initiatives. We have developed analytics that will assist us in continuous evaluation of this project and include metrics encompassing the impact of unequal distribution of health damaging experiences for our members. HAP will continue its partnership with EXL to integrate risk stratification and member analytic capabilities into care coordination tools and processes to identify and engage with higher risk members. The new platform will also have a member 360 view that will integrate member SDOH, barriers, and top interventions allowing HAP to leverage care coordination resources most effectively.

Informing Members

HAP has a summary that is posted in a central location that is accessible for current and prospective members that describes all available Population Health Management programs. Information is located on HAP's website for Medicaid members under the health programs tab. Additional information about Population Health Management Programs is contained in member handbooks.

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FY22 SDOH Intervention Reporting

Focus is on the following:

- SDoH Areas: Food insecurity, Housing, Utility assistance, Employment/Education/Training
- BH Areas: Stress, Depression, Anxiety
- Expand the stratification of their data by race/ethnicity, region, age, gender, etc.

FY22 PHM REPORT
GOAL: Expand member assessment, referral, and community partnerships to improve social outcomes for targeted Medicaid members Click here to enter text.
OBJECTIVE 1: Utilize the Enhanced Risk Stratification Tool to identify members for SDoH assessment.
OBJECTIVE 2: Utilize SDoH Assessment to identify needs of the targeted populations and track referrals and outcomes.
OBJECTIVE 3: Continue integration of Population Health Information with Henry Ford Health System.
OBJECTIVE 4: Continue provider education and collaboration with regional health systems and physician groups on population health billable codes.

When a member expresses an SDoH concern, the HAP Empowered Case Management (CM) team member refers the member to the appropriate agency for assistance. Based on the member's responses and geographical location, the CM team completes the referrals to appropriate services and community resources. The information collected from this SDoH Assessment is used for developing clearly defined performance indicators such as the number of assessments completed, the number of identified needs, the number of referrals made based on those needs, and the outcome of the referrals, such as the number of successful, unsuccessful, and ongoing referrals.

HAP Empowered has taken steps to ensure future tracking of SDoH referrals is effective and will capture accurate information. HAP Empowered has enhanced the SDoH survey to align with the Population Health Management project requirements. This will allow for more detailed data on the needs identified behind each referral. A large factor in this process shift is the need to confirm that a member was able to successfully receive an SDoH service. HAP Empowered implemented the use of the FindHelp platform for the referral process.

Integration of Behavioral Health and Physical Health Services
HAP Empowered coordinates care provided to members with the Prepaid Inpatient Health Plans (PIHP)that manage services for those individuals. It is further the policy of HAP Empowered to work cooperatively with other PIHPs to jointly identify priority need populations for purposes of care

coordination. Ongoing activities are noted below:

- At least monthly, identify which members are assigned to an MHP and have sought services through the PIHP
- Quarterly, demonstrate that joint care plans exist for members with appropriate severity risk that have been identified as receiving services from both HAP Empowered and the PIHP
- Participate in the MHP-PIHP Workgroup. Activities include:
    - Enhancements to CC360 to streamline member search and risk stratification
    - Working to add homeless indicator and homeless vulnerability score to CC360
    - Worked to develop at least two standard of care protocols for care coordination as identified collaboratively with MDHHS
- Completed data validation for the following performance measures with the shared metrics with the PIHPs: Plan All-Cause Readmissions (PCR) and Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)
- Participate in MiHIN (Michigan Health Information Network)
- Establish and implement joint care plan management standards and processes to ensure appropriate communication exists and enough efforts are being made to support success in integration. The joint care plans will foster an environment of collaboration between HAP Empowered and the PIHPs for the ongoing coordination and integration of services

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Member Survey Results

SPH Analytics (SPH), a Centers for Medicare and Medicaid Services (CMS) certified Survey Vendor, was selected by HAP Empowered Medicaid to conduct its 2022 Medicaid CAHPS* Survey.

Survey Objective:

The overall objective of the CAHPS* study is to capture accurate information about consumer-reported experiences with health care. Specifically, the survey aims to measure how well plans are meeting their member's expectations and goals; to determine which areas of service have the greatest effect on members' overall satisfaction; and to identify areas of opportunity for improvement.

The 2022 Medicaid Adult 5.1H CAHPS surveys were collected via a mail and phone methodology. Members eligible for the survey were those 18 years and older (as of December 31 of the measurement year) who were continuously enrolled in the plan for at least five of the last six months of the measurement year.

The following survey results are compiled from the 232 HAP Empowered Medicaid members who corresponded to the survey, for a response rate of 13.4%.

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Health Alliance Plan (HAP

SUMMARY RATE SCORES

MEDICAID ADULT

	2022 Valid n	2020	2021	2022	HAP QC % Tile	2022 QC
Rating Questions(% 9 or 10)						
★ Q28. Rating of Health Plan	218	70.4%	70.8%	64.2%	61st	62.0%
★ Q8. Rating of Health Care	140	58.9%	58.2%	59.3%	71st	56.5%
★ Q18. Rating of Personal Doctor	183	72.4%	71.6%	72.7%	80th	68.3%
★ Q22. Rating of Specialist	90^	70.8%	76.2%	67.8%	53rd	68.3%
★ **Getting Needed Care(% Usually or Always)**	**121**	**86.8%**	**88.0%**	**80.9%**	**39th**	**81.9%**
Q9. Getting care, tests, or treatment	142	92.9%	91.0%	86.6%	66th	84.7%
Q20. Getting specialist appointment	101	80.7%	85.0%	75.2%	28th	78.6%
★ **Getting Care Quickly(% Usually or Always)**	**96^**	**86.4%**	**87.9%**	**85.2%**	**76th**	**80.2%**
Q4. Getting urgent care	64^	90.5%	92.6%	84.4%	70th	80.9%
Q6. Getting routine care	129	82.4%	83.1%	86.0%	86th	79.8% ▲
★ **Q17. Coordination of Care**	**73^**	**85.6%**	**91.4%**	**84.9%**	**54th**	**84.0%**
Customer Service +(% Usually or Always)	**102**	**91.8%**	**90.7%**	**91.6%**	**84th**	**88.9%**
Q24. Provided information or help	101	88.2%	86.4%	87.1%	84th	83.4%
Q25. Treated with courtesy and respect	104	95.5%	95.0%	96.2%	83rd	94.6%
How Well Doctors Communicate †(% Usually or Always)	**145**	**94.6%**	**95.3%**	**95.4%**	**92nd**	**92.5%**
Q12. Dr. explained things	145	95.8%	97.0%	94.5%	75th	92.6%
Q13. Dr. listened carefully	146	93.7%	94.8%	95.2%	84th	92.7%
Q14. Dr. showed respect	145	94.6%	97.0%	96.6%	86th	94.3%
Q15. Dr. spent enough time	145	94.1%	92.5%	95.2%	92nd	90.4% ▲
Q27. Ease of Filling Out Forms †(% Usually or Always)	**215**	**94.7%**	**94.7%**	**96.3%**	**61st**	**95.5%**

Significance Testing: Current score is significantly higher/lower than the 2021 score (↑/↓), the 2020 score (‡/‡) or benchmark score (▲/▼). ***^Denominator less than 100. NCQA will assign an NA to this measure.***

MY 2021 Commercial Adult CAHPS Report

Performance Summary

- Getting Routine Care and Ease of Filling Out Forms are the only measures to improve incrementally year-over-year
- Getting Routine Care is significantly higher than the benchmark QC score
- The two largest declines from 2021 were: Rating of Specialist (8.4-percentage points), Getting Needed Care (7.1-percentage points)
- Scores for Rating of Health Plan, Rating of Specialist, Getting Needed Care, Coordination of Care, are the lowest in the past three years
- A majority of measures and composites are below the 75th percentile. Conversely, Rating of Personal Doctor, Getting Care Quickly, Customer Service and How Well Doctors Communicate all performed at or above the 75th percentile
- Getting Needed Care is primary driven down by decreasing ratings for getting an appointment with a specialist
- Getting Care Quickly declines due to less members reporting access to urgent care when needed

Improvement Strategies

- Review recommendations/actions for related CAHPS composite measures: How Well Doctors Communicate, Getting Care Quickly, Getting Needed Care, Coordination of Care.
- Share, report and discuss relative CAHPS health care performance and feedback at the health system and/or within network level.
- Provide resources, articles, tools and training sessions via multiple channels to support and drive improvement in physician-patient communication and patient-centered interviewing.

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Provider Satisfaction

HAP Empowered annually conducts a Provider Satisfaction Survey to assess the strength of their relationship with providers in the plan and to identify areas of improvement. Providers in HAP Empowered's network are surveyed for satisfaction in the following areas:

- Provider Relations
- Network
- Utilization Management
- Quality Improvement
- Finance Issues
- Pay for Performance bonus programs
- Pharmacy and Drug Benefits

Objectives

This annual research effort seeks to obtain an understanding of overall satisfaction among provider practices within the network, with the following objectives:

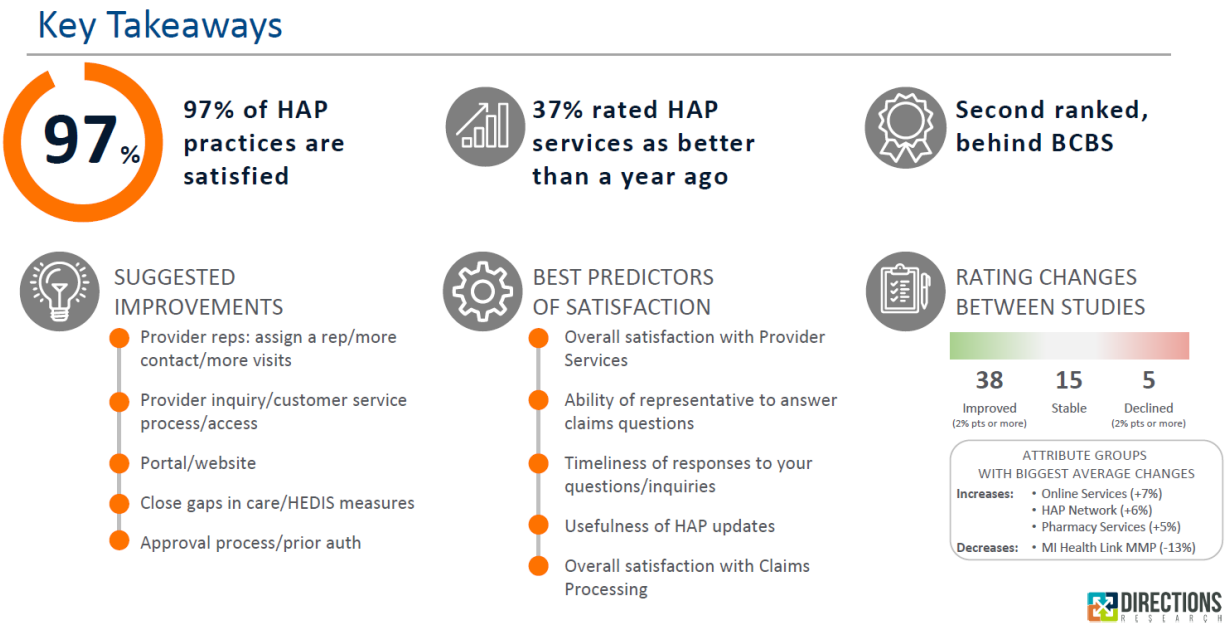
- Assess and monitor provider practice satisfaction
- Identify opportunities for HAP to improve services to provider partners
- Provide data to support and develop internal stakeholder initiatives

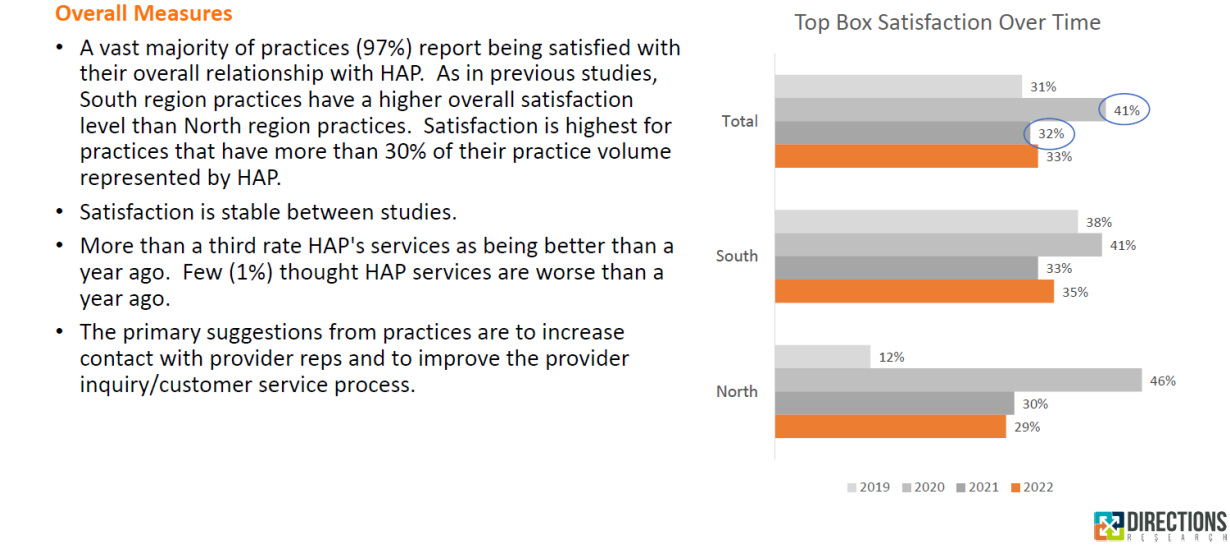
Methodology

- The 2022 methodology focused on emailed survey invitations. HAP provided email addresses for some practices, and Directions Inc. appended emails for additional practices based on calling results from previous research conducted on HAP's behalf in 2021. Two-thirds of practices (66%; 814 of 1239 practices) had an initial email associated with the practice. Those practices were sent an email invitation to participate in the survey by web.
- Initial telephone calls were placed concurrently with email invitations to encourage participation. During the course of telephone contacts, additional email addresses were collected, and survey invitations were emailed. In total, 907 practices (73%) were emailed survey invitations, some at multiple addresses.
- All practices who did not respond to the email inquiries were mailed a packet in mid-October including a survey, cover letter, and return envelope. Instructions were given on how to complete surveys by mail, web, or phone. To bolster participation, 250 practices were sent a second mailing in mid-November.
- The mailing included a unique six-digit identification number that was used to track participating practices.
- Follow-up telephone calls were placed concurrently with email and mail invitations to encourage participation by mail or web. Fax surveys were not offered in 2022. Up to five phone calls were placed to each practice to encourage participation.
- Survey results were collected between September 7 and December 7, 2022.
- The results in this report reflect only those from the 244 HAP Empowered practices. Practices were not designated as HAP Empowered in years prior to 2022, and therefore previous data was

recoded such that any practice that was either designated as MMP or Medicaid was presumed to be HAP Empowered.

2022 Provider Satisfaction Results





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Top Findings

Changes Since 2021

- The results for HAP are positive in 2022, with increases of at least two percentage points for 38 of the 58 items. Declines of at least two percentage points were found for 5 attributes, all MI Health Link MMP items. The attributes with the largest increases from the previous study were:
  - Q20. HCC Process (+10%)
  - Q60. The number of specialists in HAP's provider network (+8%)
  - Q61. Level of collaboration from specialists for shared patients (+8%)
  - Q21. Managing user IDs and passwords (+7%)
  - Q18. Overall satisfaction with HAP's online provider portal (+7%)
  - Q22. Access to patient records and gaps in care (+7%)
  - Q62. Timeliness and completeness of feedback from specialists (+7%)

Predictors of Satisfaction

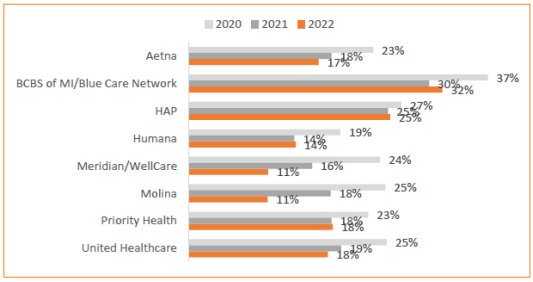
- The top predictors of overall satisfaction with HAP are related to Provider Services and specifically responsiveness to inquiries.

Competitive Positioning

- In the context of other health plans, HAP is rated in the second-place position, behind Blue Cross Blue Shield of Michigan. Meridian/WellCare has the highest level of dissatisfaction.

Top Attribute Correlations to Satisfaction:

- Q8. Overall satisfaction with Provider Services
- Q16. Ability of representative to answer claims questions
- Q17. Timeliness of responses to your questions/inquiries
- Q5. Usefulness of HAP updates
- Q24. Overall satisfaction with Claims Processing



DIRECTIONS RESEARCH

Ratings Over Time

Total HAP Empowered

	Total HAP Empowered			
	2020 (n=183)	2021 (n=162)	2022 (n=244)	Change
Overall Satisfaction				
Q1. Your overall relationship with HAP	41%	32%	33%	+1%
Provider Information				
Q4. Overall satisfaction with the Provider Information you receive from HAP	33%	25%	26%	+1%
Q5. Usefulness of HAP updates	35%	28%	28%	0%
Q6. Usefulness of online provider information	35%	26%	29%	+3%
Provider Services				
Q8. Overall satisfaction with Provider Services	33%	27%	29%	+2%
Q9. Accessibility of Provider Services representatives	29%	26%	27%	+1%
Q10. Timeliness of responses from representatives	30%	27%	27%	0%
Q11. Ability to address your question or concern	27%	25%	27%	+2%
Q12. Ease of providing updated practice information to HAP	31%	28%	27%	-1%
Provider Inquiry				
Q13. Overall satisfaction with Provider Inquiry service	32%	26%	29%	+3%
Q14. Ease of using the automated phone system to verify benefits and member eligibility	36%	24%	30%	+6%
Q15. Length of phone wait time to speak with a representative	26%	19%	22%	+3%
Q16. Ability of representative to answer claims questions	30%	24%	27%	+3%
Q17. Timeliness of responses to your questions/inquiries	30%	24%	28%	+4%

↓ Significantly lower than previous study
↑ Significantly higher than previous study
(90% Confidence Level)

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Total HAP Empowered

	Total HAP Empowered			
	2020 (n=183)	2021 (n=162)	2022 (n=244)	Change
Online Services				
Q18. Overall satisfaction with HAP's online provider portal	32%	26%	33%	+7%
Q19. Claims appeal application	32%	21%	25%	+4%
Q20. HCC Process	32%	20%	30%	+10% ↑
Q21. Managing user IDs and passwords	32%	21%	28%	+7%
Q22. Access to patient records and gaps in care	31%	20%	27%	+7%
Claims Processing				
Q24. Overall satisfaction with Claims Processing	28%	26%	28%	+2%
Q25. Ease of submitting claims	34%	25%	31%	+6%
Q26. Clarity of HAP claims remittance advice (RA)	30%	26%	28%	+2%
Q27. Ease of checking claims status using the provider portal	30%	27%	29%	+2%
Q28. Ease of checking claims status using the automated phone system	32%	25%	27%	+2%
Q29. Timeliness of claims processing	31%	25%	28%	+3%
Q30. Timeliness of reimbursement payments	31%	26%	28%	+2%
Utilization Management				
Q31. Overall satisfaction with the utilization management process	26%	23%	22%	-1%
Q32. Length of phone wait time to speak with a UM representative	26%	22%	24%	+2%
Q33. Knowledgeable UM staff	29%	21%	23%	+2%
Q34. Timeliness of UM decisions on pre-authorization requests	26%	18%	22%	+4%
Q35. The in-network outpatient referral management process	27%	20%	22%	+2%
Q36. The out-of-network outpatient referral management process	26%	19%	22%	+3%
Q37. HAP's efforts to reduce or eliminate hassle factor of getting patients the services they need	27%	22%	23%	+1%

↓ Significantly lower than previous study
↑ Significantly higher than previous study
(90% Confidence Level)

DIRECTIONS RESEARCH

Total HAP Empowered

	Total HAP Empowered			
	2020 (n=183)	2021 (n=162)	2022 (n=244)	Change
EviCore Referrals and Authorizations				
Q39. EviCore for High Tech Imaging	31%	20%	24%	+4%
Q40. EviCore for Cardiac Implantables	32%	28%	29%	+1%
Q41. EviCore for Pain Management	28%	26%	26%	0%
Q42. EviCore (formerly MedSolutions) for sleep studies	29%	25%	28%	+3%
Pharmacy Services				
Q43. Ease of determining if a prescription drug requires prior authorization	23%	15%	20%	+5%
Q44. Ease of submitting a request for prior authorization for prescription drugs	24%	16%	21%	+5%
Q45. Ease of determining if a medical drug requires prior authorization	24%	15%	21%	+6%
Q46. Ease of submitting a request for prior authorization for medical drugs (online through CareAffiliate)	26%	18%	20%	+2%
Q47. Resolution of appeals for medications	24%	16%	22%	+6%
Behavioral Health				
Q48. Overall satisfaction with HAP's Coordinated Behavioral Health Management (CBHM) staff	27%	23%	23%	0%
Q49. Timeliness of feedback from Behavioral Health providers	26%	21%	22%	+1%
Q50. Referrals to behavioral health providers using CareAffiliates	25%	24%	23%	-1%

↓ Significantly lower than previous study
↑ Significantly higher than previous study
(90% Confidence Level)

DIRECTIONS RESEARCH

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Total HAP Empowered

	Total HAP Empowered			
	2020 (n=183)	2021 (n=162)	2022 (n=244)	Change
MI Health Link MMP				
Q55. Participation in Integrated Care Team (ICT) meetings	38%	33%	20%	-13%
Q56. Participation in Individual Integrated Care and Supports Plan (IICSP) development	37%	34%	20%	-14%
Q57. The PCP referral process to Specialists	37%	28%	22%	-6%
Q58. The PCP referral process to Long Term Services and Supports (LTSS) providers	38%	39%	24%	-15%
Q59. The PCP referral process to Prepaid Inpatient Health Plan (PIHP) providers	42%	41%	23%	-18%
HAP Network				
Q60. The number of specialists in HAP's provider network	24%	18%	26%	+8% ↑
Q61. Level of collaboration from specialists for shared patients	22%	17%	25%	+8% ↑
Q62. Timeliness and completeness of feedback from specialists	23%	16%	23%	+7%
Q63. Timeliness and completeness of feedback from hospitals or ER facilities	25%	17%	21%	+4%
Q64. Timeliness and completeness of feedback from Skilled Nursing or Rehab facilities	24%	17%	21%	+4%
Q65. Timeliness and completeness of feedback from external hospital laboratories		19%	22%	+3%
HAP Care Management Programs				
Q67. Overall satisfaction with the HAP Care Management programs	36%	33%	33%	0%
Q68. Helpfulness of HAP's Care Management clinical staff	38%	32%	33%	+1%
Q69. HAP's coordination of care for patients with multiple or complex conditions	43%	32%	32%	0%

↓ Significantly lower than previous study
↑ Significantly higher than previous study
(90% Confidence Level)

DIRECTIONS RESEARCH

Patient Safety/Quality of Care

HAP Empowered addressed patient safety during 2022 in a variety of areas, including:

- Maintained oversight of regulatory guidelines from the Centers for Medicare and Medicaid Services (CMS) and to apply updates to HAP processes for compliance with monitoring health care acquired conditions.
- Maintain an ongoing process to monitor and investigate hospital-acquired conditions (HACs) and provider preventable conditions (PPCs).
- Promoted increased awareness and safe working conditions by collaborating with the Building Operations team.
- Identified HACs and PPCs through DRG-based audits conducted by HAP's vendor, Change Healthcare, Power BI claims data associated with HACs, and quality referrals from the provider appeals, inpatient admissions, case management, and high-cost review teams where access to clinical notes allows identification of potential issues.
- Continued to monitor and track HACs and PPCs to identify trends of potential quality concerns at HAP-contracted health systems and associated hospitals. The Peer Review Committee (PRC) reviews all cases flagged with claims associated with HAC 01 (Foreign Object Retained After Surgery) and reports its findings to the Quality and Safety Committee (Q&S Committee) for disposition.
- The Peer Review Committee reviewed and discussed all cases involving members who had claims associated with HACs to determine whether withholding monies for services rendered was warranted for reporting to the U.S. Office of Inspector General (OIG) Annual Integrity Report and referred those cases to the Q&S Committee for disposition.
- Continued strong collaborative association with HFH Director of Performance Excellence and

Quality regarding process improvements to decrease quality concerns.

- Participated in the ongoing community Michigan Health and Hospital Association, Quality Improvement Directors' meetings, and other forums to address and support quality and safety improvement initiatives locally and statewide.
- Continued participation in the Michigan Quality Improvement Consortium (MQIC) to promulgate evidence-based medicine, preventive services, health promotion, disease management programs, and clinical practice guidelines to practitioners in Southeast Michigan and for use by HAP.

Customer Service Call Center Utilization

Workforce management and customer service work together to monitor our metrics (number calls received, average speed to answer and abandonment rate). The workforce management uses historical data to predict future staffing needs. The workforce management team creates schedules that best fit the forecasted model to make sure that we have enough staff for the predicted calls. Forecasting is anticipating call volume based on historical trends, current trends, and business insights. Reports are also created to view historical trends across a variety of key indicators. The team monitors and tracks queue level performance which includes tracking agents' activities in real time. Real time management is the process of monitoring call center Key Performance Indicators (KPI's) and agents in real time statuses so that adjustments can be made to meet the department's service level goals. In addition to monitoring and forecasting trends both teams meet regularly to discuss the forecast and real-time data to make updates as needed. The workforce management and customer service are in constant contact with each other to make sure that we are aligned with how to handle operations day-to-day.

	Received Contacts	Average Wait Time	
Name 0	All	Answered	Abandon Rate
HAP	37265	00:00:37	3.4
Midwest-CustSvc	37265	00:00:37	3.4
Jan	3414	00:02:05	13.2
Feb	2570	00:00:26	2.3
Mar	3180	00:00:42	3
Apr	2781	00:00:42	2.5
May	2705	00:00:45	3.3
Jun	2981	00:00:34	2.4
Jul	2709	00:00:25	1.3
Aug	3481	00:00:47	3.4
Sep	3148	00:00:12	1
Oct	3138	00:00:18	1.3
Nov	3174	00:00:18	1.4
Dec	3984	00:00:24	4.3
	37265	00:00:37	3.4

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Quality Evaluation Summary

Overall, HAP Empowered has made progress in improving the quality of care, safety, and service to our members. We continue to work with our providers to educate and provide access on the web site for the following:

- Communications (administrative manual, newsletters, etc.)
- Quality Program Documents
- Provider and staff directories
- Forms and resources
- Pharmacy and formulary
- Privacy practices
- Member eligibility
- Claims/appeals
- Clinical practice guidelines
- Member roster
- Authorizations/referrals

HAP Empowered has improved member experience, care coordination, community outreach and member services. Throughout 2022, there have been continuous enhancement in the structure for the Medicaid improvement efforts including:

- Holding monthly interdepartmental team focus on Medicaid initiatives aimed at improving HEDIS/CAHPS measures
- Monitoring monthly HEDIS rates progress toward goals through the Medicaid dashboard
- Maintaining and revising the Medicaid Initiative Work Plan focused on improving HEDIS and CAHPS rates
- Working with Provider Network to identify quality measures for the Provider Best Practice Program

2023 Initiatives

- Quality Program Performance*:*
    - Maintain HEDIS, CAHPS and NCQA® plan rankings
    - Achieve band 2 status for Medicaid Auto Assignment
    - Attain the Michigan state average for the Medicaid Consumer Guide
- Through the Member Connections Committee, coordinate CAHPS member satisfaction improvement initiatives to achieve corporate member satisfaction goals
- Address social determinants of health, and initiate efforts to reduce racial and ethnic disparities with a focus on existing disparities in access to healthcare and health outcomes through ongoing interventions in support of Quality Improvement Projects (QIP) and Performance Improvement Projects (PIPs)
- Maintain a Population Health approach in providing integrated, interdisciplinary care coordination at HAP across all clinical settings and members' circumstances optimizing the use of community resources
- Address Purchaser, Accreditation and Regulatory requirements as evidenced by achieving NCQA Health Plan accreditation
    - Maintain Health Plan Accreditation
    - Maintain LTSS Distinction

  - Maintain MED Module Accreditation
- HAP Provider Network Performance is optimized to support members based on value driven care, clinically appropriate utilization, and high-quality population outcomes
  - Monitor over and underutilization of services
  - Provide monthly HEDIS reports to participating POs
  - Alternative Payment Model
- Review, investigate, and monitor concerns regarding affiliated providers which have the potential to negatively affect the quality, safety or integrity of services rendered to members and to determine appropriate follow-up as necessary.
- Evaluation of the Quality Program Activities as evidenced by completion of the annual evaluation of the Quality Program, Work Plan, and Quantitative Assessment
- Continue efforts toward maintaining regulatory, State, and CMS compliance
- Continue to identify health disparities and implement interventions to reduce racial/ethnic disparities in care
- Monitor and track performance monitoring standards for the following measures:
  - Healthy Michigan Plan (HMP) Measures
  - MDHHS Dental Measures
  - CMS Core Set Measures / HEDIS / Managed Care Quality Measures
- Continue collaboration on the following quality improvement projects:
  - Low Birth Weight
  - Pediatric Sickle Cell
  - LGBTQ+
  - Hepatitis C
  - Population Health Management: SDOH
  - Integration of Behavioral Health
- Promote Coordination of Medical and Behavioral Health care
  - Collaborate between pre-paid Inpatient Health Plans (PIHPs) and HAP Empowered teams.
  - Continue to access data on joint members, develop joint care management standards and processes, and implement joint care managements processes.
  - Continue monthly meetings to review high risk members
  - Continue bi-monthly meetings with the PIHPs; MHPs; and MDHHS for the purpose of improving coordination processes