Quality Assessment and Performance Improvement Program

Annual Evaluation

2021

CQMC: 4/12/22

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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 2021, HAP Empowered continued to work on making improvements in quality care for the well-being and safety of members. As of December 2021, HAP Empowered Medicaid membership was 26,622. This Program Evaluation is applicable to Medicaid unless otherwise noted.

Highlights of the 2021 Quality Assessment and Performance Improvement Program All-Product (QAPI) includes the following achievements and organizational accomplishments:

- HAP ranked #1 in Member Satisfaction Among Commercial Health Plans in Michigan, according to the J.D. Power 2021 U.S. Member Health Plan Study, an honor HAP has earned two of the past three years.

- HAP's Medicare HMO and Medicare PPO both earned a 4.5 star rating out of five from the Centers for Medicare and Medicaid Services (CMS). HAP is the only Michigan-based insurer to achieve a 4.5-star rating for its Medicare HMO the last two years in a row and achieve 4 stars or higher for both HMO and PPO each of the past three years.

- HAP was named a "Best Insurance Company for Medicare Advantage Plans" by *U.S. News & World Report*, one of only three insurers in Michigan to earn this prestigious recognition.

- HAP announced a partnership with MSU Health Care, which will greatly expand HAP's Medicare reach. This announcement is one of the early results of Henry Ford's historic 30-year partnership with MSU. Thanks to its new partnership with MSU Health Care and the new growth initiatives with Henry Ford, HAP has already begun marketing its 2022 Medicare products to more than 150,000 new prospects.

- HAP was the only insurer to win two Pinnacle Awards from the Michigan Association of Health Plans in 2021. HAP took top honors in the Chronic Disease Management – Medicare category for its work with Osteoporosis Management in Women and won in the immunizations category for its work on COVID-19 vaccinations.

- HAP and Aetna finalized an agreement that will allow Aetna to serve as HAP's national network partner effective Jan. 1, 2022. HAP and ASR will access the Aetna PPO network through the Aetna Signature Administrators™ program, which has more than 1.4 million providers that include more than 6,100 hospitals and thousands of MinuteClinic® locations around the country.

- Effective 11/1/2021, HAP implemented ProgenyHealth for Maternity Management Case Management services. The care management program includes a personalized care journey and resources for pregnant women, guidance and navigation through pregnancy and post-delivery (remote monitoring, support between visits, etc.) and technology enabled health services that includes care plans, focused medical record and digital engagement.

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- Continued interdepartmental team focus on Medicaid initiatives aimed at increasing HEDIS/CAHPS measure rates that impact:
    - Auto Assignment
    - MDHHS Performance Bonus Measures
    - Consumer Guide scores

- HAP responded to COVID-19 by making treatment more accessible and coverage more affordable for our members – including businesses and their employees – as they continued to face economic disruption due to the pandemic. This included:

    - Waiving member cost sharing for the ***treatment*** of COVID-19 through the first three quarters of 2021.
    - Continuing to waive member cost sharing for the diagnostic ***testing*** of COVID-19 for the duration of the public health emergency.
    - Targeted vaccination education outreach to vulnerable populations (particularly Medicare and Medicaid members) that included text and telephone reminders of the Ford Field mass vaccination clinic, as well as a partnership with Henry Ford's Global Health Initiative mobile vaccination clinic to take the vaccine to underserved zip codes (including some area McDonald's restaurants).

- HAP partnered with Henry Ford Health System to transform HAP Troy into a top-performing mass vaccination site, with more than 80,000 doses of COVID-19 vaccine administered by HFHS clinicians in 2021.

- In December 2021, HAP Troy became the site of a monoclonal antibody treatment clinic, a partnership between Henry Ford Health System, Ascension and Medstar (southeast Michigan's largest EMS and mobile health provider). The monoclonal antibody treatment (mAb) administered is a single-dose infusion available to patients who have mild to moderate COVID-19 and is an important part of the fight against the pandemic.

- As a result of HAP's outreach efforts throughout the year, more than 204,000 HAP members have received at least one dose of the COVID vaccine. This represents nearly 65% of HAP's membership (ages 5 and older). Nearly 40% of HAP's Medicare Advantage members have received a booster, and nearly 20% of HAP's overall membership have received a booster.

- HAP added five key industry leaders to its board of directors in 2021. These industry influencers are strategic additions to help HAP achieve its digital transformation goals and help us address the critical issues of health inequities, social disparities, and rising health care costs.

- HAP added several executive leadership team members in 2021:
    - Nike Otuyelu, Chief Compliance Officer
    - Marc Ahlquist, VP, Human Resources

  - Gordon Salm, Interim Chief Financial Officer
  - Archana Rajendra, Deputy General Counsel

- Through its community outreach efforts, HAP touched a total of nearly 978,000 lives in 2021. This included:
  - Administering and managing 181 grants, charitable donations, and corporate sponsorships with non-profit and community partners, directly touching more than 933,000 lives.
  - Partnering with Henry Ford Health System, Federally Qualified Health Centers, and municipal health departments at more than 200 community COVID-19 vaccination events, helping to deliver nearly 44,000 doses of vaccine, including many in underserved communities.
  - Coordinating more than 80 Medicare member engagement events, attended by more than 800 members.
  - Enhancing HAP's Medicaid new member orientation sessions, which saw quadrupled attendance compared to 2020, thanks in large part to new texting outreach capabilities.

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 Report provide 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.

- 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 previously identified issues department

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 uses the Healthcare Effectiveness Data and Information Set (HEDIS®) tool each year as one of the ways to help make sure that our members are getting the preventive screening and services needed with the intent of keeping members healthy and/or assist in the identification of potential health problems early.

Purpose
The intent of this information is to provide a brief, high-level summary of HAP's Medicaid Measurement Year 2020 HEDIS® measures and to highlight any rate improvements made over the past year.

HEDIS® Analysis

HAP Empowered implements population health management programs with an overall focus on keeping members healthy, managing members with emerging risk, addressing patient safety or outcomes across settings and managing multiple chronic illnesses. Programs are selected based on analysis of demographic and epidemiological characteristics of the member population including social determinants of health through review and analysis of multiple data sources.

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

Two Year Trending Analysis HEDIS®

The analysis includes information related to two-year trending of measures and compares the final HEDIS® MY 2020 rates against the NCQA National Committee for Quality Assurance (NCQA) National Benchmarks and Thresholds. A two-year trend of data was used because the HAP membership had a significant change in 2020 when Region 10 population was included. **Please reference the HEDIS® table for further information.**

The following benchmarks were achieved for the measure identified in the HEDIS® table

- 3 - Measure Met or Exceeded the 90th percentile

  - Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy (M 21-75)
  - Statin Therapy for Patients with Diabetes - Received Statin Therapy
  - Antidepressant Medication Management - Effective Acute Phase Treatment
- 6 - Measures Met or Exceeded 75th percentile
  - Asthma Medication Ratio (51-64)
  - Statin Therapy for Patients with Cardiovascular Disease - Statin Adherence 80% (M 21-75)
  - Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy (F 40-75)
  - Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy (Total)
  - Statin Therapy for Patients with Diabetes - Statin Adherence 80%
  - Antidepressant Medication Management - Effective Continuation Phase Treatment
- 7 - Measures Met or Exceeded 50th percentile
  - 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 Physical Activity
  - Breast Cancer Screening
  - Chlamydia Screening in Women (Total)
  - Statin Therapy for Patients with Cardiovascular Disease - Statin Adherence 80% (Total)
  - Comprehensive Diabetes Care - HbA1c Testing
  - Adults' Access to Preventive/Ambulatory Health Services (65+)

Prevention

HAP Empowered provides a spectrum of primary and preventive care and uses the principles of population health management to prevent chronic disease and coordinates care along the continuum of health and wellbeing. Use of these principles will assist in maintaining or improving the physical and psychosocial wellbeing of individuals through cost-effective and tailored health solutions, incorporating all risk levels along the continuum.

The following information describes activities performed related to childhood wellness and prevention.

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 and 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 the age-appropriate services, HAP offers Primary Care Physicians and members EPSDT financial incentives.

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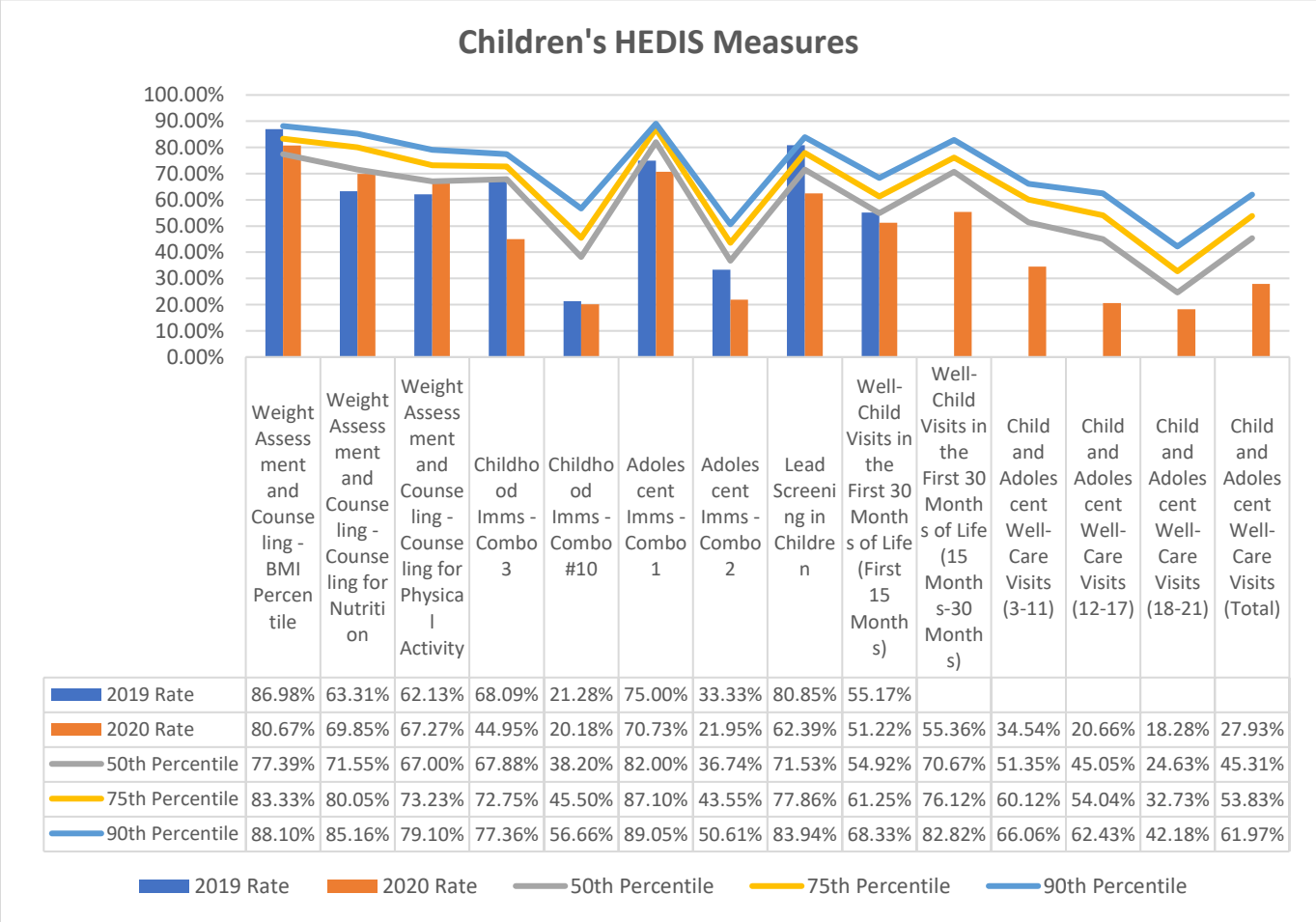
Well-Child Visits

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 measurements, a physical examination, various screenings – sensory, developmental, behavioral – oral health and various blood tests.

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.



	Weight Assessment and Counseling - BMI Percentile	Weight Assessment and Counseling - Counseling for Nutrition	Weight Assessment and Counseling for Physical Activity	Childhood Imms - Combo 3	Childhood Imms - Combo #10	Adolescent Imms - Combo 1	Adolescent Imms - Combo 2	Lead Screening in Children	Well-Child Visits in the First 30 Months of Life (First 15 Months)	Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	Child and Adolescent Well-Care Visits (3-11)	Child and Adolescent Well-Care Visits (12-17)	Child and Adolescent Well-Care Visits (18-21)	Child and Adolescent Well-Care Visits (Total)
2019 Rate	86.98%	63.31%	62.13%	68.09%	21.28%	75.00%	33.33%	80.85%	55.17%					
2020 Rate	80.67%	69.85%	67.27%	44.95%	20.18%	70.73%	21.95%	62.39%	51.22%	55.36%	34.54%	20.66%	18.28%	27.93%
50th Percentile	77.39%	71.55%	67.00%	67.88%	38.20%	82.00%	36.74%	71.53%	54.92%	70.67%	51.35%	45.05%	24.63%	45.31%
75th Percentile	83.33%	80.05%	73.23%	72.75%	45.50%	87.10%	43.55%	77.86%	61.25%	76.12%	60.12%	54.04%	32.73%	53.83%
90th Percentile	88.10%	85.16%	79.10%	77.36%	56.66%	89.05%	50.61%	83.94%	68.33%	82.82%	66.06%	62.43%	42.18%	61.97%

Summary of Findings/Improvement Opportunities

The results reveal the majority of the preventive care measures did not meet benchmarks; decreased from the previous year and are areas for improvement. There were two measures in the graph that met or exceeded the 50th NCQA Quality Compass percentile – BMI percentile and Counseling for Physical Activity.

Barriers

In Measurement Year 2020 HAP Empowered experienced member disengagement with healthcare due to COVID-19 pandemic. Provider offices were closed during part of the year and members were reluctant to physically visit provider offices for fear of contracting the disease.

Additional factors affecting the preventive care rates include COVID 19, ineffective outreach from physicians and the Plan, missing, incorrect, or incomplete contact information that results in unsuccessful member contact, members having transportation issues, members needing childcare for other children, members not wanting to take their children to the doctor unless they are sick, member/provider knowledge deficit regarding incentives, and member knowledge deficit regarding the importance of preventive screening and/or the existence of transportation assistance.

Barriers related to lead screening in children include Parental opposition - unwillingness to have their child undergo the trauma of a blood draw or capillary stick; lack of blood draws or capillary sticks in the physician office and failure of parents to follow up on a lead screening order.

Additional barriers include racial and ethnic disparities, and Social Determinants of Health – housing and food insecurity, income, type of employment, poverty, and education.

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 completing lead screening; well child visits/access visits; immunizations
- 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.
- 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
- Consider mobile vaccination and child focused clinic visits.
- In conjunction with Provider Services, analyze provider practice and billing awareness, provide interventions including provider education regarding billing the appropriate code (96110) when developmental screening is performed.
- Continue to employ Alternative Payment Models and Value Based Payments.
- Developing and implementing a formal performance improvement project focused on increasing access to care, prevention and screening, child and adolescent well visit domains.

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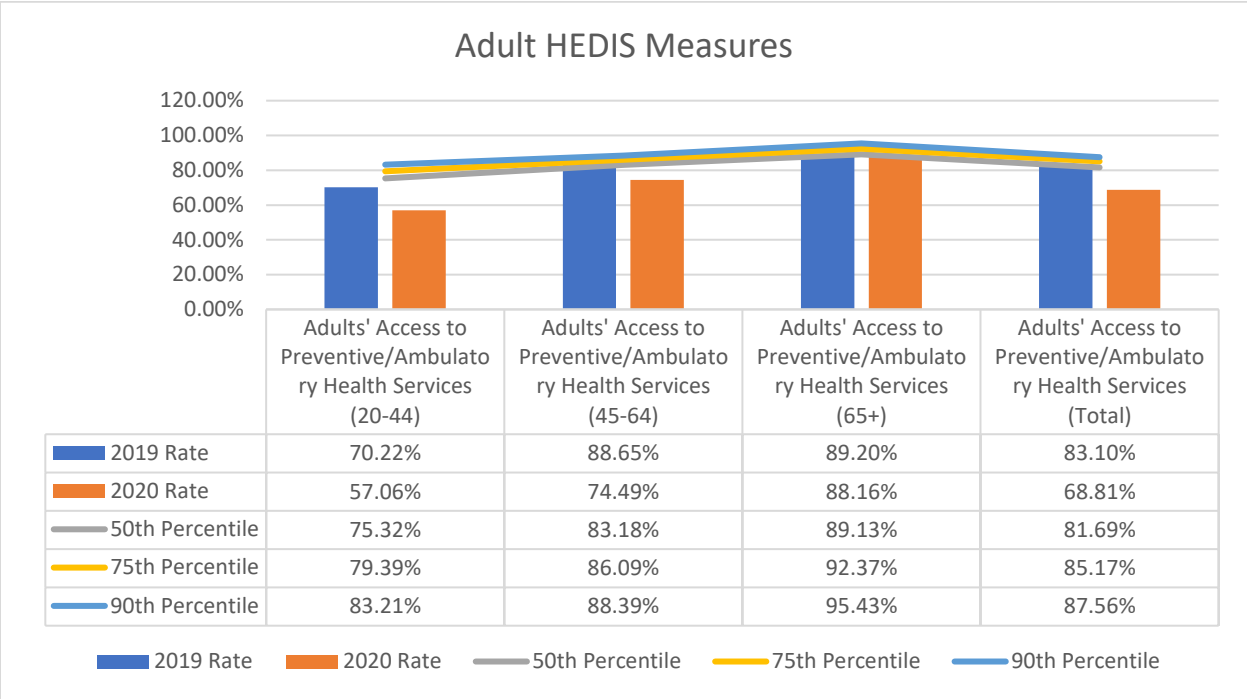

	Adults' Access to Preventive/Ambulatory Health Services (20-44)	Adults' Access to Preventive/Ambulatory Health Services (45-64)	Adults' Access to Preventive/Ambulatory Health Services (65+)	Adults' Access to Preventive/Ambulatory Health Services (Total)
2019 Rate	70.22%	88.65%	89.20%	83.10%
2020 Rate	57.06%	74.49%	88.16%	68.81%
50th Percentile	75.32%	83.18%	89.13%	81.69%
75th Percentile	79.39%	86.09%	92.37%	85.17%
90th Percentile	83.21%	88.39%	95.43%	87.56%

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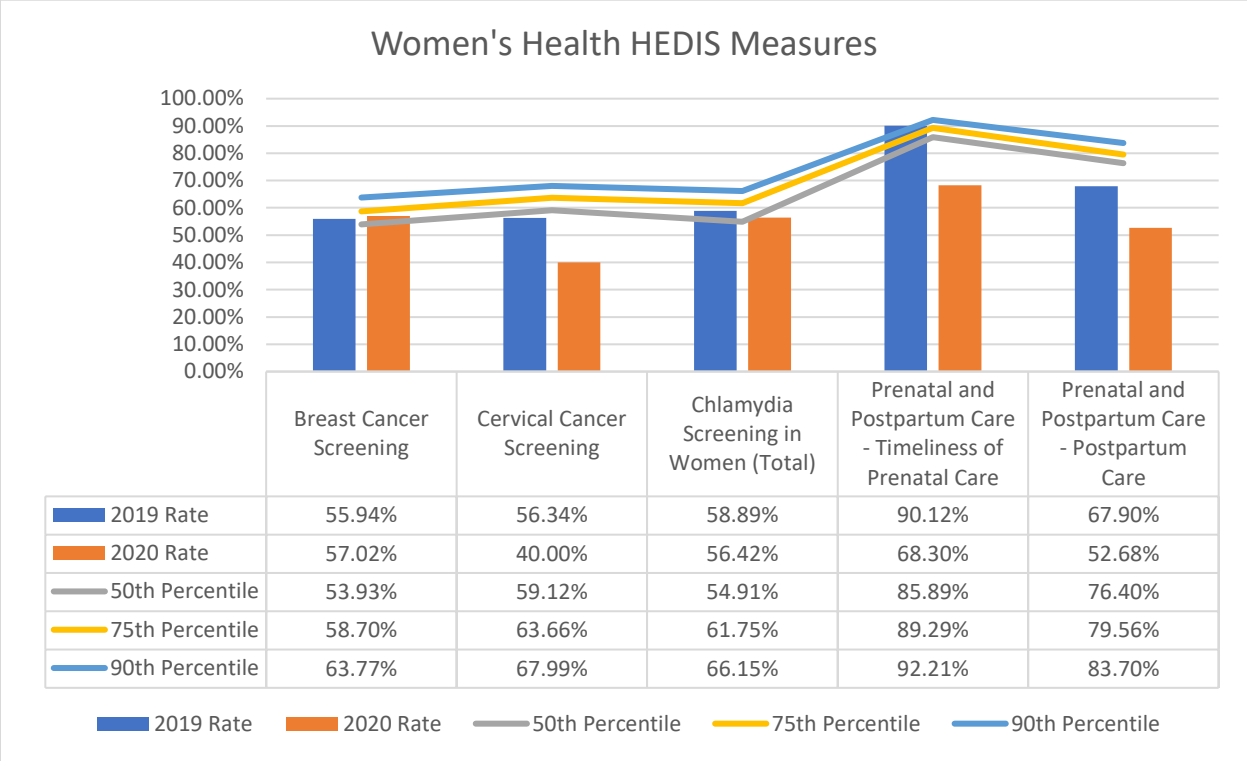

	Breast Cancer Screening	Cervical Cancer Screening	Chlamydia Screening in Women (Total)	Prenatal and Postpartum Care - Timeliness of Prenatal Care	Prenatal and Postpartum Care - Postpartum Care
2019 Rate	55.94%	56.34%	58.89%	90.12%	67.90%
2020 Rate	57.02%	40.00%	56.42%	68.30%	52.68%
50th Percentile	53.93%	59.12%	54.91%	85.89%	76.40%
75th Percentile	58.70%	63.66%	61.75%	89.29%	79.56%
90th Percentile	63.77%	67.99%	66.15%	92.21%	83.70%

Summary of Findings

HAP Empowered struggled to meet benchmarks for the Adult Access to Care with one measure, AAP 65+ meeting the 50th NCQA QC benchmark. For the women's preventive measures, two measures, breast cancer screening and Chlamydia screening met the 50th NCQA QC benchmark.

Barriers

As noted previously, in 2020 HAP Empowered experienced member disengagement with healthcare due to COVID-19 pandemic. Provider offices were closed during part of the year and members were reluctant to physically visit provider offices for fear of contracting the disease.

HAP Empowered is developing and implementing a formal performance improvement project focused on increasing access to care, prevention and screening, child and adolescent well visit domains.

Additional factors affecting the preventive care rates include COVID 19, ineffective outreach from physicians and the Plan, missing, incorrect, or incomplete contact information that results in unsuccessful member contact, members having transportation issues, members needing childcare for their children, member/provider knowledge deficit regarding incentives, and member knowledge deficit regarding the importance of preventive screening and/or the existence of transportation assistance.

Additional barriers include racial and ethnic disparity, and Social Determinants of Health – housing and, food insecurity, income, type of employment, poverty, and education.

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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.

Diabetes Care Measures – Chronic Condition

In 2020 HAP Empowered continued to improve care and services to members with chronic conditions through case management and HEDIS® interventions. Ongoing monitoring and evaluation of member's health through claims reports continue to help identify members with specific conditions.

The HEDIS® MY 2020 rates for the diabetes measures are displayed in the graphs below.

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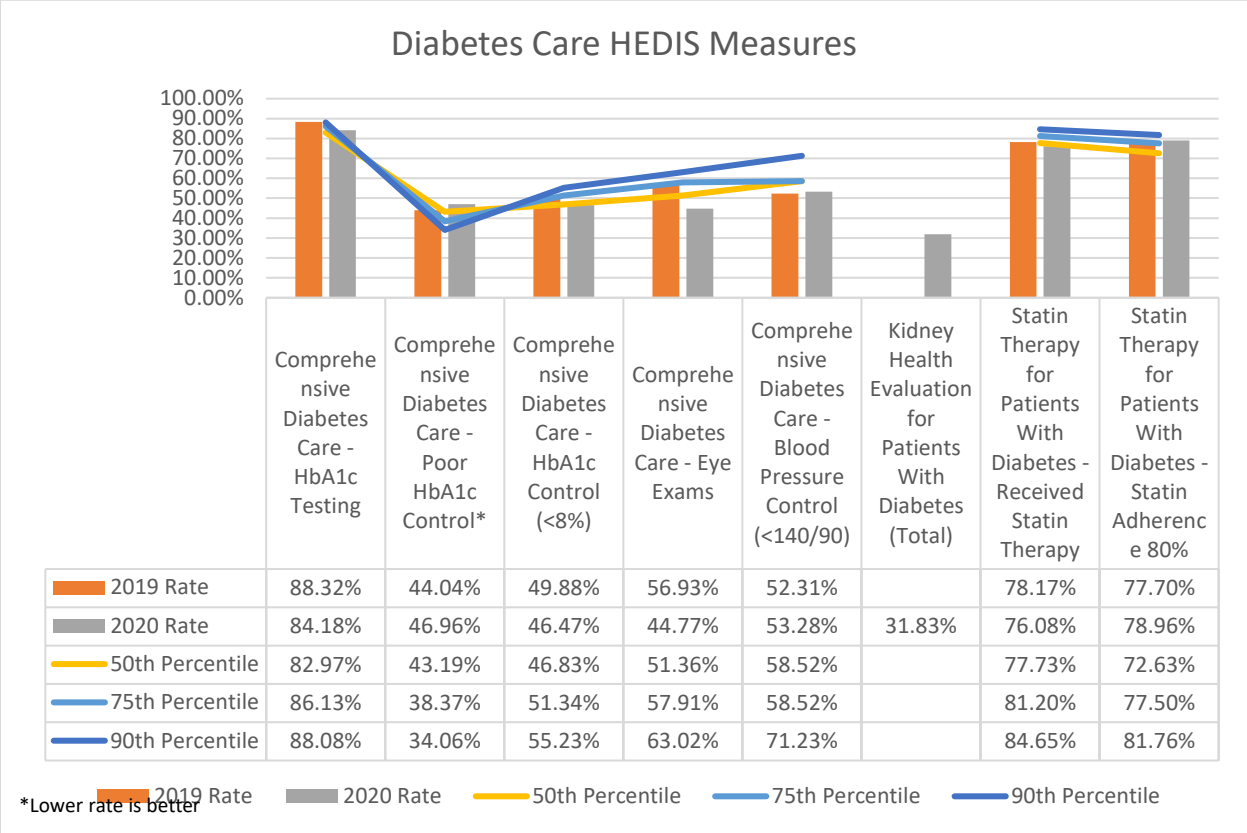

	Comprehensive Diabetes Care - HbA1c Testing	Comprehensive Diabetes Care - Poor HbA1c Control*	Comprehensive Diabetes Care - HbA1c Control (<8%)	Comprehensive Diabetes Care - Eye Exams	Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	Kidney Health Evaluation for Patients With Diabetes (Total)	Statin Therapy for Patients With Diabetes - Received Statin Therapy	Statin Therapy for Patients With Diabetes - Statin Adherence 80%
2019 Rate	88.32%	44.04%	49.88%	56.93%	52.31%		78.17%	77.70%
2020 Rate	84.18%	46.96%	46.47%	44.77%	53.28%	31.83%	76.08%	78.96%
50th Percentile	82.97%	43.19%	46.83%	51.36%	58.52%		77.73%	72.63%
75th Percentile	86.13%	38.37%	51.34%	57.91%	58.52%		81.20%	77.50%
90th Percentile	88.08%	34.06%	55.23%	63.02%	71.23%		84.65%	81.76%

Summary of Findings

HAP Empowered scores for diabetes did not meet most benchmarks. The measures that met NCQA QC benchmarks include HbA1c, and statin therapy for patients with diabetes.

Barriers

There are multiple barriers that may have contributed to low HEDIS® rates. These barriers are:

- Missing, incorrect, or incomplete contact information that result in unsuccessful member contact.
- Members may not seek preventive care services to avoid or reduce complications of diabetes
- Members unaware of the importance of having preventive services completed
- Additional barriers include racial and ethnic disparities, and Social Determinants of Health – housing and, food insecurity, income, type of employment, poverty, and education.

Improvement Activities

Multiple interventions were implemented for this population including member and provider incentives, mailings, and telephonic outreach. HAP Empowered also identifies racial and ethnic disparities through data analysis and focuses efforts (programs, initiatives) to address the disparities.

Additionally, HAP Empowered uses a vendor, Matrix Medical Network to complete face-to-face visits with members needing a diabetic eye exam. While in the home the nurse will complete the eye exam and if needed a HbA1c test. For some members who do not need a diabetic eye exam, the vendor Home Access will send the member a HbA1c kit.

HAP Empowered HEDIS Table – Measurement Years 2019 - 2020

Measure/Data Element	MY 2019 Rate	MY 2020 Rate	NCQA Quality Compass 2021		
			50th Percentile	75th Percentile	90th Percentile
Effectiveness of Care: Prevention and Screening					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)					
BMI Percentile	86.98%	**80.67%**	77.39%	83.33%	88.10%
Counseling for Nutrition	63.31%	69.85%	71.55%	80.05%	85.16%
Counseling for Physical Activity	62.13%	**67.27%**	67.00%	73.23%	79.10%
Childhood Immunization Status (cis)					
Combination #2	70.21%	49.54%	71.18%	75.18%	79.32%
Combination #3	68.09%	44.95%	67.88%	72.75%	77.36%
Combination #10	21.28%	20.18%	38.20%	45.50%	56.66%
Immunizations for Adolescents (ima)					
Combination #2	33.33%	21.95%	36.74%	43.55%	50.61%
Lead Screening in Children (LSC)					
Lead Screening in Children	80.85%	62.39%	71.53%	77.86%	83.94%
Breast Cancer Screening (BCS)					
Breast Cancer Screening	55.94%	**57.02%**	53.93%	58.70%	63.77%
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening	56.34%	40%	59.12%	63.66%	67.99%
Chlamydia Screening in Women (CHL)					
Chlamydia Screening in Women (16-20)	61.29%	51.98%	40.46%	58.90%	65.30%
Chlamydia Screening in Women (21-24)	57.63%	59.75%	60.65%	65.52%	70.66%
Chlamydia Screening in Women (Total)	58.89%	**56.42%**	54.91%	61.75%	66.15%
Asthma Medication Ratio (AMR)					
Asthma Medication Ratio (5-11)	0.00%	100%	79.49%	82.38%	84.76%
Asthma Medication Ratio (12-18)		50%	69.18%	73.61%	77.57%
Asthma Medication Ratio (19-50)	47.22%	34.21%	56.30%	60.04%	64.08%
Asthma Medication Ratio (51-64)	72.73%	**61.54%**	57.14%	61.23%	66.67%
Asthma Medication Ratio (Total)	55.93%	46.27%	64.78%	70.67%	75.32%
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure	57.18%	52.55%	55.35%	62.53%	66.79%

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Measure/Data Element	MY 2019 Rate	MY 2020 Rate	NCQA Quality Compass 2021		
			50th Percentile	75th Percentile	90th Percentile
Statin Therapy for Patients With Cardiovascular Disease (spc)					
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (M 21-75)	88.70%	87.85%	82.04%	84.98%	87.26%
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (M 21-75)	82.35%	**77.66%**	71.77%	76.59%	80.93%
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (F 40-75)	77.06%	**81.08%**	77.73%	81.20%	84.65%
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (F 40-75)	73.81%	66.67%	72.63%	77.50%	81.76%
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)	83.04%	**84.4%**	80.34%	82.90%	85.64%
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)	78.49%	**72.28%**	72.21%	76.98%	81.31%
Comprehensive Diabetes Care (CDC)					
Comprehensive Diabetes Care - HbA1c Testing	88.32%	**84.18%**	82.97%	86.13%	88.08%
Comprehensive Diabetes Care - Poor HbA1c Control	44.04%	46.96%	43.19%	38.37%	34.06%
Comprehensive Diabetes Care - HbA1c Control (<8%)	49.88%	46.47%	46.83%	51.34%	55.23%
Comprehensive Diabetes Care - Eye Exams	56.93%	44.77%	51.36%	57.91%	63.02%
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	52.31%	53.28%	58.52%	58.52%	71.23%
Kidney Health Evaluation for Patients With Diabetes (KED)					
Kidney Health Evaluation for Patients With Diabetes (18-64)	-	30.86%	NA	NA	NA
Kidney Health Evaluation for Patients With Diabetes (65-74)	-	34.23%	NA	NA	NA
Kidney Health Evaluation for Patients With Diabetes (75-85)	-	30.61%	NA	NA	NA
Kidney Health Evaluation for Patients With Diabetes (Total)	-	31.83%	NA	NA	NA
Statin Therapy for Patients With Diabetes (SPD)					
Statin Therapy for Patients With Diabetes - Received Statin Therapy	78.17%	76.08%	66.47%	69.33%	72.23%
Statin Therapy for Patients With Diabetes - Statin Adherence 80%	77.70%	**78.96%**	68.75%	73.43%	80.00%
Antidepressant Medication Management (AMM)					
Antidepressant Medication Management - Effective Acute Phase Treatment	53.00%	70.59%	56.66%	61.83%	67.74%
Antidepressant Medication Management - Effective Continuation Phase Treatment	42.00%	**47.06%**	40.28%	45.61%	52.49%

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Measure/Data Element	MY 2019 Rate	MY 2020 Rate	NCQA Quality Compass 2021		
			50th Percentile	75th Percentile	90th Percentile
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Adults' Access to Preventive/Ambulatory Health Services (20-44)	70.22%	57.06%	75.32%	79.39%	83.21%
Adults' Access to Preventive/Ambulatory Health Services (65+)	89.20%	**88.16%**	82.72%	88.67%	92.19%
Adults' Access to Preventive/Ambulatory Health Services (Total)	83.10%	68.81%	78.30%	81.97%	84.78%
Adults' Access to Preventive/Ambulatory Health Services (45-64)	88.65%	74.49%	83.18%	86.09%	88.39%
Prenatal and Postpartum Care (PPC)					
Prenatal and Postpartum Care - Timeliness of Prenatal Care	90.12%	68.3%	85.89%	89.29%	92.21%
Prenatal and Postpartum Care - Postpartum Care	67.90%	52.68%	76.40%	79.56%	83.70%
Well-Child Visits in the First 15 Months of Life (w15)					
Well-Child Visits in the First 30 Months of Life (First 15 Months)	55.17%	51.22%	54.92%	61.25%	68.33%
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	-	55.36%	70.67%	76.12%	82.82%
Child and Adolescent Well-Care Visits (WCV)					
Child and Adolescent Well-Care Visits (3-11)	-	34.54%	51.35%	60.12%	66.06%
Child and Adolescent Well-Care Visits (12-17)	-	20.66%	45.05%	54.04%	63.43%
Child and Adolescent Well-Care Visits (18-21)	-	18.28%	24.63%	32.73%	41.18%
Child and Adolescent Well-Care Visits (Total)	-	27.93%	45.31%	53.83%	61.97%

Note: measures that are **bolded** met the 50th, 75th , or 90th percentile. The QC percentile fields/cells that are highlighted in green represent the percentile that was attained.

COVID Outreach

Member information from the Region 10 and Region 6 Population Assessment were reviewed to address the disparities and health risks identified by the Centers for Disease Control and Prevention and the high rates of COVID in Michigan. The focus of the data analyses was to identify high risk members identified by the CDC for telephonic outreach. HAP Empowered identified members with diabetes, high blood pressure, Children Special Health Care Services, and pregnancy as high risk. Additionally, members in the counties with the highest rates of COVID were included. Of note is that the counties/cities with the highest rates of COVID were also those with the some of greatest disparity and health risks. The following is an overview of member identification.

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The Community Outreach team works closely with the Health Care Management team on the initiatives below:

- COVID-19 Outreach Calls to "at-risk" members to:
- Confirm basic needs were met
- Connect members with resources
- Review COVID-19 safety measures
- Promote telehealth/mail order Rx
- Help close gaps in care for members:
- Communicate the importance of preventive care
- Assist member in making doctor appointments
- Arrange free transportation
- Creating community events and "clinic days"

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 2021 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, well 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.

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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 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 2021 (Measurement Year 2020) is below.

Total HEDIS 2021 Denominator	Number referred to MIHP	Enrolled in MIHP
224	74	20

Summary of Quality Improvement Initiatives

- HAP Empowered has a women's health workgroup consisting of representatives from the Quality Management, Performance Improvement/HEDIS, Community Outreach, and Care Management departments. This workgroup meets monthly to discuss ongoing barriers, interventions, and strategies to improve women's health, including prenatal care.
- Continued the Empower Your Health Rewards Program
    - Revised the member incentive program to include a gift card incentive for completing a prenatal exam within the first three months or within 42 days of enrolling with HAP Empowered and for completing a postpartum exam 7-84 days after delivery
    - Continue partnering with the Provider Network team in educating providers on the Member Incentive Program

- Revised the Care Management Prenatal Survey to include triggers for complex/high risk members

Low Birth Weight (LBW)

HAP Empowered partnered with Molina Healthcare and McLaren Health Plan to implement member and provider interventions to reduce the low-birth-weight rate in Region 6 during 2021. The project goals were to design and implement interventions addressing documented health disparities and health inequities, improve infant health outcomes and reduce the low-birth-weight rate in Michigan.

The following objectives were established:

- Provide pregnant women with access to community resources/support
- Improve providers and members knowledge and engagement with MIHP to increase member referrals
- Enroll members in HAPs internal care management program

Regional successes/lessons learned

- Collaboration amongst plans was effective in working with providers and community organizations.
- Developed standardized interventions for members and providers
- Held joint member focus groups in Region 6

In FY22, MDHHS will utilize 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 will continue to implement collaborative interventions with the Region 6 and Region 10 health plans. Monthly workgroup meetings with all plans have been established to review action plans and discuss ongoing low birth weight improvement strategies.

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 2021.

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.

HAP acquired Trusted Health Plan in September 2019. Trusted and HAP functioned as separate entities throughout the remainder of 2019 and were formally merged into HAP Empowered on January 1, 2020. Since there was no overlap in the two entities throughout Remeasurement 2 (October 2018 - October 2019), Trusted and HAP submitted (2) separate submissions in 2020 for Remeasurement 2. In an effort to maintain trending for Remeasurement 3, HAP Empowered will breakdown the membership using the member demographics so that the Remeasurement 3 submission will have two (2) study indicators:

- **Region 6 study indicator**: Measuring the percentage of Black/African American pregnant women who have a prenatal visit within 42 days of enrollment or within the first trimester. (Note: no disparity was identified in data mining) within Region 6 (Genesee County, Huron County, Lapeer County, Sanilac County, Shiawassee County, St. Clair County and Tuscola County).
- **Region 10 study indicator**: To increase the number of women who receive their prenatal care visits within the required timeframe and have a live birth delivery at either Remeasurement 1, 2, or 3 (Note: no disparity was identified in data mining) within Region 10 (Wayne, Oakland and Macomb counties).

PIP Results Baseline to Remeasurement 3

Study Indicator #1 (Region 6):

The Baseline measurement period is the 2018 HEDIS® rate. The overall total measurement year 2020 prenatal care rate is 71.4%; this is an increase of 15.7 percentage points compared to the HEDIS® 2018 rate of 55.7%. HAP Empowered further compared the study indicator of the Black/African American baseline rate for HEDIS® 2018 to measurement year 2020. HEDIS® 2018 results are 13 out of 27 (48.2%) Black/African American members received prenatal care compared to 30 out of 43 (69.7%) in measurement year 2020. This is an improvement of 21.5 percentage points from the baseline. Using the Fishers two tailed exact test, the p-value equals 0.0829. The improvement in the rate is considered to be to be not quite statistically significant.

Study Indicator #2 (Region 10):

The Timeliness of Prenatal Care for Region 10 maintained considerably improvement from the baseline period of HEDIS® 2018 with 35.3% to HEDIS® measurement year 2020 with 64.3%, an overall increase of 29 percentage points. Region 10 indicator used the Chi Square Tool to determine that this increase was statistically significant as it calculated that the p-value equaled 0.0001. While there was statistically significant improvement from HEDIS® 2018 to measurement year 2020, HAP Empowered did not reach its goal of the 50th NCQA Percentile (83.8%). It is important to note that the national benchmarks do change from year to year in accordance with performance of Medicaid plans across the country, however these changes are usually not significant.

HAP Empowered continues to identify opportunities for improvement and collaborate on plan interventions. HAP Empowered implemented a prenatal care workgroup consisting of representatives

from the Quality Management, Performance Improvement/HEDIS, Outreach, and Care Management departments. This workgroup meets bimonthly to discuss ongoing barriers, interventions, and strategies to improve prenatal care. The interventions will be tracked for effectiveness and reported during the next remeasurement period cycle. The workgroup completed the following activities throughout 2021:

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

In 2022, there will be a new PIP cycle with the same topic of Addressing Disparities in Timeliness of Prenatal Care. MDHHS reviewed several factors when deciding the topic including HEDIS specification changes, MHP mergers and the COVID-19 pandemic. HAP Empowered will implement the new PIP protocol. In addition to statistically significant improvement, the new protocols allow for clinically significant and programmatically significant improvement.

Adult Access to Preventive/Ambulatory Health Services (AAP)

The AAP Performance Improvement Project serves as the foundation of HAP Empowered's (HAP) commitment to continuously improve the quality of the treatment and services it provides. HAP is committed to the ongoing improvement of services that are provided in a safe, effective, patient-centered, timely recovery-oriented fashion. HAP is committed to the ongoing improvement of the quality of care its consumers receive, as evidenced by the outcomes of that care.

Analysis
HAP did not meet the 2019 NCQA Quality Compass 50th percentile (78.61%) in MY HEDIS® 2019. HAP's final rate for HEDIS® 2019 was 70.22% which was a decrease from the previous year's rate of 71.98%. In MY 2019 HAP HEDIS® data included members in Region 6. Beginning in MY 2020 data will include members from Region 10 due the acquisition of Trusted Health Plan.

Quality Improvement Activities
Refine the gaps in care outreach program, provider incentives, and member incentives. Consider an approach to member incentives that includes a behavioral economics component. Include reminders in member newsletters, focused member mailings, and provide gaps in care reports to providers. Schedule clinic days on Saturdays, complete a geographic zip code analysis to identify hot spots for targeted interventions. Continue workgroup meetings to review, discuss and revise improvement efforts.

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Improving Comprehensive Diabetes Care-Eye Exam

Analysis
HAP Empowered did not meet the 2019 NCQA Quality Compass 50th percentile goal and had a rate (56.93%) less than the previous year. In MY 2019 HAP HEDIS® data included members in Region 6. Beginning in MY 2020 data will include members from Region 10 due the acquisition of Trusted Health Plan.

Quality Improvement Activities
Refine the gaps in care outreach program, provider incentives, and member incentives. Consider including DRE in member incentives for CY 2022 and an approach that includes a behavioral economics component. Include reminders in member newsletters, focused member mailings, and provide gaps in care reports to providers. Perform a geographic zip code analysis to identify hot spots for targeted interventions. Hold a Clinic Visit day that includes diabetic retinal eye exams. Continue focused workgroup meetings to review, discuss and revise improvement efforts.

We Treat Hepatitis C Initiative
During 2021, MDHHS announced a 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.

Expanding Access to Treatment
Effective April 1, 2021, clinical prior authorization (PA) was no longer required for Mavyret when prescribed in accordance with Food and Drug Administration-approved labeling. This included removal of the requirement that HCV medications must be prescribed by or in consultation with a specialist. All providers who have prescriptive authority are able to prescribe this treatment to members with HCV.

Below are the care coordination activities focused on HCV that will continue to be enhanced 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

In 2021, MDHHS established 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.

Population Health Management

The Population Health Management (PHM) Strategy is a comprehensive and integrated approach that addresses member needs across the continuum of care for high-quality, cost-effective health care delivery. The strategy is a framework that defines how health services are offered and delivered to meet the needs of our members across all areas of population health.

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
- 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

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 integration allows for member identification as well as determines 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.

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.

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The three- year 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.

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 Clinical Quality Management Committee. 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.

COVID-19 brought a fresh focus on SDoH needs, and increased the demand for medical, social, and behavioral needs as well. The Michigan Department of Health and Human Services (MDHHS) has challenged Medicaid health plans to focus on expanding existing assessment and referral sources and community partnerships to their entire regions, as well as to identify and address stratification of data by race, ethnicity, region, age and gender.

The HAP Empowered Care Management team has implemented an SDoH Assessment to be used across all programs. The assessment is used to determine the specific member SDoH needs through a series of questions regarding the following:

- Food insecurity
- Housing
- Utility assistance
- Employment/education/training
- Stress/anxiety/depression
- Transportation
- Other financial concerns

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 in 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 has recently implemented the use of the Aunt Bertha platform for the referral process. This platform allows HAP Empowered team members to access a dashboard that tracks progress on member referrals. These two updates were implemented in August of 2021 and should have a positive impact on HAP Empowered's referral and outcome data for the rest of calendar year 2021.

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

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 2021 Medicaid CAHPS* Survey.

SURVEY OBJECTIVE:

The overall objective of the Consumer Assessment of Healthcare Providers and Systems (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.

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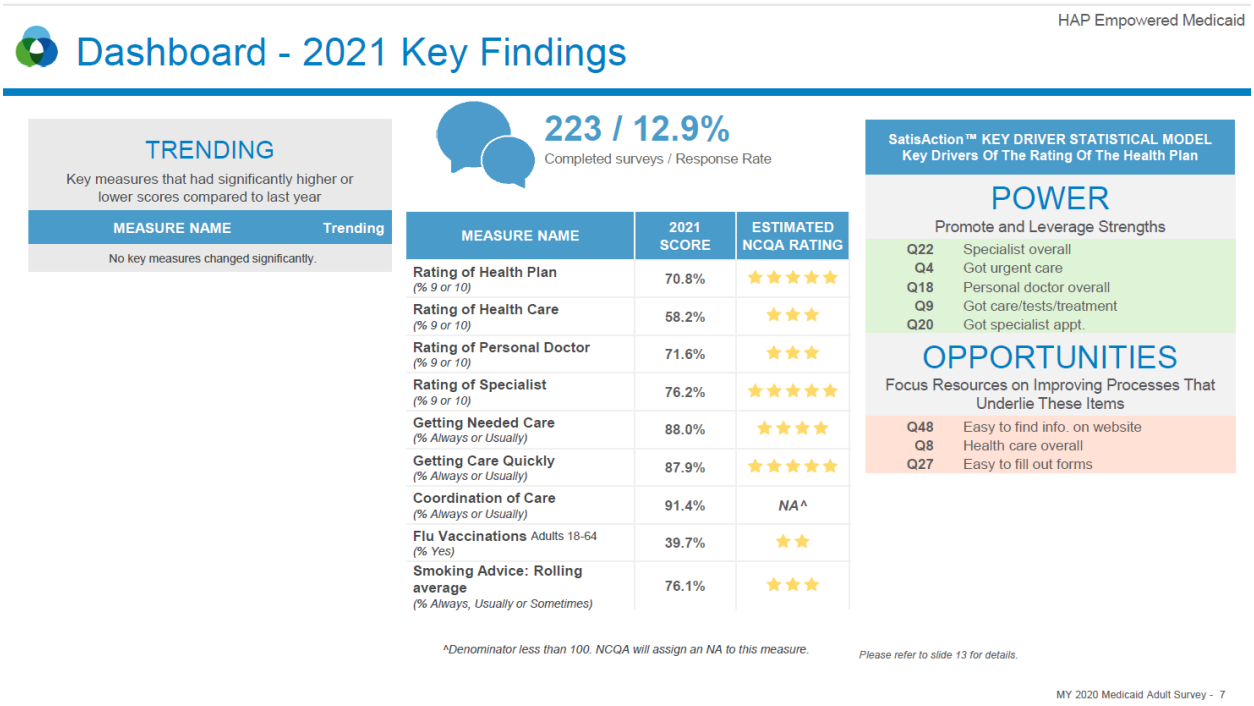
The 2021 MAPD version/MY 2020 Medicaid Adult 5.1H CAHPS surveys were collected via a mail and phone methodology. Members eligible for the survey were those 18 years and older (as of December 31 of the measurement year) who were continuously enrolled in the plan for at least five of the last six months of the measurement year.

The following survey results are compiled from the 223 HAP Empowered Medicaid members who corresponded to the survey, for a response rate of 12.9%.



HAP Empowered Medicaid

Dashboard - 2021 Key Findings

TRENDING

Key measures that had significantly higher or lower scores compared to last year

MEASURE NAME	Trending
No key measures changed significantly.	

223 / 12.9%
Completed surveys / Response Rate

MEASURE NAME	2021 SCORE	ESTIMATED NCQA RATING
Rating of Health Plan *(% 9 or 10)*	70.8%	★★★★★
Rating of Health Care *(% 9 or 10)*	58.2%	★★★
Rating of Personal Doctor *(% 9 or 10)*	71.6%	★★★
Rating of Specialist *(% 9 or 10)*	76.2%	★★★★★
Getting Needed Care *(% Always or Usually)*	88.0%	★★★★
Getting Care Quickly *(% Always or Usually)*	87.9%	★★★★★
Coordination of Care *(% Always or Usually)*	91.4%	*NA^*
Flu Vaccinations Adults 18-64 *(% Yes)*	39.7%	★★
Smoking Advice: Rolling average *(% Always, Usually or Sometimes)*	76.1%	★★★

^Denominator less than 100. NCQA will assign an NA to this measure.

SatisAction™ KEY DRIVER STATISTICAL MODEL
Key Drivers Of The Rating Of The Health Plan

POWER

Promote and Leverage Strengths

Q22	Specialist overall
Q4	Got urgent care
Q18	Personal doctor overall
Q9	Got care/tests/treatment
Q20	Got specialist appt.

OPPORTUNITIES

Focus Resources on Improving Processes That Underlie These Items

Q48	Easy to find info. on website
Q8	Health care overall
Q27	Easy to fill out forms

Please refer to slide 13 for details.

MY 2020 Medicaid Adult Survey - 7

CQMC: April 12,2022

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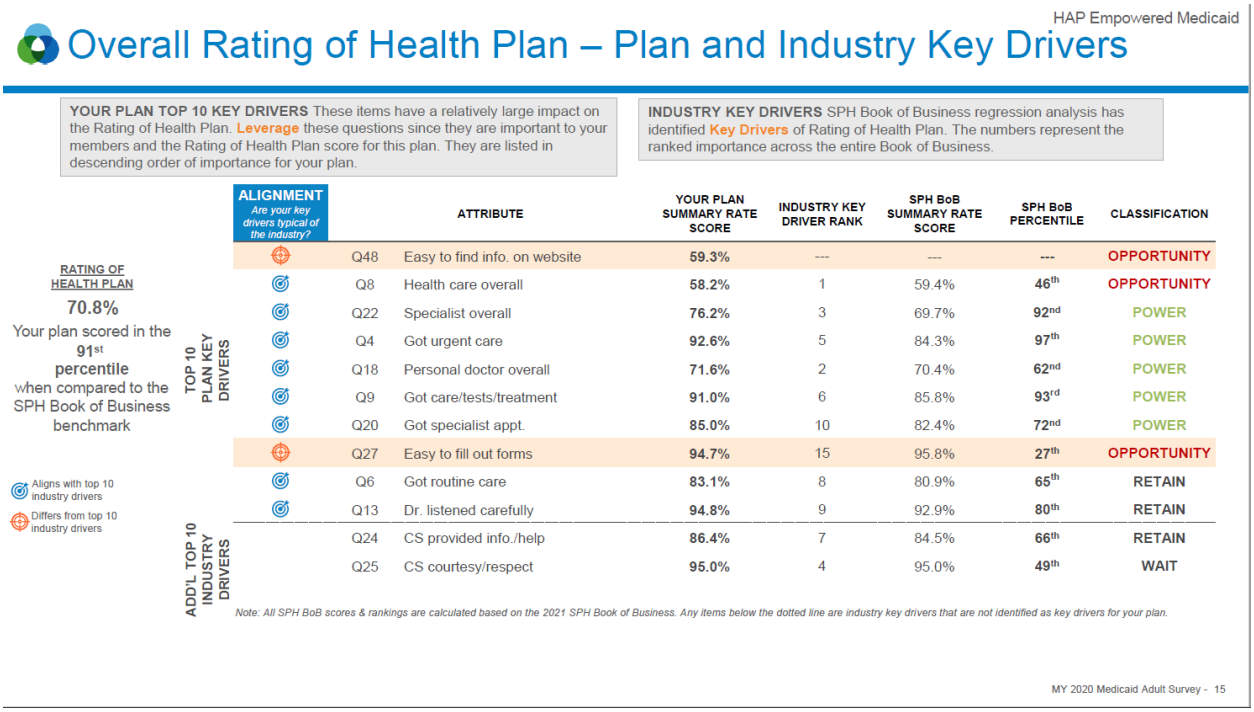


HAP Empowered Medicaid

Overall Rating of Health Plan – Plan and Industry Key Drivers

YOUR PLAN TOP 10 KEY DRIVERS These items have a relatively large impact on the Rating of Health Plan. **Leverage** these questions since they are important to your members and the Rating of Health Plan score for this plan. They are listed in descending order of importance for your plan.

INDUSTRY KEY DRIVERS SPH Book of Business regression analysis has identified **Key Drivers** of Rating of Health Plan. The numbers represent the ranked importance across the entire Book of Business.

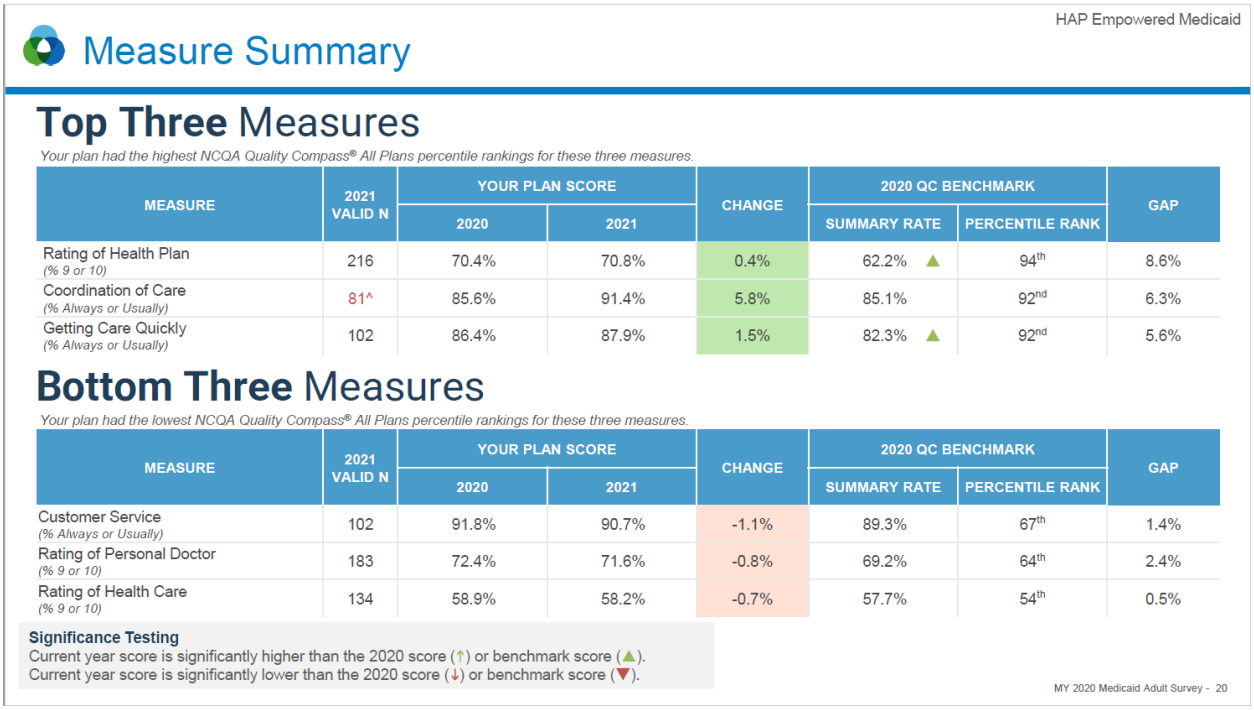
RATING OF HEALTH PLAN
70.8%
Your plan scored in the **91st percentile** when compared to the SPH Book of Business benchmark

Aligns with top 10 industry drivers
Differs from top 10 industry drivers

	ALIGNMENT (Are your key drivers typical of the industry?)		ATTRIBUTE	YOUR PLAN SUMMARY RATE SCORE	INDUSTRY KEY DRIVER RANK	SPH BoB SUMMARY RATE SCORE	SPH BoB PERCENTILE	CLASSIFICATION
TOP 10 PLAN KEY DRIVERS	◎	Q48	Easy to find info. on website	59.3%	---	---	---	OPPORTUNITY
	◎	Q8	Health care overall	58.2%	1	59.4%	46th	OPPORTUNITY
	◎	Q22	Specialist overall	76.2%	3	69.7%	92nd	POWER
	◎	Q4	Got urgent care	92.6%	5	84.3%	97th	POWER
	◎	Q18	Personal doctor overall	71.6%	2	70.4%	62nd	POWER
	◎	Q9	Got care/tests/treatment	91.0%	6	85.8%	93rd	POWER
	◎	Q20	Got specialist appt.	85.0%	10	82.4%	72nd	POWER
	◎	Q27	Easy to fill out forms	94.7%	15	95.8%	27th	OPPORTUNITY
	◎	Q6	Got routine care	83.1%	8	80.9%	65th	RETAIN
	◎	Q13	Dr. listened carefully	94.8%	9	92.9%	80th	RETAIN
ADD'L TOP 10 INDUSTRY DRIVERS		Q24	CS provided info./help	86.4%	7	84.5%	66th	RETAIN
		Q25	CS courtesy/respect	95.0%	4	95.0%	49th	WAIT

Note: All SPH BoB scores & rankings are calculated based on the 2021 SPH Book of Business. Any items below the dotted line are industry key drivers that are not identified as key drivers for your plan.

MY 2020 Medicaid Adult Survey - 15



HAP Empowered Medicaid

Measure Summary

Top Three Measures

Your plan had the highest NCQA Quality Compass® All Plans percentile rankings for these three measures.

MEASURE	2021 VALID N	YOUR PLAN SCORE 2020	YOUR PLAN SCORE 2021	CHANGE	2020 QC BENCHMARK SUMMARY RATE	2020 QC BENCHMARK PERCENTILE RANK	GAP
Rating of Health Plan *(% 9 or 10)*	216	70.4%	70.8%	0.4%	62.2% ▲	94th	8.6%
Coordination of Care *(% Always or Usually)*	81^	85.6%	91.4%	5.8%	85.1%	92nd	6.3%
Getting Care Quickly *(% Always or Usually)*	102	86.4%	87.9%	1.5%	82.3% ▲	92nd	5.6%

Bottom Three Measures

Your plan had the lowest NCQA Quality Compass® All Plans percentile rankings for these three measures.

MEASURE	2021 VALID N	YOUR PLAN SCORE 2020	YOUR PLAN SCORE 2021	CHANGE	2020 QC BENCHMARK SUMMARY RATE	2020 QC BENCHMARK PERCENTILE RANK	GAP
Customer Service *(% Always or Usually)*	102	91.8%	90.7%	-1.1%	89.3%	67th	1.4%
Rating of Personal Doctor *(% 9 or 10)*	183	72.4%	71.6%	-0.8%	69.2%	64th	2.4%
Rating of Health Care *(% 9 or 10)*	134	58.9%	58.2%	-0.7%	57.7%	54th	0.5%

Significance Testing
Current year score is significantly higher than the 2020 score (↑) or benchmark score (▲).
Current year score is significantly lower than the 2020 score (↓) or benchmark score (▼).

MY 2020 Medicaid Adult Survey - 20

IMPROVEMENT STRATEGIES

Customer Service:

- Provide on-going periodic CSR service training, open discussions and routine refresher programs.

CQMC: April 12,2022

- Involve the CS team in QI activities, seeking concrete customer-based input and improvements.
- Ensure they are fully informed of updates/changes to process & procedures.

Rating of Personal Doctor:

- 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.

Rating of Health Care:

- Communicate and educate all areas of company on CAHPS, sharing findings, initiatives and outcomes.
- Foster strong relationships with contracted providers via regular communications and collaboration.
- Seek to simplify requirements, processes, and/or procedures impacting the member experience of care
- and access to care, tests or treatment.

PROVIDER SATISFACTION:

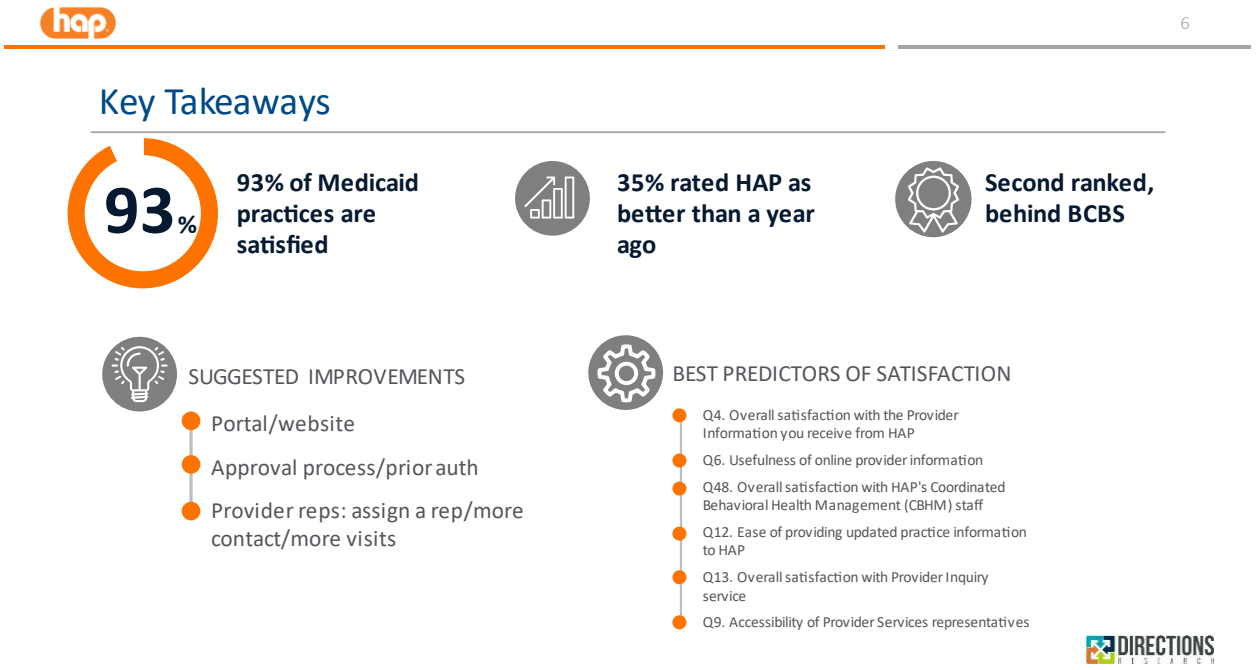
HAP Empowered annually conducts a Provider Satisfaction Survey to obtain an understanding of overall satisfaction among provider practices within the HAP network with the following objectives:

- Assess and monitor provider practice satisfaction with HAP utilization management (UM) process to support HMO and PPO NCQA Accreditation
- Identify opportunities for HAP to improve services to provider partners
- Provide data to support and develop internal stakeholder initiatives

Methodology

- The 2021 methodology focused on emailed survey invitations. HAP provided email addresses for some practices, and RAI appended additional emails for additional practices based on calling results from previous research conducted on HAP's behalf in 2020. More than two-fifths of practices (45%; 1149 of 2526 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, 1411 practices (56%) were emailed survey invitations, some at multiple addresses.
- All practices who did not respond to the email inquiries were mailed a packet in mid-September including a survey, cover letter, and return envelope. Instructions were given on how to complete surveys by mail, web, or phone. As in 2020, only a single mailing was made to practices.
- The mailing included a unique six-digit identification number that was used to track participating practices.

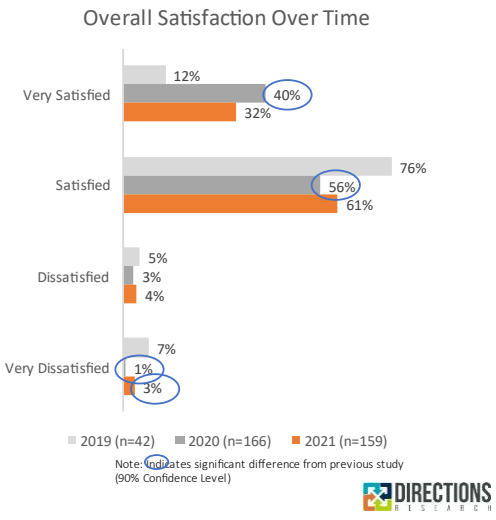
- Follow-up telephone calls were placed concurrently with email and mail invitations to encourage participation by mail or web. Fax surveys were not offered in 2021. Up to five phone calls were placed to each practice to encourage participation.
- Survey results were collected between August 17, 2021, and November 16, 2021.
- The results in this report reflect only those from the 159 Medicaid practices. The 2019 study only included Region 6 Medicaid practices, but beginning in 2020, Region 10 practices were also included.



Top Findings

Overall Measures

- A vast majority of practices (93%) reported being satisfied with their overall relationship with HAP.
- Satisfaction levels increased in2020 and remained stable in 2021.
- Nearly two-fifths (36%) of practices rated HAP's services as being better than a year ago. Few (5%) thought the services were worse than a year ago.
- The primary suggestions from practices were to improve the provider portal, approval process, and contact with provider reps.



HAP Empowered
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Ratings Over Time

Medicaid Practices

	Total Medicaid 2019 (n=43)	2020 (n=173)	2021 (n=159)	Change
Overall Satisfaction				
Q1. Your overall relationship with HAP	12%	40%	32%	-8%
Provider Information				
Q4. Overall satisfaction with the Provider Information you receive from HAP	15%	33%	26%	-7%
Q5. Usefulness of HAP updates	18%	36%	28%	-8%
Q6. Usefulness of online provider information	16%	35%	27%	-8% ↓
Provider Services				
Q8. Overall satisfaction with Provider Services	14%	33%	28%	-5%
Q9. Accessibility of Provider Services representatives	15%	29%	27%	-2%
Q10. Timeliness of responses from representatives	15%	30%	27%	-3%
Q11. Ability to address your question or concern	16%	27%	25%	-2%
Q12. Ease of providing updated practice information to HAP	-	31%	28%	-3%
Provider Inquiry				
Q13. Overall satisfaction with Provider Inquiry service	9%	32%	26%	-6%
Q14. Ease of using the automated phone system to verify benefits and member eligibility	15%	36%	25%	-11% ↓
Q15. Length of phone wait time to speak with a representative	6%	26%	19%	-7%
Q16. Ability of representative to answer claims questions	12%	30%	24%	-6%
Q17. Timeliness of responses to your questions/inquiries	9%	30%	24%	-6%

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

Medicaid Practices

	Total Medicaid 2019 (n=43)	2020 (n=173)	2021 (n=159)	Change
Online Services				
Q18. Overall satisfaction with HAP's online provider portal	21%	32%	26%	-6%
Q19. Claims appeal application	10%	31%	21%	-10% ↓
Q20. HCC Process	11%	34%	20%	-14% ↓
Q21. Managing user IDs and passwords	21%	33%	20%	-13% ↓
Q22. Access to patient records and gaps in care	27%	32%	19%	-13% ↓
Claims Processing				
Q24. Overall satisfaction with Claims Processing	13%	28%	26%	-2%
Q25. Ease of submitting claims	15%	34%	26%	-8%
Q26. Clarity of HAP claims remittance advice (RA)	14%	31%	26%	-5%
Q27. Ease of checking claims status using the provider portal	17%	31%	28%	-3%
Q28. Ease of checking claims status using the automated phone system	18%	32%	26%	-6%
Q29. Timeliness of claims processing	16%	32%	26%	-6%
Q30. Timeliness of reimbursement payments	16%	32%	26%	-6%
Utilization Management				
Q31. Overall satisfaction with the utilization management process	13%	26%	24%	-2%
Q32. Length of phone wait time to speak with a UM representative	10%	27%	22%	-5%
Q33. Knowledgeable UM staff	8%	30%	21%	-9%
Q34. Timeliness of UM decisions on pre-authorization requests	4%	26%	18%	-8%
Q35. The in-network outpatient referral management process	12%	28%	20%	-8%
Q36. The out-of-network outpatient referral management process	9%	27%	20%	-7%
Q37. HAP's efforts to reduce or eliminate hassle factor of getting patients the services they need	14%	28%	23%	-5%

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

Medicaid Practices

	Total Medicaid 2019 (n=43)	2020 (n=173)	2021 (n=159)	Change
EviCore Referrals and Authorizations				
Q39. EviCore for High Tech Imaging	15%	31%	21%	-10% ↓
Q40. EviCore for Cardiac Implantables	17%	32%	28%	-4%
Q41. EviCore for Pain Management	18%	28%	26%	-2%
Q42. EviCore (formerly MedSolutions) for sleep studies	15%	29%	25%	-4%
Pharmacy Services				
Q43. Ease of determining if a prescription drug requires prior authorization	6%	23%	15%	-8% ↓
Q44. Ease of submitting a request for prior authorization for prescription drugs	6%	24%	16%	-8% ↓
Q45. Ease of determining if a medical drug requires prior authorization	3%	24%	16%	-8% ↓
Q46. Ease of submitting a request for prior authorization for medical drugs (online through CareAffiliate)	3%	26%	18%	-8%
Q47. Resolution of appeals for medications	4%	24%	16%	-8%
Behavioral Health				
Q48. Overall satisfaction with HAP's Coordinated Behavioral Health Management (CBHM) staff	13%	28%	24%	-4%
Q49. Timeliness of feedback from Behavioral Health providers	13%	27%	21%	-6%
Q50. Referrals to behavioral health providers using CareAffiliates	12%	26%	24%	-2%

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

Medicaid Practices

	Total Medicaid 2019 (n=43)	2020 (n=173)	2021 (n=159)	Change
MI Health Link MMP				
Q55. Participation in Integrated Care Team (ICT) meetings	100%	39%	33%	-6%
Q56. Participation in Individual Integrated Care and Supports Plan (IICSP) development	100%	38%	34%	-4%
Q57. The PCP referral process to Specialists	100%	38%	28%	-10%
Q58. The PCP referral process to Long Term Services and Supports (LTSS) providers	100%	38%	39%	+1%
Q59. The PCP referral process to Prepaid Inpatient Health Plan (PIHP) providers	100%	43%	41%	-2%
HAP Network				
Q60. The number of specialists in HAP's provider network	12%	24%	18%	-6%
Q61. Level of collaboration from specialists for shared patients	8%	23%	17%	-6%
Q62. Timeliness and completeness of feedback from specialists	5%	24%	16%	-8%
Q63. Timeliness and completeness of feedback from hospitals or ER facilit	11%	26%	18%	-8% ↓
Q64. Timeliness and completeness of feedback from Skilled Nursing or Rel facilities	13%	26%	18%	-8%
Q65. Timeliness and completeness of feedback from external hospital laboratories	-	-	19%	
HAP Care Management Programs				
Q67. Overall satisfaction with the HAP Care Management programs	40%	38%	33%	-5%
Q68. Helpfulness of HAP's Care Management clinical staff	40%	40%	32%	-8%
Q69. HAP's coordination of care for patients with multiple or complex conditions	40%	45%	32%	-13%

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

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PATIENT SAFETY

HAP Empowered addressed patient safety during 2021 in a variety of areas, including:

- Maintained oversight of regulatory guidelines from the Center for Medicare and Medicaid Services (CMS) and to apply updates to HAP processes for compliance with monitoring health care acquired conditions.
- Maintained an ongoing process to monitor and investigate hospital-acquired conditions (HACs) and provider preventable conditions (PPCs).
  Monitoring & investigating for the CMS Serious Reportable Events (SRAE's) and Hospital Acquired Conditions (HAC)
- Publishing safety information for members in the HAP Empowered member newsletters and handbooks.
- Publishing safety information for providers in the HAP Empowered PCP newsletter, administrate manual for providers and website
- Promoted increased awareness and safe working conditions by collaborating with the Director of Support Services for Building Operations in response to the COVID pandemic.
- Collaborated with HAP's Director of Support Services for Building Operations to promote awareness of corporate safety responses to emergencies including pandemics, fire and weather disasters, and workplace violence.
- Maintained liaison relationship with HFHS for alignment of patient and member safety goals through participation on the HFHS Resuscitation Advisory Council (RAC) and communicated pertinent discussions to the Quality & Safety Committee.
- 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 and for use by HAP.

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 access our 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

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HAP Empowered has improved member experience, care coordination, community outreach and member services. Throughout 2021, there have been continuous enhancement in the structure for the Medicaid improvement efforts including:

- Holding bi-weekly 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 (P4P)

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2022 Initiatives

- Enhance HEDIS Performance Monitoring/Reporting and provider and member outreach
    - Adults' Access to Preventive and Ambulatory Health Services (AAP)
    - Children and Adolescents' Access to Primary Care Practitioners (CAP)
    - Women's Health Measures
    - Diabetes Care
- Maintain HEDIS, CAHPS and NCQA plan rankings
- Continue efforts toward maintaining regulatory, State, and CMS compliance
- Continue to develop and enhance performance improvement projects
- Continue to enhance and collaborate with Provider Network team on the Provider Best Practice Program
- 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
    - Hepatitis C
    - Population Health Management focusing on Social Determinants of Health and Behavioral Health