michigan complete health

2020 MI Health Link Annual Evaluation Overview

I. Introduction

Michigan Complete Health (MCH) is a health plan that contracts with both Medicare and Michigan Medicaid to provide the benefits of both programs to qualifying enrollees under the MI Health Link demonstration program. MCH is owned and operated by Centene. Centene is a premier health care enterprise insuring more than 23 million lives, nationally. In addition to being the largest Medicaid Managed Care Organization in the United States, Centene is proud to be a national leader in managed care long-term services and support. MCH evaluates its MI Health Link Quality Improvement (QI) program, annually, to identify best practices, as well as identify opportunities for improvement. This document summarizes the MI Health Link Quality Improvement Annual Evaluation. The full Annual Evaluation is available to in-network providers upon request.

II. The COVID-19 Pandemic Impact

In March 2020, the State of Michigan declared a state of emergency due to the ongoing coronavirus disease 2019 (COVID-19) pandemic. The "Stay at Home" Executive Order had an exhaustive effect upon every facet of the United States healthcare system, from postponed/cancelled non-emergent or elective medical procedures and appointments to widespread provider office closures and extremely limited physician availability. Once State mandated restrictions were partially lifted, members' hesitancy to attend in-person office visits remained at an all-time high. Furthermore, revised federal mandates considerably modified eligibility requirements, MCH's member enrollments and retention rates increased and disenrollments ceased in 2020. In efforts to support the community during difficult times, MCH established various member-focused initiatives such as health and safety guidance, mass mask distribution, care coordination services, COVID-19 testing facilitation and vaccination education.

III. Population Overview

MCH has been operating in the State of Michigan as a Medicare-Medicaid managed care organization since March of 2015, servicing two counties: Wayne and Macomb. As a result of the acquisition of WellCare, MCH has been structurally integrated with MeridianComplete (Meridian). However, it remains a distinct health plan. MCH is a Medicare-Medicaid plan servicing 2,900 dual-eligible enrollees in the State of Michigan as of December 2020. MCH's population is 95.8% English-speaking with 48.5% of enrollees reporting their race as Black (Non-Hispanic), 38.5% as White (Non-Hispanic), and 1.9% as Hispanic. The majority of the population is ages 65+ years or older, 53.2%.

IV. Disease Management Program

MCH continued to successfully maintain the multi-year Chronic Care Improvement Program (CCIP) which focuses on assisting members on antidepressant medication and the management of their condition. Major depression can lead to serious impairment in daily functioning,

including change in sleep patterns, appetite, concentration, energy and self-esteem, and can lead to suicide, the 10th leading cause of death in the United States each year. The mission of MCH's current CCIP is to engage members in the Antidepressant Medication Management (AMM) HEDIS® measure population with an increased outreach initiative to improve health outcomes and increase member satisfaction The program promotes effective medication management, helps improves the care and health outcomes for impacted members in the population over a three year span. Many behavioral health services are carved out in the State of Michigan. MCH works collaboratively with the State of Michigan behavioral health benefits administrator through Prepaid Inpatient Health Plans (PIHP). MCH worked collaboratively with the PIHPs to implement interventions to the target population to improve AMM performance. Performance fell short of program goals in 2020. MCH has experienced a steady decline in both AMM rates from 2018 to 2020. MCH will continue working with PIHPs to implement new processes and strategies targeting improvement of AMM rates in 2021.

2018-2020 AMM Rates

Measure	HEDIS® 2018	HEDIS® 2019	HEDIS® 2020
Antidepressant Medication Management-Effective Acute Phase Treatment	83.52%	64.41%	61.54%
Antidepressant Medication Management-Effective Continuation Phase Treatment	58.24%	54.24%	53.85%

V. Quality Improvement Project

In 2020, MCH continued the MDHHS selected multi-year Quality Improvement Project (QIP), Follow-Up After Hospitalization for Mental Illness within 30 days (FUH). The three-year initiative focuses on increasing the rate at which enrollees follow-up after hospitalizations due to a behavioral health diagnosis. The goal of the QIP is to specifically increase compliance of 30-day follow-up visits with a mental health provider after the occurrence of a behavioral health admission. MCH was unable to successfully meet the requirements of the QIP in 2020, but continues to work towards improving future performance of the QIP. The table below displays the final performance results for the measure for years 2018-2020.

HEDIS® FUH- 30 Days Scores

Year	HEDIS Score
2018	41.51%
2019	29.41%
2020	40.35%

A. Year over year comparison to the baseline year's performance (2018) of the FUH HEDIS® measure rates are utilized to determine QIP success. The 2018 (Baseline year) FUH measurement yielded a rate of 41.5%. The 2019 yielded a rate of 29.4%. In 2020, The FUH rate, 40.35%, demonstrated an increase of 10.9%.

B. The significant rate improvement in 2020 is attributed to targeted interventions for the QIP, which involves intensive member engagement process via MCH's Transition of Care program, provider education and collaborations with external partners.
C. The goal for the three year project was 56%. MCH did not meet the goal.

VI. Behavioral Health

Many behavioral health services covered by MI Health Link are a carve-out and are managed by Michigan Prepaid Inpatient Health Plans (PIHPs). The PIHPs are organizations that the Department of Community Health contracts with to administer the Medicaid-covered community mental health benefit. BH services are provided for people with mental illness, intellectual/developmental disability, and/or substance use disorder. MCH collaborates with the PIHPs to jointly coordinate members' care. Routine meetings were held to discuss pertinent member needs and key indicators.

VII. Long Term Support Services (LTSS)

LTSS is a comprehensive benefit offered to all MCH enrollees. The goal of LTSS is to improve health and maximize independence. LTSS is covered by the MI Health Link program and includes services such as preventive nursing services, respite, home delivered meals and much more. MI Health Link has a unique benefit with a rigorous qualification process called the Home and Community Based Services (HCBS) Waiver.

A. A few of the services offered to MI Health Link program members include but are not limited to the following; personal emergency response systems (PERS), chore services, adult day program, non-medical transportation, adaptive medical equipment, environmental modifications.
B. A few of the most authorized LTSS services for MCH members in 2020 were home delivered meals, personal emergency response systems (PERS) and chore services. In 2020, 17.13% (502) of MCH members received HCBS services and 9.01% (264) received nursing facility services

VIII. Provider Satisfaction

A. To assess provider satisfaction for MCH in 2020, MCH contracted with a vendor to conduct a provider satisfaction survey. The survey included PCPs, specialists and behavioral health providers. Of the 1,345 providers included in the sample, MCH received a response rate of 7.0%.
B. Key Takeaways
    i. MCH scored at the 49th percentile in overall satisfaction with the plan and when compared to 2019 Summary rate scores improved by 2020 by 6 percentage points. MCH also increased performance in Comparative Rating to All Other Plans and Finance Issues.
    ii. MCH also had a Net Satisfaction Score of 54.0% and a Net Loyalty Score of 39.0%. This indicates that though MCH's overall summary rates have not

increased, MCH overall is making improvements to maintain provider satisfaction.

iii. In 2021, MCH will continue to work proactively with providers and office staff to improve upon overall provider satisfaction.

Highest Rated Composites	Lowest Rated Composites
Overall Provider Satisfaction	Provider Relations
Willingness to Recommend Health Plan	Pharmacy
Health Plan Call Center Staff Service	Network/Care Coordination

C. MCH will continue to train providers on the different processes, increase applicable communication, and assist providers in best serving members. As well as create an interdepartmental Member and Provider Satisfaction Workgroup that will partner closely with stakeholders from across the organization to address opportunities for improvement and address potential provider future provider abrasions

IX. Patient Safety

MCH is committed to improving the safety of clinical care provided to members in any patient care setting. MCH actively seeks out opportunities and addresses member safety issues as they arise. MCH recognizes the role that culture, literacy, and disparities play in the provision of safe and effective health care and works to reduce the impact of these factors.

A. MCH promotes the use of Michigan Quality Improvement Consortium (MQIC) Clinical Practice Guidelines (CPGs) for the MCH Provider Network to reference. In addition, MCH references other CPGs which include, but are not limited to:
   i. American Heart Association
   ii. Department of Veterans Affairs (VA)
   iii. National Institute for Health & Clinical Excellence (NICE)
   iv. The National Practice Guideline

B. The active CPGs are available to providers and are located on the health plan's website. At least every two years, each CPG is reviewed internally to determine relevance and if it is still a best practice. Providers are notified via the Provider Newsletter, email, fax, or other correspondence when CPGs are updated, changed, or retired. CPGs are available for both medical and behavioral health needs

C. MCH works with the provider network and PIHP partner to ensure critical incidents are reported timely and accurately. Critical incidents, quality of care grievances, and adverse event summaries are reviewed at the Quality Improvement Committee meeting.

X. Care Coordination

MCH has a robust Care Coordination model that promotes the organization of member care activities between two or more participants (including the member) involved in a member's care. The services provided by Care Coordination are to facilitate the appropriate delivery of long-term support, community, specialty, and behavioral and physical health care services. MCH's Care Coordination team collaborates with the provider network, including long-term support services, medical, behavioral health, and pharmaceutical services. Overall effectiveness of Care Coordination is discussed at the Quality Improvement Committee meeting.

XI. Member Satisfaction

MCH values and utilizes feedback provided by members to implement new or improve upon processes that will increase overall member satisfaction. In 2020, MCH focused on the following quality initiatives to increase member satisfaction:

A. Enrollee Satisfaction Surveys

i. MCH's Quality Improvement department analyzes data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, which is conducted annually through a certified vendor. Although CMS eliminated 2020 survey data submission requirements for MA & PDP CAHPS due to COVID-19, MCH's surveys were previously distributed in the field so data received was used for QI purposes.

ii. The 2020 response rate was 22.4%, which was a slight decrease when compared to the 2019 response rate of 26.3%.

iii. In 2021, MCH plans to conduct interventions, including a Member and Provider Satisfaction workgroup, to address these barriers and improve satisfaction.

iv. Performance on the following composites was noted:

Highest Rated Composite Measures*	Lowest Rated Composite Measures*
Customer Service	Annual Flu Vaccine
Getting Needed Prescriptions	Getting Care Quickly
Care Coordination	Getting Needed Care

*Compared to the National MMP average for 2019

B. Consumer Advisory Committee

i. Quarterly Consumer Advisory Committee (CAC) meetings are conducted to obtain direct member feedback. The feedback obtained from the CAC meetings is used to enhance the MI Health Link program, better serve the needs of members, and improve overall member satisfaction. New for 2020, MCH obtained member feedback via a virtual meeting setting. Various topics were discussed during the 2020 CAC meetings including, but not limited to; member experience of care, member surveys, member call campaigns, member rewards program, member

benefits, marketing materials, medical management/ care coordination updates, member services updates, vendor management updates, review Ombudsman report, review CAHPS® scores, and COVID-19 updates. MCH will continue conducting quarterly CAC meetings into 2021 and will continue encouraging members to lead the discussion on topics of choice. Member feedback will be utilized to inform and strengthen QI interventions.

XII. Accessibility of Practitioners and Availability of Practitioners

A. In 2020, MCH completed the annual Access and Availability Study on primary care providers (PCP) and specialty and behavioral health (BH) providers to assess the ease with which enrollees could obtain services at the time they are needed.
B. There must be one PCP within a 30 minute travel distance for every 2,000 MCH members and one high volume specialist within a 30 minute travel distance for every 3,000 MCH members. In 2019 and 2020, MCH's network was sufficient to meet the needs of its membership and is able to provide appropriate access and availability to members.
C. Identified opportunities for improvement are reported to the Quality Improvement Committee with a plan to rectify deficiencies.

Measure	2019	2020
Network Adequacy	100%	100%

XIII. Culturally and Linguistically Appropriate Services Analysis

A. In 2020, MCH conducted the annual assessment of cultural, ethnic, and linguistic needs of the member population to ensure that composition of the provider network adequately supports member needs
B. The goal is for at least 98% of members in MCH service counties to have access to a provider who speaks their language. The goal of 98% language match, was not met and MCH has identified opportunities for improvement. Achieving this 98% goal is one way MCH works to improve quality of care and reduce disparities in care. The rate of access was determined to be 96.9%.
C. MCH continues to offer educational materials to providers to help encourage them to use cultural competency in their practices. Annual cultural competency training is required for all in network providers. Practices that improve cultural competency skills can result in a reduction in misdiagnoses and increased member engagement. Internal associates are required to complete annual training on cultural competency to ensure they are doing their part to improve member satisfaction
D. MCH's Network Development team will continue to acquire more diverse physicians within all service areas. This will include targeting providers and health systems in counties outside of the service area to address future growth

XIV. Utilization Management

A. Utilization Management clinical associates are responsible for utilization management decisions that involve the application of clinical criteria. All clinical associates complete an inter-rater assessment biannually to assess consistency and accuracy in application of clinical criteria. These results are shared at the quarterly Quality Improvement Committee meeting

B. MCH analyzes denial data quarterly to determine patterns in utilization, make necessary policy changes, and identify opportunities for improvement

XV. HEDIS®

A. MCH participates annually in HEDIS® reporting. HEDIS® performance, in combination with CAHPS® performance, has been shown to be an effective means of displaying a reliable method for assessing the evolution of health plan quality performance. Calendar year 2020, MCH was successfully audited for HEDIS® compliance, as is required for all health plans reporting HEDIS® data.

B. In 2020, many measure COVID-19 negatively impacted members' ability to attend regular primary care visits and complete preventive services. In addition, the pandemic affected MCH's ability to collect hybrid medical records and conduct year round medical record abstraction for supplemental data.

C. MCH will continue to work toward improving performance on all HEDIS® measures, with an emphasis on improving efforts toward increasing the COA measure performance. Because both, medical record review and office visits were limited by COVID-19, MCH plans to conduct additional interventions and provider education in 2021. MCH also saw larger decreases with controlling high blood pressure, diabetic eye exams and preventive care measures. MCH will also review and identify interventions for measures with small populations that exhibited decreases during measurement year 2020 in order to increase performance, such as OMW and ART Prevention and Screening measures, Cardiovascular Condition measures through various channels of member and provider outreach, education, and engagement

D. The table below represents some key measures that MCH monitors:

Domain	Measure	HEDIS® 2019	HEDIS® 2020	HEDIS® 2021	MMP State Average^	HEDIS® 2020 - HEDIS® 2021 % Change
Prevention and Screening	Breast Cancer Screening	53.81%	54.42%	52.54%	58.8%	-1.88%
	Colorectal Cancer Screening	39.66%	40.39%	41.36%	50.9%	0.97%
	Care for Older Adults: Advance Care Planning	33.82%	55.47%	29.44%	47.2%	-26.03%
	Care for Older Adults - Medication Review	96.35%	95.13%	83.21%	73.8%	-11.92%

	Care for Older Adults - Functional Status Assessment	67.40%	71.53%	40.63%	64.2%	-30.90%
	Care for Older Adults – Pain Assessment	67.88%	69.10%	43.07%	73.7%	-26.03%
Respiratory Conditions	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	23.40%	15.22%	18.00%	26.5%	2.78%
	Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid	66.07%	59.70%	56.72%	70.2%	-2.98%
	Pharmacotherapy Management of COPD Exacerbation – Bronchodilator	87.50%	95.52%	80.60%	88.9%	-14.92%
Cardiovascular Conditions	Controlling High Blood Pressure	57.42%	54.74%	41.12%	63.9%	-13.62%
	Persistence of Beta-Blocker Treatment After a Heart Attack	100.00%	100.00%	60%	92.4%	-40.00%
	Statin Therapy for Patients with Cardiovascular Disease – Received Statin Therapy	78.46%	76.71%	72.73%	78.1%	-3.98%
	Statin Therapy for Patients with Cardiovascular Disease – Statin Adherence 80%	74.51%	71.43%	72.92%	74.8%	1.49%
Diabetes	Comprehensive Diabetes Care – HbA1c Testing	91.26%	86.30%	78.1%	88.7%	-8.20%
	Comprehensive Diabetes Care – Poor HbA1c Control*	46.72%	81.37%	70.07%	39.1%	-11.30%
	Comprehensive Diabetes Care – HbA1c Control (<8.0%)	45.08%	15.34%	26.52%	51.4%	11.18%
	Comprehensive Diabetes Care – Eye Exams	59.02%	50.41%	37.71%	64.2%	-12.70%
	Comprehensive Diabetes Care – Medical Attention for Diabetic Nephropathy	91.80%	90.14%	89.29%	93.2%	-0.85%
	Comprehensive Diabetes Care – Blood Pressure Control <140/90	60.38%	35.34%	39.66%	60.4%	4.32%
	Statin Therapy for Persons with Diabetes – Received Statin Therapy	77.33%	75.74%	77.31%	72.5%	1.57%
	Statin Therapy for Persons with Diabetes – Statin Adherence 80%	82.76%	71.90%	85.63%	75.4%	13.73%
Musculoskeletal Conditions	Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	60.00%	80.00%	45.45% (NR)	70.2%	-34.45%
	Osteoporosis Management in Women Who Had a Fracture	25.00%	20.00%	0% (NR)	14.9%	-20.00%

Behavioral Health	Antidepressant Medication Management – Effective Acute Phase Treatment	83.52%	61.54%	69.12%	61.6%	7.58%
	Antidepressant Medication Management – Effect Continuation Phase Treatment	58.24%	53.85%	61.76%	46.3%	7.91%
	Follow-Up After Hospitalization for Mental Illness – 7 Days	32.08%	29.82%	28.36%	24.4%	-1.46%
	Follow-Up After Hospitalization for Mental Illness – 30 Days	41.51%	40.35%	49.25%	48.7%	8.90%
	Follow-Up After Emergency Department Visit for Mental Illness – 7 Days	21.43%	25.00%	19.05%	21.0%	-5.95%
	Follow-Up After Emergency Department Visit for Mental Illness – 30 Days	35.71%	48.08%	38.10%	41.4%	-9.98%
	Potentially Harmful Drug-Disease Interactions in the Elderly*	31.79%	25.76%	17.39%	42.9%	-8.37%
	Use of High-Risk Medications in the Elderly *	12.13%	N/D	10.89%	19.4%	N/A
Risk Adjusted Utilization	Plan All-Cause Readmissions – Observed to Expected Ratio (ages 18-64)*	0.50	0.86	1.075	0.66	0.215
	Plan All-Cause Readmissions – Observed to Expected Ratio (ages 65+)*	N/D	1.56	1.073	0.68	-0.49

(*)Lower rates indicate better performance

^MMP State Average is displayed for 2019 for HEDIS® measures due to CMS reporting requirements changed as a result of COVID-19

XVI. Overall Summary

In 2020, the COVID-19 pandemic added an additional layer of complexity to MCH's efforts to successfully close health care gaps across the health plan and improve overall satisfaction. MCH's QI Program was considered effective as it achieved its QI Program objectives. In 2021, the health plan will continue strengthening its partnership with the PIHP partners and improve collaboration efforts on the behavioral health transition of care (TOC) process. This focus will be an effort to improve upon the FUH rate for the QIP and the CCIP. MCH will also continue to focus on implementing initiatives towards increasing Cardiovascular Health, Diabetes Care measures, Behavioral Health measures, and other preventive health measures where performance declined. MCH will also focus on continuing efforts to improve member and provider satisfaction, and further integration of BH and Long Term Supports and Services (LTSS) within the Quality Improvement Program.