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Quality Improvement

Program Evaluation
Michigan Medicaid
MY 2025



Table of Contents

I.	Executive Summary	4
II.	Introduction and Program Overview.....	6
III.	Organization Structure and Administration	8
A.	QI Program Oversight Bodies and Committees	9
	HAP CareSource Board of Directors (BoD)	9
	HAP CareSource Joint Operations Committee (JOC)... Error! Bookmark not defined.	
	HAP CareSource Quality Improvement Committee (QIC)	10
	HAP CareSource Provider Advisory Committee (PAC).....	10
	Member Advisory Council (MAC)	100
	Quality Enterprise Committee (QEC).....	11
	Enterprise Provider Advisory Committee (EPAC)	11
	Pharmacy & Therapeutics Committee (P&TC).....	12
	Enterprise Compliance Committee (ECC)	13
	Utilization Management / Care Management Committee (UMCMC).....	14
	Clinical Policy Governance Committee (CPGC).....	14
B.	Leadership Management and Practitioner Participation in the QI program	14
C.	QI Program Resources	15
IV.	Population Profile.....	21
V.	QI Program Systems & Program Components.....	24
A.	Clinical Practice Guidelines.....	24
B.	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT).....	26
C.	External Quality Review Organization Activity	30
D.	Performance Improvement Projects (PIPs).....	32
D.	Member Safety and Welfare.....	40
E.	Population Health Management Strategy.....	41
F.	Accreditation activities.....	42
VI.	Clinical Measurement Activities: Process and Outcomes.....	43
A.	Healthcare Effectiveness Data and Information Set (HEDIS®).....	43



B.	Consumer Assessment of Healthcare Providers and Systems (CAHPS®)	76
C.	Provider Satisfaction Survey	79
D.	Behavioral Health (BH) Member Satisfaction Survey	81
E.	Network Adequacy	83
F.	Customer Care.....	87
G.	Other processes and outcome measures.....	91
VII.	Delegation Oversight.....	96
VIII.	Overall Effectiveness and Adequacy of QI program, Resources, Staffing, and Committee Structure	97
	MAJOR ACCOMPLISHMENTS:.....	98
	BARRIERS:	99
	OPPORTUNITIES FOR IMPROVEMENT:	99
	RESOURCES/STAFFING:	99
IX.	Acknowledgement and Approval.....	101
X.	Appendix A: Accomplished MY2025 Goals and Objectives.....	102
XI.	Appendix B: Definitions	107



I. Executive Summary

Strategies to Improve Quality

HAP CareSource of Michigan adopted the following quality strategies to achieve its goals and fulfill its mission:

- Focus on preventive health for the served members by ensuring access to care in a timely manner and by maintaining evidence-based guidelines in prevention and health promotion.
- Focus on managing chronic conditions through robust Population Health and other programs and by adhering to and providing best practices in care
- Focus on Continuous Quality Improvement (CQI) to drive improvement across health plan's functional areas.
- Focus on ongoing compliance with the quality assurance accreditation requirements.
- Focus on oral health for the served members by ensuring access to care in a timely manner and by embedding dental quality improvement directly into existing population health and care coordination infrastructure.

Progress towards Quality Improvement (QI) Goals in CY2025:

HAP CareSource of Michigan QI Program focused on improving the quality of care and services provided to its members. During the CY2025, the program concentrated on implementing interventions to improve performance in various areas, inclusive of, but not limited to:

- Improving processes and systems to align with the Michigan Quality Strategy.
- Healthcare Effectiveness Data and Information Set (HEDIS®) and other clinical program.
- Member and provider experience.
- Access, Availability and Network Adequacy.
- Member safety.

Program Impact:

HEDIS®



In CY2025 efforts to improve HEDIS® scores supported HAP CareSource's goal to demonstrate QI and preventive health activities. The health plan set a goal of reaching 3 STARS performance according to the National Committee for Quality Assurance (NCQA) Health Plan Ratings (HPR) System. HAP CareSource demonstrated a year over year (YoY) improvement in most of the HPR and non-HPR measure HEDIS® dataset during the measurement period. Some of the high priority HEDIS® measures where the rates had a YoY decline or that did not attain goal are:

- Cervical Cancer Screening, CCS
- Diabetic Eye Exam, EED
- Chlamydia Screening, CHL
- Adult Access to Care 65+, AAP
- Immunizations for Adolescents, IMA
- Child and Adolescent Well Care Visit (All bands), WCV

Ongoing Improvement Activities in support of HEDIS®

HAP CareSource made it a priority for the organization to improve HEDIS® rates in CY2023 and beyond. To continuously improve performance, HAP CareSource will continue to improve its data collection methodologies, processes, and procedures.

Member Experience

In addition to HEDIS® clinical measures, the QI Program supported efforts to improve members' experience with services offered by the company and its provider network. In CY2025, the plan administered the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey which demonstrated the following:

- HAP CareSource saw increase on how well doctors communicate with members for both adults and children CAHPS scores.
- Doctors in our network in coordination with HAP CareSource staff saw an increase in coordination of care for our adult members.
- HAP CareSource also saw an increase in our CAHPS child measure in getting care quickly, which achieved a five-star rating.
- HAP CareSource received a 10% overall increase in rating of health care among child members in 2025 compared to 2024.

Ongoing Improvement Activities in support of member experience



HAP CareSource has initiated multi-disciplinary workgroups to improve member experience. The QI team, along with the enterprise Consumer Experience (CX) team with other functional area departments such as Utilization Management (UM), Network Management, Member Services collaborate with providers and other internal departments to improve member experience.

The HAP CareSource Community Outreach team hosted numerous care gap closure events throughout 2025, taking a “white glove” approach by reaching members in their own communities. This approach involved scheduling members for the events, arranging transportation to and from the locations, providing immediate rewards for qualifying services received, offering snacks, and sharing educational information about plan benefits while members waited for care. Leveraging data from the QI team, this strategy enabled the closure of hundreds of member care gaps during 2025.

Network Adequacy

HAP CareSource monitors performance areas affecting and reflecting provider and practitioner network adequacy. In order to ensure adequate access to primary, specialty and behavioral health (BH) care, HAP CareSource works diligently to meet network standards across its service area. The health plan will complete an analysis of availability and accessibility of CY2025 findings and take action.

II. Introduction and Program Overview

HAP CareSource¹ is a nonprofit, mission driven managed care organization (MCO) in the state of Michigan. HAP CareSource began serving Medicaid members 10/01/2023 with a purpose to deliver affordable, member-centered care delivery model that prioritizes preventive care, chronic condition management, and culturally competent services. HAP CareSource aims to support healthier communities through integrated care networks, personalized member support, and community engagement. The plan focuses on addressing social determinants of health and removing barriers to care, ensuring members receive the right care at the right time, in the right setting.

HAP CareSource focuses on being a responsible fiduciary agent of federal and state funds, channeling dollars into enhanced population health, member services and value-based programs. Currently the health plan is serving resident



of nineteen counties of the state serving members in the TANF, ABD, CHIP, CSHCS, and HMP Medicaid programs.

HAP CareSource of Michigan maintains a QI Program that provides the foundation and resources to ensure that high quality, cost-effective and safe care, and services are provided to Medicaid members. The program is designed to continuously monitor and improve multi-faceted member needs such as medical care, member's safety, BH services and the delivery of services. QI Program and its associated QI Work Plan are evaluated on an annual basis through the process of an annual QI Program Evaluation. The QI Program Evaluation provides a formal process to systematically monitor, objectively evaluate, and continuously improve the company's overall operations to ensure that member needs are met. Through the QI Evaluation, the plan is able to identify strengths in the program as well as opportunities for improvement, so that modifications to existing programs and program components inform the development of new interventions that will address identified program needs. The health plan reviews the annual QI Program Evaluation and uses the findings to establish quality management and performance improvement goals for the upcoming year. Opportunities for improvement identified in the evaluation or articulated by external regulators, accrediting bodies or other key stakeholders drive the development of the goals and objectives.

During the calendar year (CY) 2025¹, the health plan focused on evaluating existent processes and infrastructure in order to continually improve the delivery of high-quality care and services to the served membership through ongoing focus on access, quality and safety of care and services, member, and provider satisfaction along with ongoing efforts to advance health equity.

The two (2) guiding tenants of the HAP CareSource of Michigan QI Program are:

1. *"Our mission, which is our heartbeat, is to make a lasting difference in our members' lives by improving their health and well-being. Our vision is to transform lives through innovative health and life services."*
2. *The Institute for Healthcare Improvement Quintuple Aim: "Simultaneously improving the health of the population, enhancing the experience and outcomes of the patient, and the per capita cost of care for the benefit of communities focusing on: (1) Improving health outcomes; (2) Reducing per capita cost of care by ensuring members receive the right care at the right time and in the right setting; (3)*

¹ All subsequent references to activities and results from activities in 2025 (01/01/2025-12/31/2025) are referred to as calendar year (CY), measurement year (MY) regardless of the reporting periods.



Improving member experience; (4) Improving provider experience and; (5) Advancing Health Equity.”²

The overarching goals of the CY2025 QI Program were driven by the two (2) tenants along with the following primary goals:

- Member needs inclusive of health, safety, and welfare.
- Provider feedback.
- Evidence-based standards of care and best practices.
- Regulatory and business needs.

QI activities support the goals and objectives of the QI Program; the following components form the framework to meet identified goals:

- QI Program
- QI Work Plan
- QI Program Evaluation
- Policies and Procedures

The CY2025 QI Program Evaluation discusses various components of the QI Program and associated QI Work Plan activities, inclusive of, but not limited to, networks and access to care and services, performance improvement projects (PIP), program infrastructure and management, member, and provider satisfaction and, lastly, internal quality management improvement processes. This evaluation is concluded with an assessment of the overall effectiveness and impact of the CY2025 QI Program followed by discussion of identified areas for improvement.

III. Organization Structure and Administration

HAP CareSource of Michigan has a comprehensive QI committee structure comprised of various cross-functional committees that review, evaluate, and make recommendations for the improvement of services, care and experience for the served membership supported by the health plan’s leadership and dedicated resources.

Table 1: 2025 QI Structure

QI Committee Structure	QI Work Plan Activity	Met Threshold Y/N
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² Institute for Healthcare Improvement: Quintuple Aim. www.ihl.org



Quality Improvement Committee (QIC)	Quarterly	Y
Provider Advisory Committee (PAC)	Quarterly	Y
Member Advisory Committee (MAC)	Quarterly	Y
Quality Enterprise Committee (QEC)	Quarterly	Y
HAP CareSource Board of Directors (BOD)		Y
Pharmacy & Therapeutics Committee (P&TC)	Quarterly	Y
Clinical Policy Governance Committee (CPGC)	Monthly	Y

Table 1 demonstrates the CY 2025 QI committee structure activities and thresholds. All committees met as per the QI Program prescribed frequencies.

A. QI Program Oversight Bodies and Committees

HAP CareSource Board of Directors (BoD)

The HAP CareSource Management Group Board (CSMGB) has the ultimate authority and responsibility for the care and services delivered to the health plan's members. CSMGB is informed of all plan activities, performance, and outcomes through the review of the annual summaries and quarterly reports provided to the board by the HAP CareSource Executive Vice President (EVP) – Chief Medical Officer (CMO).

HAP CareSource Joint Operations Committee (JOC)

The primary purpose of the JOC, on behalf of the BoD, is to provide oversight of quality activities and their integration across the administration, health plan, communities and participating providers which includes review and approval of the QAPI Program Description, QI Work Plan, QAPI program evaluation and ongoing monitoring of QI activities, inclusive of delegation oversight and monitoring of delegated entities. Responsibilities of the JOC during CY2025 included:

- Annual review and approval of the QAPI program description, QI Work Plan and QAPI Program Evaluation.
- Ongoing monitoring of Value Based Payment Arrangements.
- Ongoing monitoring and oversight of the HAP CareSource's Population Health Management Strategy and related activities.
- Ongoing monitoring and oversight of the plan's Network Management activities.



- Ongoing monitoring and oversight of the plan's Utilization Management activities.
- Ongoing monitoring and oversight of the plan's Credentialing activities.
- Ongoing monitoring and oversight of the plan's Member Experience NCQA standard requirements and activities.
- Delegation oversight activities.

HAP CareSource Quality Improvement Committee (QIC)

The Michigan Quality Improvement Committee (QIC), chaired by the HAP CareSource Market Medical Director, provides leadership, oversight, and evaluation of the Quality Improvement Program and Work Plan for Michigan Medicaid and MI Health Link to ensure adherence to state and federal regulations. The primary responsibility of the Committee is the strategic direction, development, and continuous monitoring of annual program activities and quality and performance improvement projects.

HAP CareSource Provider Advisory Committee (PAC)

The purpose of the Provider Advisory Committee is to make available a forum for market specific practicing healthcare providers and HAP CareSource staff to discuss policy, programs, and quality initiatives. The Committee is comprised of practicing market-specific providers who are participating HAP CareSource practitioners and is representative of the major clinical specialties that serve our members. This Committee fosters discussion among practicing healthcare providers to discuss, review and make recommendations related to HAP CareSource new and revised medical policies, clinical practice guidelines, and clinical operational decisions. Establish a forum for practicing health care providers to provide input and expertise regarding new program development and changes to existing programs, to ensure clinical operations remain relevant to practicing clinicians. Provide peer review assessment and recommendations regarding HAP CareSource provider quality of care concerns, including health, safety, and welfare issues. Review and acceptance of clinical practice guidelines (medical & behavioral health) at a minimum of every two years or more often as necessary. Address ad hoc emergent Quality of Care and health, safety welfare issues. The Market Medical Director chairs the Committee. Participants include Medical and Behavioral Health Directors, Community Physicians, Dentists (if applicable) and a senior member of the Quality, Credentialing, and Health Services Departments.

Member Advisory Council (MAC)

HAP CareSource conducted four quarterly Member Advisory Committee (MAC) meetings in 2025, each addressing a range of topics. Feedback from these meetings informed strategies and policies for both the QIC and HAP CareSource



Board of Directors. The committee included diverse Medicaid members and stakeholders such as PIHPs and community organizations. In 2025, the CAC influenced member marketing strategy, plan benefit communications, and provided input on quality improvement and population health initiatives. Overall, this led to an increase in scores in targeted measures in 2025.

Quality Enterprise Committee (QEC)

The primary purpose of the QEC is to provide direction and oversight to/of quality operations across the organization by ensuring that the quality of care provided to HAP CareSource members consistently meets evidence-based care and services; and health, safety and welfare standards are all provided in a timely and consistent manner. The QEC measures, monitors, reports, sets goals and develops best practices relative to quality of care. The committee evaluates performance outcomes to support CQI. Responsibilities of the QEC during CY2025 included:

- Oversight of the Quality Improvement Programs.
- Oversight of the Quality Improvement Plans.
- Oversight of the Health, Safety, and Welfare program.
- Oversight of the Enterprise Provider Advisory Committees (PAC) activities.
- Provision of guidance on quality management priorities and projects.
- Oversight of Market quality improvement projects.
- Oversight of evaluating the effectiveness of the Market Quality Improvement Programs.
- Review of summarized reports with trending data from the Market Quality Committees, including but not limited to activities from the following areas:
 - Credentialing, Utilization Management, Pharmacy and Therapeutics, HEDIS®, Service Operations and Network / Provider Services as applicable, Grievance & Appeals, Case Management, Disease Management, and Accreditation.
- Annual review and acceptance of the Market Quality Improvement Program Descriptions, and Quality Improvement Plans.
- Annual review and acceptance of the Market Quality Improvement Program Evaluations.
- Approval of evidence-based clinical practice guidelines and nationally recognized standards of care, as well as preventive health guidelines.
- Review of NCQA standards.

Enterprise Provider Advisory Committee (EPAC)



The primary purpose of the EPAC is to provide CMOs, Clinical Quality, Policy & Appeals, Enterprise Medical Directors, BH Medical Directors, Market Medical Directors, Enterprise Dental Directors and representatives from Clinical Operations, Market Health Partners, Pharmacy, Program Integrity, Quality and Performance Outcomes, UM, and other HAP CareSource stakeholders a forum for discussions. Responsibilities of the EPAC during CY2025 included:

- Review, recommendations and adoption of Standards of Care/Evidence Based Care.
- Review, recommendations and adoption of CPGs and Preventive Service Guidelines (PSGs).
- Standardization of the Quality of Care (QoC) Case Severity Leveling System and Review Processes.
- Review Clinical Quality of Care Grievances, Quality of Care Concerns and Health, Safety and Welfare case data and trends previously reviewed and addressed by HAP CareSource Market PACs.
- Policy & Procedures related to quality of care, sentinel events, and member safety concerns.
- Develop, review, and approve standard operating procedures, quick tools and other processes related to internal and external quality reviews.
- Review trended reports and dashboards related to clinical quality of care concerns, sentinel events, and member safety cases.
- Review and make recommendations for provider performance based on quality of care, sentinel events, and member health, safety, and welfare cases.
- Provide oversight and support the convening of rapid response teams for review of sentinel events and member health, safety, and welfare cases.

Pharmacy & Therapeutics Committee (P&TC)

The primary purpose of the P&TC is to provide administration of formulary management, including specialty drugs for all lines of business. Responsibilities of the P&T Committee during CY2025 included:

- Develop and maintain formulary(ies) to ensure the pharmaceuticals covered are effective and safe.
- Review the formulary(is) in their entirety at least annually.
- Review new drugs and chemical entities, drug classes, new clinical indications, therapeutic advantages, and new safety information within six (6) months of any new market launch or change.
- Make recommendations to the Value Assessment Committee (VAC) for placement determination on the formulary using FDA-approved prescribing information, evidence-based literature, drug compendia, and



treatment guidelines. The committee will denote each pharmaceutical as: Included, Optional, and Exclude.

- Complete final review of the VAC formulary placement determinations.

Enterprise Compliance Committee (ECC)

The primary purpose of the ECC is to provide oversight of Corporate Compliance processes. Responsibilities of the CCC during MY2025 included:

- Evaluate the Company's legal, regulatory and ethical requirements
- Monitor and oversee the compliance plan
- Develop strategies to promote compliance and the detection of any potential violations, including reviewing effectiveness of the system of internal control for key processes
- Review compliance and Fraud, Waste and Abuse (FWA) training and ensure that training and education are effective and appropriately completed
- Review compliance risk assessment and ensure compliance monitoring and auditing work plan are executed
- Ensure a system for employees and First Tier, Downstream and Related Entities (FDR's) (i.e., delegated entities) to ask compliance questions and report potential instances of program noncompliance confidentially or anonymously
- Review, assess, and take appropriate action regarding reports from various sub-Committees:
- Review and approve all updates to the Corporate Compliance Plan
- Review, assess, and take appropriate action regarding reports from both internal and external compliance audits
- Review and evaluate findings and recommendations from completed compliance activities and audits, including management responses and action plans
- Review effectiveness of the system of internal controls designed to ensure compliance with Medicare regulations in daily operations
- Support compliance officer's needs for sufficient staff and resources to carry out his/her duties
- Ensure HAP CareSource has appropriate, up-to-date compliance policies and procedures
- Review and address reports of monitoring and auditing of areas in which the sponsor is at risk for program noncompliance or potential FWA and ensure that corrective action plans (CAPs) are implemented and monitored for effectiveness



- Report to the CareSource Management Group Board Audit, Risk and Compliance Committee at least quarterly, providing a detailed update on the corporate compliance program.

Utilization Management / Care Management Committee (UMCMC)

The primary purpose of the UMC is to ensure HAP CareSource UM program and processes, including review and development of clinical criteria used to make utilization review and appeal determinations adhere with state, federal and accreditation standards. Responsibilities of the UMC during MY2025 included:

- Oversees patient safety, clinical, administrative, and service quality improvement throughout HAP.
- Utilizes information gathered from the interdepartmental attendees to recommend policy decisions.
- Accountable to the Board through its Quality Committee.
- Subcommittees, such as the Credentialing Committee and the Joint Operational Committee.

Clinical Policy Governance Committee (CPGC)

The primary purpose of the CPGC is to serve as the HAP CareSource's policy setting body in support of clinical decisions that pertain to utilization review, care management (CM) activities, benefits design and other medical necessity and/or clinically related functions. Responsibilities of the CPGC during MY2025 included:

- Develop and maintain Medical Policy Statements which conform to Federal and State regulations, and which are supported by medical evidence in compliance with benefit design and which are aligned with medical necessity supporting the utilization review and care management functions of CareSource across all markets and products.
- Coordinate peer review of Medical Policy Statements by appropriate practitioners/providers.
- Coordinate integration of the relevant administrative departments responsible for the implementation of CareSource Medical Policy Statements.
- Provide Medical and Behavioral Health Director Committee referral for input as appropriate.
- Ensure Quality Enterprise Committee and Pharmacy and Therapeutics Committee status reporting.

B. Leadership, Management and Practitioner Participation in the QI program



HAP CareSource ensures that appropriate leadership and resources are available to design, oversee and improve safe, high-quality care and services to the served membership. The following program resources were dedicated to the HAP CareSource of Michigan QI program in CY2025.

C. QI Program Resources

Market Resources:

HAP CareSource Market Medical Director

The Market Medical Director is a physician with an active medical license in the state of Michigan and is responsible for the coordination and implementation of the Quality Management Improvement Program and all aspects of health services utilization and clinical strategies. The Market Medical Director chairs the quarterly Michigan QIC, PAC, Population Health, UM/CM Committee and is an active participant in various enterprise-wide subcommittees (IMSC, CPC, etc.). The Market Medical Director reviews and makes recommendations on all medical policies.

Physical Health (PH) Medical Director

In accordance with NCQA requirements, the PH Medical Director is involved in all aspects of the QI program activities. The dedicated PH Medical Director provides oversight for the clinical and quality activities and interventions, provides clinical guidance and expertise in the development of action plans and Quality Improvement Projects (QIP) and PIP, as applicable, activities.

Behavioral Health (BH) Medical Director

In accordance with NCQA requirements, the Behavioral Health (BH) Medical Director engages in all aspects of the BH Program including QI and UM activities. Our dedicated BH Medical Director provides oversight for clinical pre-service determinations for members, participates in committee meetings and is instrumental in the design of improvement initiatives to monitor and improve behavioral health outcomes.

The BH Medical Director serves as an advisor for BH programs within the health plan, which include the BH aspects of the QI Program. The BH Medical Director actively participates in various and is responsible for review and recommendations on all BH policies and procedures. The BH Medical Director provides guidance regarding the BH Strategy.

Market Dental Director



The Market Dental Director is state of Michigan licensed dental provider who is responsible for the development, implementation and ongoing oversight of activities that promote oral health.

Senior Director, Quality and Population Health

This role is assigned as Co-Chair Michigan Quality Improvement Committee and PAC. Monitors performance and outcomes across the Michigan Market to identify opportunities for improvement, leverage best practices, and share knowledge. The Senior Director oversees the development, organization, and continuously monitors the Quality Improvement Plan and QAPI annually and guides the implementation and collaboration with the Director, Population Health. The goal is to improve health outcomes through standardization of evidence-based practices. Develops, organizes, implements, and monitors the Quality Improvement Work Plan, QIP/PIP/CCIP, and QAPI. Reviews, revises, and communicates the Quality Improvement Work Plan, QIP/PIP/CCIP, and QAPI to appropriate stakeholders. Analyzes HEDIS performance and quality data to improve delivery of quality care and outcomes for members across all enterprise lines of business. The Senior Director completes quarterly reviews of the Quality Improvement program and the QAPI to appropriate stakeholders by defined timeframes. They annually evaluate the previous year's Quality Improvement Program to develop the work plan for the upcoming year.

Health & Social Partnerships Manager

Creates, executes, and manages health equity strategy for Michigan population streams as an integral part of population health and QI initiatives. This role collaborates with the IT, Health Analytics, and Quality and Population Health teams to ensure that health plan collects and meaningfully uses race, ethnicity, and language data to identify disparities. Subsequently, this work informs decision-making around best payer practices related to disparity reductions, including the provision of health equity and social determinant of health resources and research to leadership and programmatic areas.

In addition, the Health & Social Partnerships Manager of Health Equity provides HAP CareSource teams with relevant and applicable resources and research and ensuring that the perspectives of members with disparate outcomes are incorporated into the tailoring of intervention strategies. They coordinate and collaborate with members, providers, local and state government, community-based organizations.

Population Health Program Director

Population Health Program Director supports the market quality director on the strategic design, implementation, and evaluation of population health initiatives in addition to developing and implementing operational plans that address the



market opportunities/challenges and align with the established population health goals. This role also conducts assessments using qualitative and quantitative methodologies and continuous improvement tools to identify issues and opportunities to improve health outcomes.

Market Quality Managers and Team Leads

Managers and Team Leads are essential to the success of continuous quality improvement, as they drive the day-to-day work for the organization. Managers and Team Leads support the improvement efforts by continually seeking to identify opportunities in their daily work and in the work of their teams. HAP CareSource complies with state requirements to support dedicated Quality Improvement management to facilitate the overall coordination of quality improvement strategies within the market.

Market Quality Improvement Staff

Under the leadership of the Michigan Market Director Quality Improvement, staff trained in effective continuous improvement methodology coordinate, facilitate and/or support improvement initiatives and projects, lead improvement workgroups and facilitate completion of the annual work plan and program evaluation.

Other Quality Improvement Staff and Resources

The QI Department maintains a multidisciplinary team who carry out the various aspects of relevant QI functions, which include:

- HEDIS® annual submission.
- Regular review and follow-up of performance outcomes.
- Accreditation activities.
- Clinical quality monitoring.
- Clinical Quality of Care Concerns, Quality of Service Concerns, Clinical Grievance and Sentinel Events.

Regulatory Compliance

Regulatory Compliance is responsible for ensuring compliance and tracking of applicable State and Federal requirements related to clinical, service, and operational QI activities that include annual review and update of the Compliance Plan. The Enterprise Compliance Officer is responsible for oversight and direction of Regulatory Compliance to the Senior Leadership Team.

Senior Leadership Team

The Senior Leadership Team is integral to the success of performance improvement by leading the creation of an organizational culture that supports



improvement efforts, using management practices that sustain improvement efforts and creating an environment where all staff can develop their potential.

Department Directors

Through the leadership of the Senior Management Team, each department is expected to participate and work collaboratively on QI activities that are a priority throughout the organization. At the departmental level, the goal is to improve clinical care, services delivered, operation effectiveness, and efficiency.

Managers and Team Leads

Managers and Team Leads are essential to the success of CQI, as they drive the day-to-day work for the organization. Managers and Team Leads support the improvement efforts by continually seeking to identify opportunities in their daily work and in the work of their teams.

Individual Contributors

Quality improvement lives at the point of care and service. All HAP CareSource employees are responsible for ensuring safe, high-quality care for each member. Individual contributors are essential to the success of improvement efforts, as they complete the day-to-day delivery of care and services.

Enterprise Resources

Executive Vice President (EVP) – Enterprise Chief Medical Officer (CMO)

The EVP and CMO is responsible for the overall direction of all clinical programs, including the QI Program, and is also a member of or provides oversight to the Executive Council, Physician Advisory, Credentialing, and P&TC. The EVP and CMO has the responsibility to oversee the activities of the Market dedicated PH and BH Medical Directors and is responsible for oversight and direction of all physician reviewers and those serving on peer committees. The EVP and CMO facilitates participation of practitioners/providers in the overall QI program through the various committees they chair or those for which they provide oversight.

Vice President (VP) Quality and Performance Outcomes

The VP Quality and Performance Outcomes oversees the operations of the Enterprise QI Department and is responsible for the execution and coordination of QI activities at the Enterprise level. It is the VP's responsibility to interface with other departments on QI issues and report any areas of concern to the EVP and CMO and Executive Leadership Team.

Associate Vice President (AVP) Market Quality Operations



The AVP, Market Quality is responsible for ensuring effective execution of Market-based Quality Programs and their respective Work Plans to achieve Enterprise Quality goals. It is the AVP's responsibility to influence quality outcomes through assisting in the development, implementation, and monitoring of remediation strategies to improve HEDIS, NCQA, and Star program results. The AVP develops Market-wide Provider Engagement strategies toward optimizing the efficacy of the Health Partner and Market-based clinical interactions to close gaps in care.

AVP Enterprise Quality Assurance and Accreditation

The AVP Enterprise Quality Assurance and Accreditation is responsible for ensuring effective oversight of Enterprise systems and resources to support the execution of market-based Quality Programs that achieve organizational goals, advancing accreditation compliance and organizational excellence, and effectively aligning industry innovations with organizational needs. Facilitation of the QEC. Provides guidance on enterprise-wide best practices. Works with Markets to scale adopted improvement strategies. Manages Quality Innovation team which maintains relationships with Vendors utilized to close member gaps in care.

Senior Director, Consumer Experience (CX)

The Senior Director of CX is responsible for ensuring effective oversight of Enterprise systems, processes, and resources to support the execution of market-based CX strategy. This position is responsible for the analysis and identification of performance improvement captured through the CAHPS surveys and other experience information seeking modalities for members and providers.

Senior Director Enterprise HEDIS Operations & Analytics

The Senior Director of Regulatory Analysis provides strategic leadership to a team of Analysts and Managers responsible for all aspects of HEDIS® and Medicare Advantage Stars measures and analytics. The Senior Director leads HEDIS®, CAHPS®, and Stars reporting projects for multiple markets with year-round monitoring and required annual reporting. The Senior Director supports state required non-HEDIS® quality management (QM) metric reporting. S/he serves as enterprise Subject Matter Expert for HEDIS®, Stars, and performance measurement. The Senior Director collaborates with Executive Management on enterprise and market goals with targeted focus on state pay-for-performance programs, NCQA accreditation requirements, and CMS Stars. Using improvement science, the Director Isolates and implements opportunities to improve rates or efficiency of data collection, including identifying alternative sources for data, including electronic clinical data systems (ECDS), and health information exchanges (HIE). The Senior Director maintains NCQA-certified HEDIS® software and evaluates state-specific measurement methodology.



Senior Director, Utilization Management

The Senior Director of UM is required to have a current unrestricted RN license or other appropriate professional license leading and managing the oversight of all UM functions for all the HAP CareSource lines of business to ensure consistent, efficient delivery of services throughout the healthcare continuum. Responsible for monitoring utilization and cost of care data developing and implementing processes to address identified trends.

Health Information Systems

The HAP CareSource Health Information Systems (HIS), in accordance with 42 CFR §§ 438.242(a) and (b), is used to collect, analyze, and integrate data that informs the Quality Management Improvement Program on areas of opportunity to pursue. The plan's HIS also supports all aspects of the Data integrity and is maintained to ensure that data for informational and decision-making purposes is as accurate and complete as possible. HAP CareSource maintains health information for CMS and state review as requested. Data sources are monitored and audited on a regular basis. These data sources include but are not limited to:

- Enrollment files
- Claims Processing System (Medical and Dental)
- Pharmacy and Dental Claims data (vendor)
- Provider Credentialing database
- Encounter data submissions to regulatory entities, including State and Federal as requested or required.
- Analytic data view
- Encounter data view
- Enterprise Data Warehouse
- Clinical authorization and Care Coordination data
- Bi-directional data sharing such as Admissions-Transfers-Discharges (ADT) feeds, HIE
- Supplemental data feeds such as lab data, ancillary vendor, or provider data
- State and regional demographic data

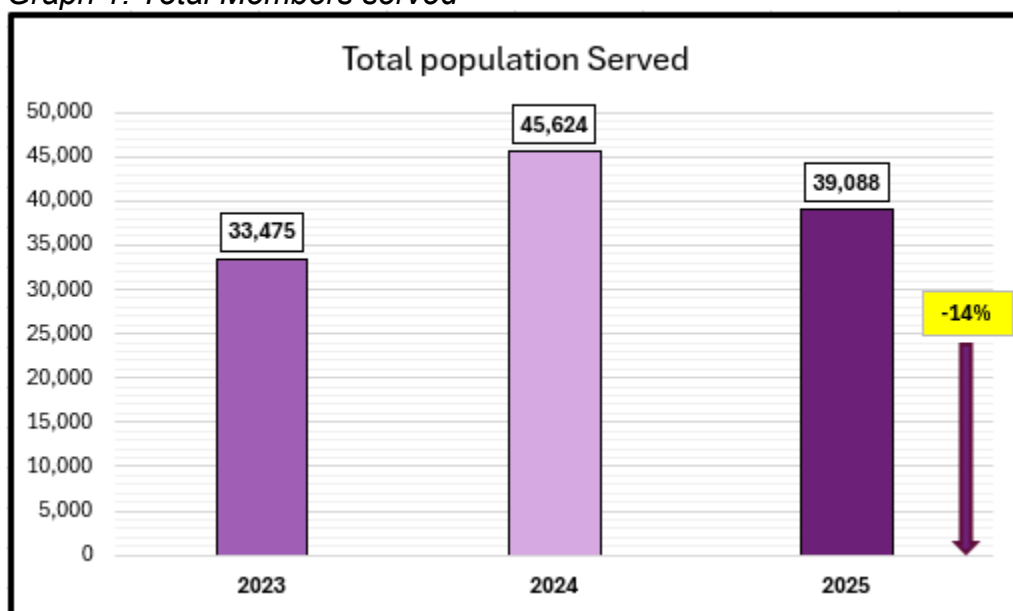
HAP CareSource operates a framework of internal IT controls and information security policies and procedures to maintain the HIS' compliance with HIPAA and other privacy laws, as well as commonly accepted professional standards of health information management. Key quality-related infrastructure components include:



- Tools to track, analyze and report performance measures and data from QI activities, focused studies, Improvement Projects, PIPs, QIPs, incentive programs, value-based reimbursements (VBR), and other QI -related activities and initiatives.
- Interface with state HIE, as available, to share data and information and maximize data integration or provider electronic health record (EHR) systems.
- Integration of state HIE and immunization registries to obtain file extracts to supplement clinical data.
- Provider portal platform which allows bi-directional data and information sharing.
- Member portal platform which hallows bi-directional data and information sharing.

IV. Population Profile

Graph 1: Total Members served



HAP CareSource of Michigan served a total of 39,088 members in CY2025 (see Graph 1) which demonstrates a 14.32% YoY decrease compared to CY2024 (year prior).

Table 2: Age & Gender Distribution



Age Band		
AgeBand	Unique Members	Percent of Total
00-01	1,920	4.91%
02-10	7,426	19.00%
11-19	5,579	14.27%
20-29	6,511	16.66%
30-39	7,270	18.60%
40-49	4,437	11.35%
50-59	3,665	9.38%
60-74	2,125	5.44%
75+	155	0.40%
Total	39,088	100.00%

Male vs Female		
Gender	Unique Members	Percent of Total
Female	19,694	50.38%
Male	19,394	49.62%
Total	39,088	100.00%

Age and gender distribution is noted in Table 2 above. The HAP CareSource of Michigan Medicaid membership in CY2025 is largely pediatric, adolescent, and young adult, with the highest representation among members ages 2–10 (19.00%), followed by adults ages 30–39 (18.60%) and 20–29 (16.66%). Adolescents ages 11–19 account for an additional 14.27%, demonstrating that a substantial proportion of the population falls within pediatric and adolescent life stages, with comparatively fewer members in older adult age groups. Gender distribution is nearly balanced, with females comprising 50.38% of the membership and males comprising 49.62%.

Table 3: Race, Ethnicity and Language

Race/Ethnicity		
Ethnicity_Race	Unique Members	Percent of Total
Caucasian	17,305	44.27%
Black	16,570	42.39%
Other Race or Ethnicity	4,568	11.69%
Asian or Pacific Islander	446	1.14%
Native American	136	0.35%
Native Hawaiian	41	0.10%
Unknown	22	0.06%
Hispanic		
Mutually Defined		
Total	39,088	100.00%

Language		
Language	Unique Members	Percent of Total
English	38,304	97.99%
Spanish	303	0.78%
Arabic	245	0.63%
Other	229	0.59%
Somali	7	0.02%
Unknown		
Total	39,088	100.00%

Table 3 presents the served membership Race, Ethnicity and Language profiles for CY2025. Race, Ethnicity, and Language Distribution. The CY2025 HAP CareSource of Michigan Medicaid population is racially diverse, with Caucasian (44.27%) and Black (42.39%) members representing the majority of the membership, and is predominantly English-speaking (97.99%), with small proportions of members preferring Spanish, Arabic, Somali, or other languages.

Table 4: CY2025 prevalence of chronic conditions



All Chronic Conditions		
EDCDesc	Unique_CC_Members	% Condition_Prevalence
Hypertension, w/o major complications	4,963	12.70%
Obesity	3,867	9.89%
Disorders of lipid metabolism	3,715	9.50%
Asthma, w/o status asthmaticus	3,092	7.91%
Nonspecific signs and symptoms	2,506	6.41%
Developmental disorder	1,340	3.43%
Type 2 diabetes, w/ complication	1,329	3.40%
Degenerative joint disease	1,218	3.12%
Other endocrine disorders	1,149	2.94%
Migraines	1,103	2.82%
Disorders of the immune system	1,080	2.76%
Inherited metabolic disorders	951	2.43%
Emphysema, chronic bronchitis, COPD	894	2.29%
Type 2 diabetes, w/o complication	847	2.17%
Hypothyroidism	812	2.08%
Ischemic heart disease (excluding acute m...	772	1.98%
Peripheral neuropathy, neuritis	754	1.93%
Respiratory signs and symptoms	741	1.90%
Cardiac arrhythmia	711	1.82%
Autism Spectrum Disorder	706	1.81%
Hypertension, with major complications	691	1.77%

Prevalence is calculated using overall unique members as the denominator, not only members with chronic conditions

Table 4 demonstrates that chronic condition prevalence among HAP CareSource of Michigan Medicaid members in CY2025 is primarily driven by cardiometabolic and respiratory conditions. Hypertension without major complications was the most prevalent condition, affecting 12.70% of members, followed by obesity (9.89%) and disorders of lipid metabolism (9.50%). Asthma (no status asthmaticus) represented the fourth most prevalent condition at 7.91%, while nonspecific signs and symptoms accounted for 6.41% of the population. Collectively, these top five conditions highlight a significant burden of preventable and manageable chronic disease, underscoring the importance of continued focus on cardiovascular risk reduction, weight management, and chronic respiratory disease management strategies.

Table 5: Inpatient Utilization Management

Top 20 IP Discharge Diagnosis					
EDCDDescription	MemCnt	ClmCnt	% of Total Claims	Util per 1,000	PMPM
Newborn status, uncomplicated	575	577	20.13%	16.68	\$5.42
Pregnancy and delivery with complications	435	444	15.49%	12.84	\$4.92
Pregnancy and delivery, uncomplicated	156	156	5.44%	4.51	\$1.39
Septicemia	112	120	4.19%	3.47	\$5.58
Hypertension, with major complications	94	108	3.77%	3.12	\$2.99
Seizure disorder	64	75	2.62%	2.17	\$1.34
Cerebrovascular disease	55	57	1.99%	1.65	\$2.32
Acute pancreatitis	44	55	1.92%	1.59	\$0.64
Substance use	49	54	1.88%	1.56	\$0.81
Acute respiratory failure	44	51	1.78%	1.47	\$1.52
Hypertension, w/o major complications	46	47	1.64%	1.36	\$0.51
Type 2 diabetes, w/o complication	39	42	1.46%	1.21	\$0.58
Infections, other	36	37	1.29%	1.07	\$0.43
Complications of mechanical devices	33	35	1.22%	1.01	\$1.27
Acute lower respiratory tract infection	32	34	1.19%	0.98	\$0.39
Acute myocardial infarction	31	32	1.12%	0.93	\$1.14
Adverse effects of medicinal agents	29	32	1.12%	0.93	\$1.62
Fractures (excluding digits)	32	32	1.12%	0.93	\$1.19
Type 1 diabetes, w/o complication	24	31	1.08%	0.90	\$0.39
Chronic liver disease	22	30	1.05%	0.87	\$3.56
Gastrointestinal obstruction/perforation	28	30	1.05%	0.87	\$0.67

Members with multiple IP stays will show up under each discharge diagnosis

Metric box filters for all non-EDC and non-BH slicers

These selections represent:

2,210

Unique members with

2,867

Unique IP claims totaling

\$60.32

In IP PMPM and

82.90

IP claims per 1,000 members per year



Table 5 visually depicts the inpatient utilization trend for the HAP CareSource of Michigan during CY2025. In CY2025, inpatient utilization was concentrated among a small subset of members, with 2,210 unique members generating 2,867 inpatient claims, resulting in a total cost of care exceeding \$60 million and a PMPM of \$82.90. The most frequent inpatient discharge diagnoses were septicemia (8.75%), hypertension without major complications (5.97%), and complications of mechanical devices (3.98%), followed by heart failure and acute kidney failure. These findings highlight the impact of acute and potentially preventable conditions and suggest opportunities to strengthen chronic disease management and transitions of care to reduce repeat hospitalizations.

Table 6: ED utilization trends for CY2025

Top 20 ED Discharge Diagnosis					
EDCDescription	MemCnt	ClmCnt	% of Total Claims	Util per 1,000	PMPM
Acute upper respiratory tract infection	1,380	1,593	7.92%	46.06	\$1.01
Abdominal pain	619	918	4.57%	28.54	\$1.01
Lacerations	735	806	4.01%	23.30	\$0.51
Chest pain	630	790	3.93%	22.84	\$0.79
Contusions and abrasions	564	603	3.00%	17.43	\$0.37
Viral syndromes	548	585	2.91%	16.91	\$0.37
Pregnancy and delivery with complications	367	534	2.66%	15.44	\$0.41
Nausea, vomiting	430	511	2.54%	14.77	\$0.45
Pregnancy and delivery, uncomplicated	326	493	2.45%	14.25	\$0.40
Substance use	282	478	2.38%	13.82	\$0.39
Nonspecific signs and symptoms	344	465	2.31%	13.44	\$0.27
Administrative concerns and non-specific laboratory abno...	363	449	2.23%	12.98	\$0.22
Musculoskeletal signs and symptoms	372	428	2.13%	12.37	\$0.27
Acute sprains and strains	369	402	2.00%	11.62	\$0.21
Neurologic signs and symptoms	339	398	1.98%	11.51	\$0.27
Headaches	282	344	1.71%	9.95	\$0.30
Urinary tract infections	304	335	1.67%	9.69	\$0.33
Asthma, w/o status asthmaticus	237	327	1.63%	9.45	\$0.24
Nonfungal infections of skin and subcutaneous tissue	285	321	1.60%	9.28	\$0.21
Disorders of teeth	260	310	1.54%	8.96	\$0.16
Musculoskeletal disorders, other	288	310	1.54%	8.96	\$0.22

These selections represent:

9,966
Unique members with

20,108
Unique ED claims totaling

\$15.39
ED PMPM and

581.39
ED Claims per 1,000 members per year

Members with multiple ED visits will show up under each discharge diagnosis

Table 6 demonstrates the trends of Emergency Department (ED) utilization in CY2025 for HAP CareSource of Michigan members. In CY2025, Emergency Department utilization was concentrated among 9,966 unique members, generating 20,108 ED claims, indicating repeat ED use within a subset of the population, and contributing to an ED PMPM of \$15.39. The most frequent reasons for ED visits were acute upper respiratory infections, abdominal pain, viral infections, contusions/abrasions, and pregnancy-related complications, reflecting a mix of acute, non-emergent, and potentially preventable conditions. These patterns suggest opportunities to strengthen primary care access, preventive services, and care navigation to reduce avoidable ED utilization.

V. QI Program Systems & Program Components

A. Clinical Practice Guidelines



HAP CareSource adopts evidence-based CPGs and PSGs, which include PH and BH healthcare services that stem from recognized organizations or through the involvement in the development of such guidelines of board certified providers from appropriate specialties or professionals with expertise in the assessment and delivery of services that are relevant to the served health plan population.

Prior to being recommended for use, CPGs and PSGs are reviewed by the plan's Medical Director(s), practitioners, and network providers. CPGs and PSGs are reviewed, revised as appropriate at least every two (2) years. During CY2025 the following CPGs and PSGs were applicable and in place to promote high-quality care and services to the served population:

- ADHD - Diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD) For Children and Adolescents, Treatment of Attention Deficit/Hyperactivity Disorder (ADHD) For Children and Adolescents
- Adolescent Health - Adolescent and Young Adult Health Risk Behavior Assessment
- Advance Care Planning - Advance Care Planning
- Asthma - General Principles for the Diagnosis and Management of Asthma
- Back Pain - Management of Acute Low Back Pain in Adults
- Bronchitis - Management of Uncomplicated Acute Bronchitis in Adults
- Dental - Delta Dental Michigan- Clinical Criteria
- Depression - Primary Care Diagnosis and Management of Adults with Depression
- Diabetes - Management of Type 2 Diabetes Mellitus
- Heart Failure - Adults with Heart Failure with Reduced Ejection Fraction
- Hypertension - Medical Management of Adults with Hypertension Guidelines
- Kidney Disease - Diagnosis and Management of Chronic Kidney Disease
- Lipids - Lipid Screening and Management
- Office Based Surgery - In Office Use of Sedation
- Opioid Prescribing - Opioid Prescribing in Adults Excluding Palliative and End-of-Life Care
- Osteoarthritis - Medical Management of Adults with Osteoarthritis
- Osteoporosis - Management and Prevention of Osteoporosis
- Overweight and Obesity – Management of Overweight and Obesity in the Adult, Prevention and Identification of Childhood Overweight and Obesity, Treatment of Childhood Overweight and Obesity
- Pharyngitis - Acute Pharyngitis in Children (3 years and older), Adolescents and Adults



- Pregnancy - Routine Prenatal and Postnatal Care
- Pregnancy Prevention - Prevention of Pregnancy in Adolescents 12 - 17 Years, Prevention of Unintended Pregnancy in Adults 18 Years and Older
- Preventative Services - Adult Preventive Services (Age ≥ 50), Adult Preventive Services (Ages 18-49), Routine Preventive Services for Infants and Children (Birth - 24 Months), Routine Preventive Services for Children and Adolescents (Ages 2-21)
- Substance Use Disorder - Screening, Diagnosis and Referral for Substance Use Disorders
- Tobacco Control - Prevention of Tobacco and Nicotine Use Including Vaping
- Venous Thrombosis - Outpatient Management of Acute Uncomplicated Deep Venous Thrombosis

Measurement of the effectiveness of the adopted CPGs and PSGs is measuring using HEDIS® data collection and reporting of medical records review (MRR) and measure performance oversight. Evaluation focuses on clinical processes and outcomes, provider/practitioner adherence to evidence-based guidelines, and identify opportunities for quality or care improvement. The effectiveness of CY2025 CPGs and PSGs is captured and documented in the Clinical Measurement Activities section of this QI Program Evaluation.

B. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

HAP CareSource of Michigan, in accordance with 42 CFR 441 SubPart B, adheres to the requirements of the EPSDT program requirements. The health plan provides ongoing care coordination of EPSDT eligible members to ensure access to social, community, medical and BH services. The plan monitors, tracks, trends, analyzes and reports utilization of EPSDT services as required by State and Federal requirements. The plan annually reports and submits EPSDT utilization data to CMS using the EPSDT CMS-416 report including the State's collected encounter data.

OBJECTIVE:

The percentage of HAP CareSource of Michigan EPSDT eligible members 0-21 years of age who received an EPSDT screening, preventive dental services during the CY2025.

GOAL:

To reach:



- 80% screening ratio across all age cohorts for the plan's EPSDT eligible population.
- 80% of preventive dental or oral health services for all age cohorts for the plan's EPSDT eligible population.
- 80% of completed blood lead screenings for plan's EPSDT eligible population.

MEASUREMENT:

Overall effectiveness of the plan's efforts to improve EPSDT utilization is measured through the annual submission of the CMS-416 report; utilization metrics is monitored monthly.

FINDINGS:

Table 7: EPSDT Screening ratio

Metric	MY2024	MY2025	Goal	Goal Met Y/N
EPSDT Screening Ratio	0.98	0.57	80%	N

The screening ratio is the actual number of initial and periodic screening services received by EPSDT eligible members divided by the number of expected screenings based on membership. Table 7 above presents the screening ratio for MY2025 and a two (2) year trend. The plan did not meet goal.

Table 8: EPSDT Screening ratio age cohorts

EPSDT Screening Ratio MY20XX			
Age cohorts	Screening Ratio	Goal	Goal Met Y/N
< 1 years old	0.65	80%	N
1-2 years old	0.67	80%	N
3-5 years old	0.76	80%	N
6-9 years old	0.55	80%	N
10-14 years old	0.46	80%	N
15-18 years old	0.34	80%	N
19-20 years old	0.23	80%	N



Table 8 provides a further detailed evaluation of the EPSDT screening ratios assessed by age cohorts. As is evident in the data PSDT screening ratios declined steadily with increasing age, with younger children demonstrating higher screening compliance than adolescents and young adults. While children ages 3–5 years had the strongest performance (0.76), all age cohorts fell below the ≥80% goal, with the lowest rates observed among members ages 15–20 (0.34–0.23), highlighting significant gaps in preventive care utilization among older age groups.

Table 9: EPSDT Preventive Dental or Oral Health Services

Metric	MY2023	MY2024	MY2025	Goal	Goal Met Y/N
EPSDT Preventive Dental OR Oral Health Services	23.11%	37.27%	38.72%	80%	N

Table 9 demonstrates the rates of preventive dental or oral health services for EPSDT eligible members during MY2025. In MY2025, 38.72% of EPSDT-eligible members received preventive dental or oral health services, representing a modest increase from 37.27% in MY2024 and 23.11% in MY2023, but remaining well below our goal of 80%. While the upward trend over the three-year period indicates incremental improvement, overall performance reflects persistent gaps in preventive dental utilization among the EPSDT population. These findings highlight the continued need for targeted outreach, provider engagement, and strategies to reduce access and utilization barriers to preventive oral health services.

Table 10: EPSDT Dental and Oral Health age cohorts

Age cohorts	Den	Num	Preventive Dental and Oral Health Service Rates
< 1 years old	509	2	0.39%
1-2 years old	1,857	326	17.56%
3-5 years old	2,634	1,180	44.80%
6-9 years old	2,834	1,453	51.27%
10-14 years old	3,146	1,439	45.74%



15-18 years old	2,299	840	36.54%
19-20 years old	956	272	28.45%

Table 10 depicts preventive dental and oral health service rates for the EPSDT eligible population for MY2025. Preventive dental and oral health service utilization in MY2025 varied by age, with the highest rates observed among children ages 6–9 (51.27%) and 3–5 (44.80%), while utilization declined steadily among older adolescents and young adults. Members ages 15–18 (36.54%) and 19–20 (28.45%) demonstrated the lowest rates of preventive dental service use, indicating widening gaps with increasing age. Although younger age cohorts performed comparatively better, no age group met the 80% goal, highlighting the need for age-tailored outreach and engagement strategies, particularly for adolescents and transition-age youth.

Table 11: Lead Screening

Category	2023	2024	2025	2025 Goal	Met (Y or N)
Lead Screening in Children **	55.97%	54.99%	64.73%	71.11%	N

**Hybrid measure – results may continue to shift as additional clinical data are submitted and validated. Data as of January 16, 2026.

Table 11 demonstrates the 2025 administrative rate for completed blood lead screenings for EPSDT-eligible members. The administrative rate is trending higher than the final hybrid rates for blood lead screenings in 2023 and 2024. The final hybrid rate for 2025 will not be known until July 2026. At that time, a final year-over-year performance analysis will be conducted against the 2023 and 2024 rates, and strategy updates will be made as appropriate.

BARRIERS:

- Convenient, timely access to high-quality, coordinated care
- Identifying and addressing member barriers
- Member awareness and understanding of lead impacts on child development and screening recommendations

INTERVENTIONS in MY2025:

- Member outreach (e.g., telephonic, text, mail, and/or IVR)
- Local Health Dept. (MDHHS) Collaboration
- Provider Partnership Expansion, 3-way warm handoff appointment scheduling

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:



- Continue with successful strategies from 2025 while enhancing access points and engagement strategies by age cohort.
- Provider education and strategy discussions regarding plan services and benefits, best practices, gap-in-care closure strategies and tools, and operational strategies conducted during Partnership Oversight Committee (POC) meetings.

C. External Quality Review Organization Activity

In accordance with 42 CFR §438.358, 42 CFR Part 476 and Section 1152 of the Social Security Act HAP CareSource fully cooperates and supports any external evaluations and assessments of its performance conducted by the Michigan's contracted External Quality Review Organization (EQRO).

- Consider evidence-based intervention efforts and risk factors in quality and timeliness of care for the targeted population. HCS should also closely evaluate the success of each intervention strategy to determine any needs for modifications in order to achieve the desired improvement.
- Develop targeted interventions to improve performance for the Childhood Immunization Status (CIS) measure. Initiatives should be monitored and expanded upon as contributing factors to rate performance are identified. HCS could consider exploring avenues to increase awareness of vaccination importance among parents to reduce vaccination hesitancy such as a “speculation versus fact” pamphlet which includes a phone number for care management support. HCS could also consider issuing provider incentives for maintaining a complete inventory of vaccinations.
- While HCS demonstrated a significant improvement for the Child Visits for Age 15 Months to 30 Months (W30)—Two or More Well-Child Visits measure indicator, and noted several interventions currently in place to target improvement, such as hiring health outreach specialists to focus on scheduling well-child visits/gap closure outreach, contacting the provider if unable to reach members, and restructuring the member rewards program to include incentives for the Well-Child Visits for Age 15 Months to 30 Months (W30) measure indicators, performance remains low. Therefore, HSAG recommends that HCS continue its efforts to improve performance for the Well-Child Visits in the First 30 Months of Life (W30) measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified. Increased provider and member incentives for well-child visits may be an option to consider.



- While HCS demonstrated a significant improvement for the Ages 3 to 11 Years and Total measure indicators and noted several interventions currently in place to target improvement, such as hiring health outreach specialists to focus on scheduling well-child visits/gap closure outreach, contacting the provider if unable to reach members, and restructuring the member rewards program to include incentives for the measure indicators, performance remains low. Therefore, HSAG recommends that HCS continue its efforts to improve performance for the Child and Adolescent Well-Care Visits (WCV) measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified. Increased provider and member incentives for well-child visits may be an option to consider.
- Develop targeted interventions to improve performance for the Immunizations for Adolescents (IMA) measure. Initiatives should be monitored and expanded upon as contributing factors to rate performance are identified. HCS could consider exploring avenues to increase awareness of vaccination importance among parents to reduce vaccination hesitancy such as a “speculation versus fact” pamphlet which includes a phone number for care management support. HCS could also consider issuing provider incentives for maintaining a complete inventory of vaccinations.
- While HCS noted several interventions currently in place to target improvement, such as providing some provider groups with monthly HEDIS reporting packages, implementing events for women focused on providing needed screenings while also growing partnerships with providers, and evaluating each intervention by reviewing HEDIS results and comparing baseline to remeasurement periods, performance remains low for the Cervical Cancer Screening (CCS-E) measure. Therefore, HSAG recommends that HCS continue its efforts to improve performance for the Cervical Cancer Screening (CCS-E) measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified. HCS could consider the development and deployment of a digital notification system for members needing cervical cancer screening and incorporating screening reminders into current care coordination member touchpoints.
- Develop targeted interventions to improve performance for the Adults’ Access to Preventive/Ambulatory Health Services (AAP)—Ages 45 to 64 Years measure. Possible initiatives to increase patient engagement, improve upon outreach efforts, or streamline appointment scheduling (e.g., expanding upon office hours) should be considered as contributing factors to rate performance.



- Continue developing targeted interventions to improve the performance of the Prenatal and Postpartum Care (PPC) measure indicators. Initiatives should be monitored and expanded upon as additional contributing factors are identified. HCS could consider creating member incentives to promote increased prenatal and postpartum engagement, such a baby registry for pre-approved baby items and supplies.
- Develop targeted interventions to improve performance for the Asthma Medication Ratio (AMR) measure. Initiatives should be monitored and expanded upon as contributing factors to rate performance are identified. HCS could consider providing education to members on proper medication management in order to avoid ED visits.
- monitor the measures to ensure significant decreases in scores over time do not occur.

D. Performance Improvement Projects (PIPs)

HAP CareSource complies with 42 CFR 438.330 by implementing contractually required PIPs to drive improvement using rapid cycle QI science techniques. The plan collaborates with <state> and EQRO on potential topics and adheres to <state> and EQRO reporting requirements.

PIP #1

OBJECTIVE: Blood Lead Screening in Children

GOAL:

Improve the percentage of children two years old who have received at least one blood lead screening by 2nd birthday.

Improve the percentage of children who have received one blood lead screening at age one and age two. (Stratification of LSC)

MEASUREMENT: Overall effectiveness of the plan's efforts to improve blood lead screenings in Children at age one and at age two.

FINDINGS:

Baseline Year: 2025

Table 12: Lead Screening

Category	2023	2024	2025	2025 Goal	Met (Y/N)
Lead Screening in Children **	55.97%	54.99%	64.73%	71.11% (75 th)	N



****Hybrid measure – results may continue to shift as additional clinical data are submitted and validated. Data as of January 16, 2026.**

Table 12 demonstrates the Baseline MY2025 rate for at least one completed blood lead screenings for eligible members on/before their second birthday. MY2025 rate of 64.73% demonstrates goal was not met by 6.38 percentage points. This is 9.74 percentage points higher than 2024 and 8.76 percentage points higher than 2023; however, as a hybrid measure, results may continue to shift as additional clinical data are submitted and validated.

BARRIERS:

- Convenient, timely access to high-quality, coordinated care
- Identifying and addressing member barriers
- Member awareness and understanding of lead impacts on child development and screening recommendations
- Provider engagement

INTERVENTIONS IN MY2025

- Member outreach (e.g., telephonic, text, mail, and/or IVR)
- Member Rewards Program Lead screening (LSC) Incentive
- Provider Partnership Expansion, 3-way warm handoff appointment scheduling
- Value-based Reimbursement (VBR) Provider Incentive Program

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026

- Continue with successful strategies from 2025 while enhancing access points and engagement strategies by age cohort.
- Provider education and strategy discussions regarding plan services and benefits, best practices, gap-in-care closure strategies and tools, and operational strategies conducted during Partnership Oversight Committee (POC) meetings.
- Explore potential provider partnerships with high-risk FQHCs

PIP #2

OBJECTIVE: Increase the percentage of new and existing members who are 18 years of age and older who have been screened for Health-Related Social Needs during the remeasurement year.

GOAL: New Member Screening Rate: 28%
Existing Member Screening Rate: 20%



MEASUREMENT:

Newly enrolled members
who successfully completed screening for HRSN within 90 days of their
enrollment.

Existing members who successfully completed screening for HRSN.

FINDINGS: HCS internal reporting has shown an increase in HRA completions
since the integration of the MyLife app has been completed.

BARRIERS: Member successful connection.

INTERVENTIONS IN MY2025: HCS implemented the HRAs into the MyLife app,
adding an additional modality for completion designed to address the member
engagement barrier and ability for HCS staff to successfully complete the HRAs.

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026: Ingestion of MiHIN data
to increase completion rates by providers, continued implementation of the
MyLife apps.

Annually, in accordance with Michigan Medicaid contract requirements, HAP
CareSource implemented Market-Initiated Performance Improvement Projects
(PIPs) designed to achieve measurable and sustained improvement in clinical
and non-clinical quality outcomes. These PIPs focused on priority areas
impacting member health outcomes, access to care, and enrollee experience,
and were selected based on analysis of performance data, identified
opportunities for improvement, and alignment with state and enterprise quality
priorities.

Each PIP incorporated standardized quality improvement methodology, including
objective performance measurement, implementation of targeted interventions,
and ongoing monitoring to evaluate effectiveness. PIPs were structured to
support sustained improvement over time and, where applicable, included
collaboration with external partners and stakeholders to address shared quality
metrics and population-level needs.

Oversight of MY2025 PIPs was maintained through established Quality
Improvement governance structures, with regular review of progress, barriers,
and outcomes. Findings from PIP activities informed future quality planning and
supported the development of targeted strategies for continued improvement in
subsequent measurement years.



PIP #1

OBJECTIVE: W30 Rate 1 (6+ visits) in the first 15 months of Life

GOAL: Improve well child visits in the first 15 months of life from 53.32% to 61.59% during the reported measurement period.

MEASUREMENT: Overall effectiveness of the plan's efforts to improve W30 Rate 1 (6+ visits) in the first 15 months of life.

FINDINGS:

W30 Rate 1 in the first 15 months of life

Measurement Period	MM/DD/YYYY to MM/DD/YYYY	Numerator(s)	Denominator(s)	Rate(s)	Met (Y/N)
Baseline	01/01/2024 to 12/31/2024	781	1375	56.80%	n/a
Remeasurement Year # 1	01/01/2025 to 12/31/2025	286	434	65.90%	Y

W30 Rate 1 demonstrates Remeasurement YR 1 MY 2025 W30 (0-15months) YTD rate of 65.90% reflects goal was met and exceeding by 4.31 percentage points. MY 2025 is currently trending 12.58 percentage points higher than MY 2024 final rate.

BARRIERS:

- Unable to reach (UTR) members
- Identifying and addressing member barriers
- Member and Provider engagement

INTERVENTIONS IN MY2025

- Member outreach (e.g., telephonic, text, mail, and/or IVR)
- Member Rewards Program incentive for Well-Baby Visits 1-6
- Provider Partnership Expansion, 3-way warm handoff appointment scheduling
- Value-based Reimbursement (VBR) Provider Incentive Program
- Vaccination Bingo Card Initiative to improve member engagement with health care system



OPPORTUNITIES FOR IMPROVEMENT FOR MY2026

- Continue with successful strategies from 2025 while enhancing access points and engagement strategies.
- Provider education and strategy discussions regarding plan services and benefits, best practices, gap-in-care closure strategies and tools, and operational strategies conducted during Partnership Oversight Committee (POC) meetings.
- Enhance data analysis to include data heat mapping to strategically support 2026 QI and PH improvement efforts.

PIP #2

OBJECTIVE:

Improve Adult Dental Utilization by 5%

GOAL:

Improve adult dental utilization for eligible member population 19 to 64 years of age overall by 5%

MEASUREMENT:

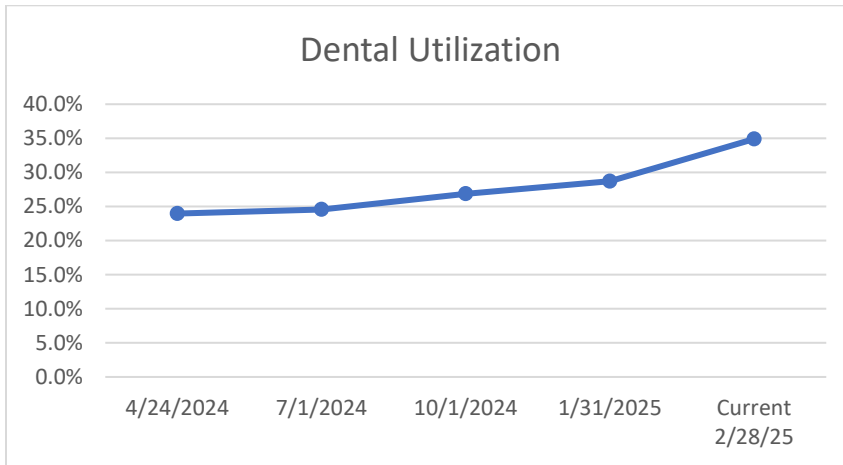
Overall effectiveness of the plan's efforts to improve adult dental utilization is measured using MDHHS PMR and Custom Measures (Adults: Any Dental Visit) and is monitored through quarterly trending of rolling measurement periods. Performance is evaluated by the percentage of eligible adults (ages 19–64) with at least one dental visit during the measurement window and compared to the MDHHS minimum standard. Results are reviewed routinely with internal stakeholders and the dental vendor to guide intervention adjustments and support the targeted 5% improvement.

FINDINGS:

MDHHS PMR and Custom Measures (Timeframe: 3/1/2024 - 2/28/2025). Current performance for Adults: Any Dental Visit = **34.9%** (Numerator 4,595 / Denominator 13,174), meeting the minimum standard of **25.0%**. Trend is displayed below.

4/24/2024	7/1/2024	10/1/2024	1/31/2025	Current 2/28/25
24.0%	24.6%	26.9%	28.7%	34.90%





For the current measurement timeframe (3/1/2024–2/28/2025), the Adult “Any Dental Visit” rate is 34.9% (4,595 of 13,174 eligible members), which meets the MDHHS minimum standard of 25.0% by 9.9 percentage points. Trend data show steady improvement across the prior reporting points: 24.0% (April 2024), 24.6% (July 2024), 26.9% (October 2024), and 28.7% (January 2025), culminating in the current 34.9% rate. Overall, this reflects a +10.9 percentage point increase from April 2024 to the current period, suggesting that expanded outreach and access-focused efforts were associated with improved utilization. However, despite meeting the minimum standard, the measure indicates that approximately 65.1% of eligible adults did not have a dental visit in the measurement window, highlighting ongoing opportunity to further increase routine preventive and diagnostic care, reduce reliance on urgent/ED dental care pathways, and improve sustained engagement in a dental home to support the PIP aim of a 5% improvement.

BARRIERS:

- Access to dental care / network capacity: Limited appointment availability, difficulty securing timely appointments, and/or challenges identifying an in-network dental home can reduce routine utilization and contribute to episodic care patterns.
- Transportation barriers: Transportation was identified as a barrier for dental clinic-day/event participation earlier in the year; although improvements were noted, transportation remains a key driver of missed appointments and lower completion of care.
- Member education and benefit awareness: Gaps in understanding covered dental benefits, how to find a provider, and when to use a dental office vs. urgent/ED settings can limit appropriate utilization.



- Member outreach reachability: “Unable to reach” members reduces the effectiveness of reminder and scheduling support efforts.
- No-show / cancellation rates: Dental clinic-day efforts noted typical no-show rates around 50% despite reminder calls
- Multi-visit treatment needs: Adult dental needs often require multiple visits to complete treatment plans
- Provider access and capacity (appointment availability establishing a dental home)
- Transportation barriers impacting visit completion
- Member awareness of benefits and appropriate care setting (dental office vs. urgent/ED)
- Unable to reach members for outreach and scheduling support
- High no-show rates limiting completed visits
- Multi-visit treatment needs (drop-off before care completion)
- Data/measurement limitations (claims lag; denominator volatility)

INTERVENTIONS IN MY2025

- Delta Dental-led outreach and scheduling support to connect adult members with an in-network dental provider.
- Monthly adult dental non-utilizer text message campaigns to promote preventive dental visits and benefit awareness.
- Community-based dental clinic days/mobile events with “white glove” member engagement (outbound scheduling, transportation coordination, and on-site benefit education/incentives as applicable).
- Provider engagement and education to reinforce oral health promotion during medical visits and improve linkage to dental care (newsletters, JOC discussions, and toolkits).
- ED dental utilization monitoring and follow-up outreach to members with dental ED visits to support navigation to definitive dental care.
- Targeted disparity-focused outreach cycles (PDSA) to improve gap closure in priority populations and refine outreach timing and approach.

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026

- Increase adult dental utilization by scaling proven outreach (Delta Dental telephonic outreach and monthly non-utilizer texting) with a focus on members least likely to use preventive services.
- Strengthen continuity of care (dental home) by improving follow-up scheduling after the first visit and targeting members who are overdue for recall/preventive services to support the 5% improvement goal.
- Expand community dental clinic days/mobile access events using data-driven targeting and transportation coordination to reduce no-shows and increase completed visits.



- Implement and evaluate ED diversion education (e.g., Pfizer dental ED card) and enhance post-ED navigation to dental providers to improve appropriate utilization.
- Enhance measurement and operational tracking to better link interventions to quarterly performance and guide rapid-cycle adjustments.

PIP #3

OBJECTIVE:

Follow-up after hospitalization for mental illness within 30days -Adults

GOAL:

Improve FUH 30day adult rate from 2024 baseline rate of 59.72% to 61.51% during the reported measurement year.

MEASUREMENT:

Measurement Period	MM/DD/YYYY to MM/DD/YYYY	Numerator(s)	Denominator(s)	Rate(s)	Met (Y/N)
Baseline	01/01/2024 to 12/31/2024	212	355	59.72%	NA
Remeasurement Year # 1	01/01/2025 to 12/31/2025	281	488	57.58% (Current YTD, data lag)	TBD

FINDINGS:

- As of 09/25, Remeasurement Year 1 FUH 30-day adult performance is 57.58% (281/488), which is below the 2024 baseline rate of 59.72% and the goal of 61.51%. These results are based on year-to-date data and are impacted by known claims and data lag, which may limit capture of completed follow-up visits. Performance is expected to improve once end-of-year claims are fully processed, and final Remeasurement Year 1 results are available.

BARRIERS:

- Neither internal or cc360 report captures all members for FUH needs
- Members often are unaware of PIHPs or how to connect
- Work was segmented across team with no dedicated individual or SME



- Lack of internal resources to devote to special population
- Data regarding FUH has considerable lag and does not always align between cc360 and HAP CareSource

INTERVENTIONS IN MY2025

- Weekly monitoring of psych inpatient report from cc360 and daily review of HAP CareSource inpatient dashboard
- Assign 100% of members identified to CM for outreach to assist in making appointments.
- Remove barriers (i.e. transportation) and follow up with members afterwards to ensure appointment was kept.
- Create and implement communication to educate members on PIHPs and how to connect
- Assigned dedicated CM to focus on initiative
- Hired Special Populations Manager to have a dedicated focus on specialty populations including relationships with PIHPs.
- Collaborate with HEDIS analytics team to create reporting that better aligns and captures FUH data more timely

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026

- Continue with successful strategies from 2025 while enhancing engagement strategies.
- Provider education
- Vital Data Technologies (VDT) data-sharing initiative-a pilot program intervention intended to improve data visibility and coordination between Care Management and PIHPs.

D. Member Safety and Welfare

Member safety and welfare is a priority for the health plan. HAP CareSource has implemented various programs and activities to ensure safe care and services are delivered to the members supported by the plan's policies and procedures. The health plan has a robust Peer Review process in place and access to various specialty providers to ensure that the highest quality of care is delivered to the membership. On an ongoing basis, staff in various departments who identifies a Potential Quality of Care (PQoC) creates a detailed intake referral for investigation. Member clinical grievances that are categorized as QoC concerns are also referred to the Enterprise Clinical Quality Health and Safety team for review and investigated, if warranted.

Table 13: PQoC referrals

	Leveling Data Definition	Measurement Periods
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PQoC Level	Standard of Care Met/Not Met	Outcome	MY23	MY24	MY25
N/A	Not Investigated	Not clinical in nature; not eligible at time of service.	0	2	4
Level 0	Met	No untoward outcome.	0	4	11
Level 1	Met	Minor adverse outcome.	1	3	2
Level 2a	Met	Moderate adverse outcome, disability, or death.	0	2	2
Level 2B	Not Met	No untoward outcome/No documentation submitted.	1	11	6
Level 3	Not Met	Minor Injury	0	0	0
Level 4	Not Met	Moderate Injury	0	1	0
Level 5	Not Met	Death or Disability	0	0	0
Indeterminate		Insufficient Documentation - cannot be determined or leveled.	0	4	4
Total			2	27	29

Table 13 above demonstrates the number of referrals filed and investigated outcomes based on HAP CareSource's leveling methodology during MY2025. A continued increase in Quality-of-Care cases in 2025 despite continued low volume of referrals. Opportunities for improvement in 2026: Ensure all identified Quality-of-Care cases are referred for review.

E. Population Health Management Strategy

On an annual basis, the health plan completes a comprehensive population profile assessment to evaluate appropriateness and availability of internal and external resources and programs against assessed population characteristics and subsequent needs. The health plan uses the assessment to identify population-based healthcare services focusing on prevention and wellness, mitigation of emerging health needs, member safety and outcomes across settings and management of chronic conditions in alignment with NCQA accreditation standards and guidelines and Michigan Population Health and Quality Strategy, as applicable.



HAP CareSource evaluates its population health management strategy, which is integrated across the QI program and program components on an annual basis using process and outcome measures, cost of care and/or utilization trends and member experience feedback regarding the plan's programs. Based on the evaluation and future-year population health assessment, the plan designs future year strategy.

The following were identified as the population health management strategy programs during MY2025. Please refer to the Population Health Management Strategy Evaluation for a comprehensive evaluation of the plan's strategy.

Table 14: Plan Population Health Programs:

Population Health Domain/Focus	Target Population	Program Focus
Keeping Members Healthy	Healthy Adults/ Healthy Kids	Rewarding members for completing healthy activities such as wellness, visits, dental exams, preventative disease screenings, and recommended immunizations.
Managing Members with Emerging Risk	Members identified with heightened potential for adverse health outcomes.	HAP CareSource's Integrated Care Management Program has a philosophy to focus on evidence-based, best practice interventions to optimize member outcomes. HAP CareSource empowers members of all ages and their families to direct their own care through provision of on-demand tools to learn about a condition, connect with local services and resources, and by streamlining support through care coordination.
Member Safety and/or Transitions of Care	Members transitioning from Skilled Nursing Facilities (SNFs) back into the community	The Transitions of Care program ensures the member has the resources they need in order to make the transition back into the community as smooth as possible
Managing Members with Multiple Chronic Conditions	Members with chronic conditions	MyHealth is electronic platform with tools that promote lifestyle habits and proactively managing chronic conditions. The goal is to drive awareness, encourage member engagement, and monitor member participation. It is designed for members 18 years and older.

F. Accreditation activities



HAP CareSource of Michigan is accredited through the NCQA accrediting body. Through the ongoing process of oversight and compliance with accreditation requirements, the plan continually evaluates its infrastructure to ensure that plan strategies and goals are met during each MY. NCQA accreditation standards and guidelines provide the health plan with the framework of gold standard and best practice that contribute to the overarching goals of the plan.

VI. Clinical Measurement Activities: Process and Outcomes

A. Healthcare Effectiveness Data and Information Set (HEDIS®)

On an annual basis, the plan evaluates and reports its performance based on HEDIS® and/or other performance indicators that are mandated by local or federal regulators. MY2025 performance metrics were monitored regularly and reported to various stakeholders through the QI committee structure. Health plan implemented various initiatives and activities throughout the year in support of the plan's goal to improve health outcomes and to align with the Michigan quality strategy. HAP CareSource monitored and reported all Medicaid required measures which included the following priority measures based on contractual priority and/or accreditation/HPR NCQA STAR ratings:

- Prevention and population HEDIS® measures:
 - Well-Child Visits in the First 30 Months of Life – First 15 months (W30-15)
 - Well-Child Visits in the First 30 months of Life – 15 through 30 months of life (W30-30)
 - Child and Adolescents Well-Care Visits (WCV)
 - Lead Screening in Children (LSC)
 - Childhood Immunization Status – Combination 3 (CIS)
 - Immunizations for Adolescents – Combination 2 (IMA-E)
 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Body Mass Index (BMI) Percentile – (WCC)
 - Adults' Access to Preventive Services (AAP)
- Women's Reproductive Health HEDIS® measures:
 - Prenatal and Post-Partum Care – Timeliness of Prenatal Care (PPC-PN)
 - Prenatal and Post-Partum Care – Post Partum Care (PPC-PP)
- Cancer Screenings HEDIS® measures:
 - Breast Cancer Screening (BCS-E)



- Cervical Cancer Screening (CCS)
- Chlamydia Screening (CHL)
- Treatment HEDIS® measures:
 - Controlling Blood Pressure (CBP)
 - Asthma Medication Ratio (AMR)
 - Eye Exam for Patients with Diabetes (EED)
 - Blood Pressure Control for Patients with Diabetes (BPD)
 - Glycemic Status Assessment for Patients with Diabetes – Glycemic Status <8% (GSD)
 - Kidney Health Evaluation for Patients with Diabetes (KED)
- BH HEDIS® measures:
 - Follow-Up After Hospitalization for Mental Illness within 30 days – 6-17 years (FUH-30)
 - Follow-Up After Hospitalization for Mental Illness within 30 days – 18+ years (FUH-30)
 - Initiation and Engagement of Substance Use Disorder Treatment – Engagement of SUD treatment (IET-E)

Childhood Immunization Status – Combination 3 (CIS-E)

OBJECTIVE:

The percentage of children 2 years of age who had Combination 3 vaccines by their second birthday. Combination 3 includes DTaP, IPV, MMR, HiB, HepB, VZV and PCV vaccinations.

GOAL:

To reach 68.86% in MY2025.

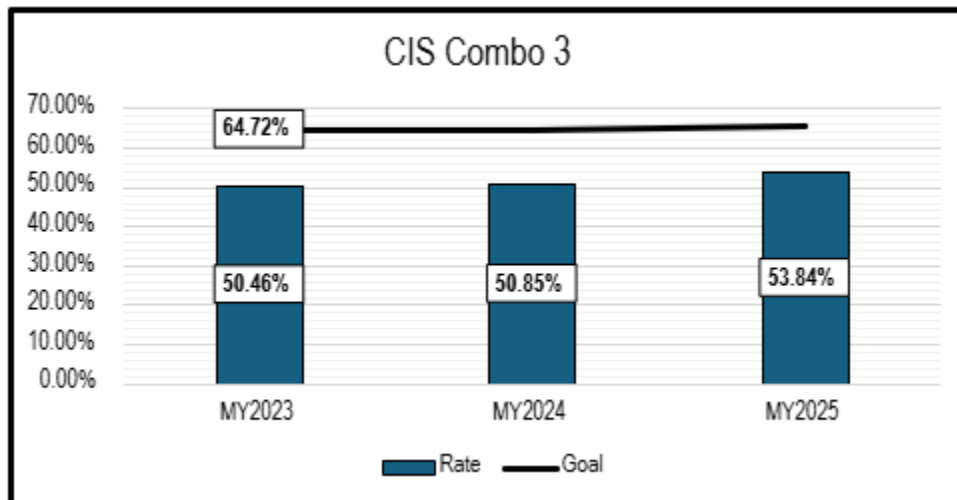
MEASUREMENT:

Overall effectiveness is measured through the annual HEDIS® reporting process; measure performance is monitored monthly.

FINDINGS:

Graph 2: CIS Combo 3





**Data as of January 16, 2026.

The plan's CIS Combo 3 rate is presented in Graph 2. MY2023 and MY2024 are final HEDIS rates. MY2025 is final admin rate CIS Combo 3 performance in MY2025 demonstrates gradual improvement, suggesting that existing outreach, provider engagement, and community-based strategies are beginning to positively influence immunization completion. However, performance remains below the established goal.

BARRIERS:

- Convenient, timely access to high-quality, coordinated care
- Identifying and addressing member barriers
- Member education and awareness of recommended immunization schedules

INTERVENTIONS IN MY2025:

- Member outreach (e.g., telephonic, text, mail, and/or IVR)
- Local Health Dept. (MDHHS) Collaboration
- Provider Partnership Expansion, 3-way warm handoff appointment scheduling
- Community Clinic Events
- Vaccination BINGO
- School-based Health Centers (SBHC)
- Adolescent Score Card

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:



- Continue with successful strategies from 2025 while enhancing access points and engagement strategies by age cohort.
- Provider education and strategy discussions regarding plan services and benefits, best practices, gap-in-care closure strategies and tools, and operational strategies conducted during Partnership Oversight Committee (POC) meetings.

Immunizations for Adolescents – Combination 2 (IMA-E)

OBJECTIVE:

The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.

GOAL:

To reach 36.02% in MY2025.

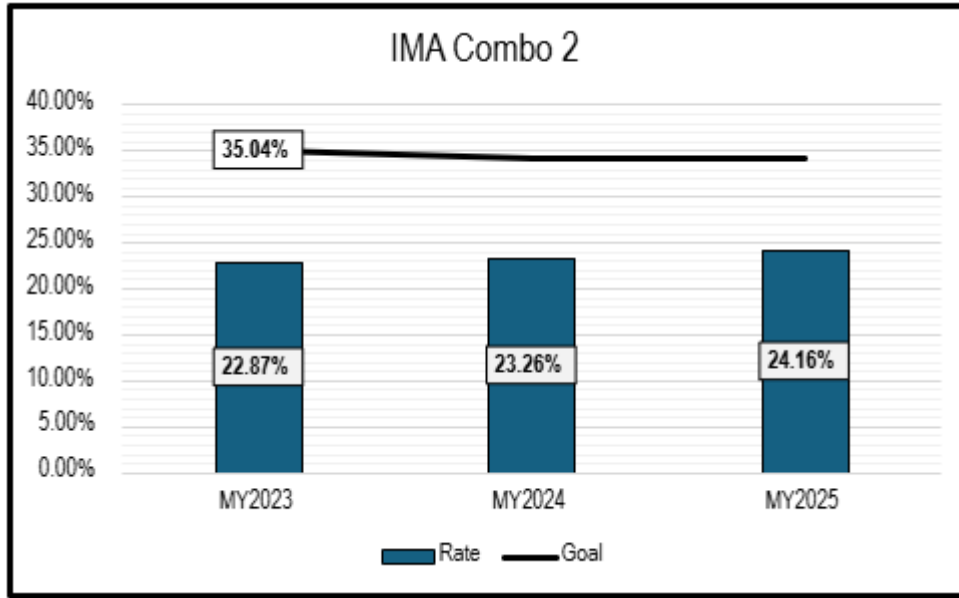
MEASUREMENT:

Overall effectiveness is measured through the annual HEDIS® reporting process; measure performance is monitored monthly.

FINDINGS:

Graph 3: IMA Combo 2





**Data as of January 16, 2026.

The plan's rate for the IMA Combo 2 measure is noted in Graph 3. IMA Combo 2 performance in MY2025 shows modest year-over-year improvement, indicating that ongoing outreach and provider engagement efforts are contributing to increased adolescent immunization uptake. Performance remains below goal. Denominator up roughly 30% year over year.

BARRIERS:

- Challenges with adolescent engagement and preventive care utilization
- Missed opportunities for immunization during routine or acute visits
- Member and caregiver awareness of recommended adolescent immunization schedules

INTERVENTIONS IN MY2025:

- Member outreach (e.g., telephonic, text, mail, and/or IVR)
- Partner with Federally Qualified Health Centers (FQHCs)
- Provider Partnership Expansion, 3-way warm handoff appointment scheduling
- Community Clinic Events
- SBHC

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:



- Continue with successful strategies from 2025 while enhancing access points and engagement strategies by age cohort.
- Provider education and strategy discussions regarding plan services and benefits, best practices, gap-in-care closure strategies and tools, and operational strategies conducted during Partnership Oversight Committee (POC) meetings.

Weight Assessment and Counseling for Nutrition and Physical Activity for
Children/Adolescents BMI Percentile – (WCC)

OBJECTIVE:

The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had Counseling for Nutrition, Counseling for Physical Activity and BMI percentile completed during the measurement year.

GOAL:

To reach 90th percentile in MY2025.

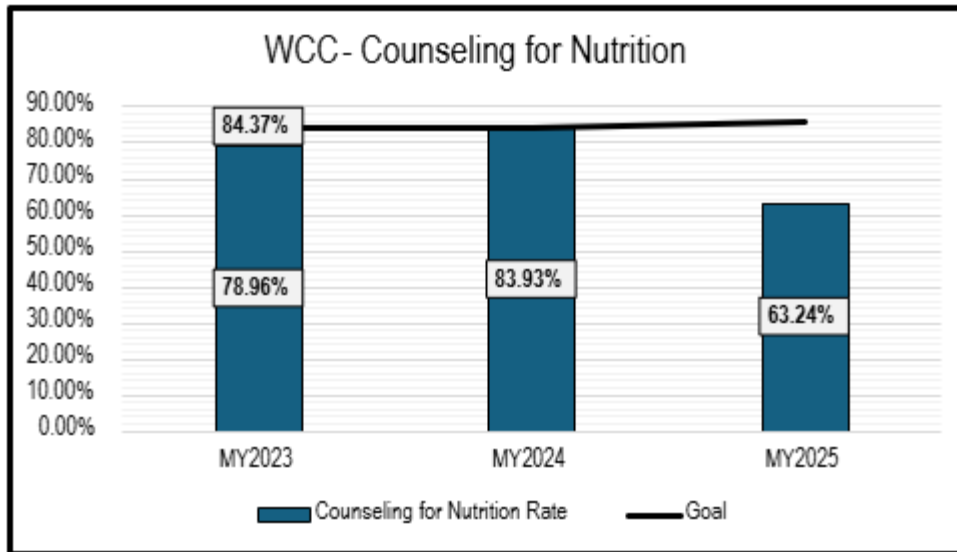
MEASUREMENT:

Overall effectiveness is measured through the annual HEDIS® reporting process; measure performance is monitored monthly.

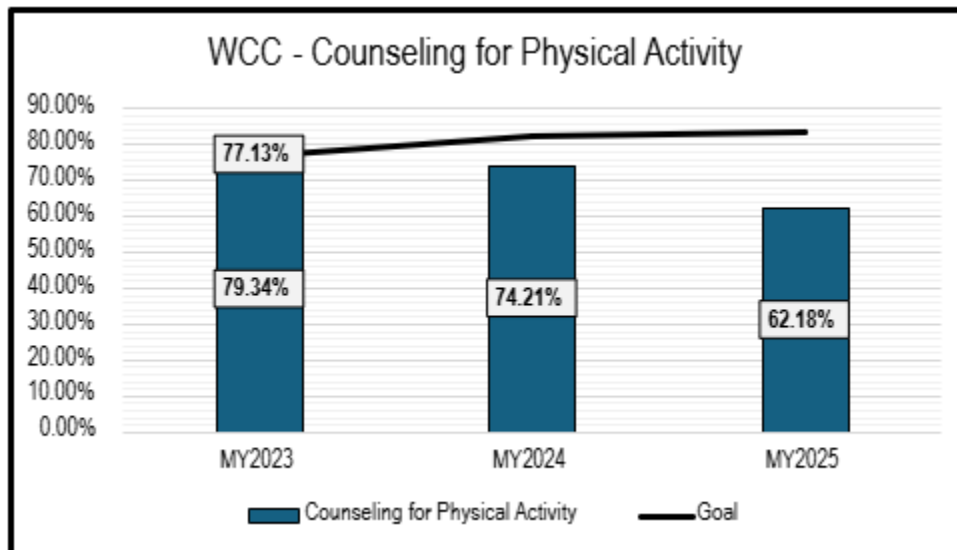
FINDINGS:

Graph 4: WCC Counseling for Nutrition, Counseling for Physical Activity and BMI percentile



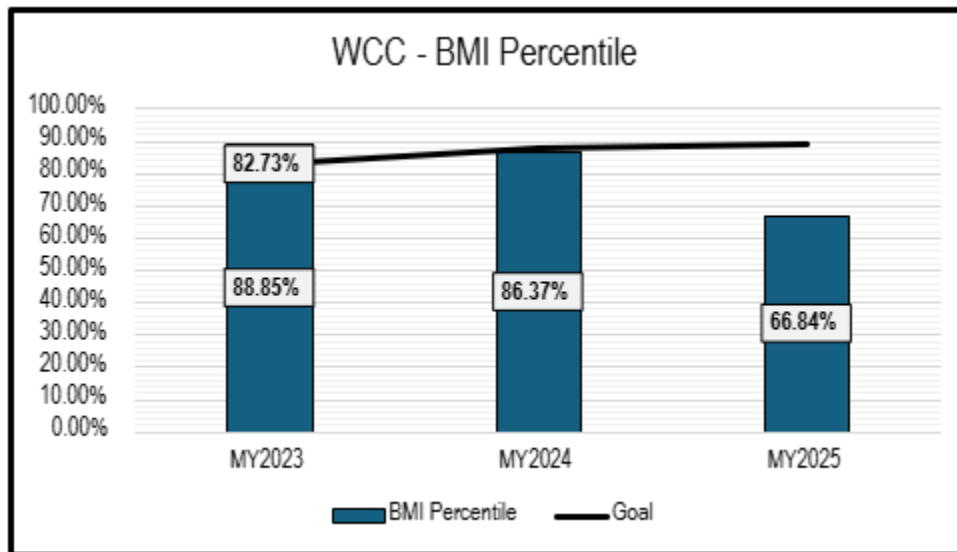


**Hybrid measure – results may continue to shift as additional clinical data are submitted and validated. Data as of January 16, 2026.



** Hybrid measure – results may continue to shift as additional clinical data are submitted and validated. Data as of January 16, 2026.





**Hybrid measure – results may continue to shift as additional clinical data are submitted and validated. Data as of January 16, 2026.

Graph 4 demonstrates the 2025 administrative rate for WCC Counseling for Nutrition, Counseling for Physical Activity and BMI Percentile. The administrative rates are trending below the prior year final hybrid rates as expected. The final hybrid rates for 2025 will not be known until July 2026. At that time, a final year-over-year performance analysis will be conducted against the 2023 and 2024 rates, and strategy updates will be made as appropriate. Denominator increases year over year by no less than 30%.

BARRIERS:

- Inconsistent documentation of counseling and BMI percentile during well-child visits
- Member and caregiver engagement challenges
- Access and scheduling barriers

INTERVENTIONS IN MY2025:

- Member outreach (e.g., telephonic, text, mail, and/or IVR)
- Provider Partnership Expansion, 3-way warm handoff appointment scheduling
- Community Clinic Events
- Vaccination BINGO
- Adolescent Score Card

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:



- Continue with successful strategies from 2025 while enhancing access points and engagement strategies by age cohort.
- Provider education and strategy discussions regarding plan services and benefits, best practices, gap-in-care closure strategies and tools, and operational strategies conducted during Partnership Oversight Committee (POC) meetings.

Well-Child Visits in the First 30 Months of Life – First 15 months (W30-15) & 15 through 30 months of Life (W30-30)

OBJECTIVE:

The percentage of members who had well child visits with a PCP during the last 15 months: (1) Children who turned 15 months old during the MY and who completed six (6) or more well-child visits; (2) Children who turned 30 months old during the MY and who completed two (2) or more well-child visits.

GOAL:

To reach 64.99% in MY2025 for W15 and 73.09% in MY2025 for W30.

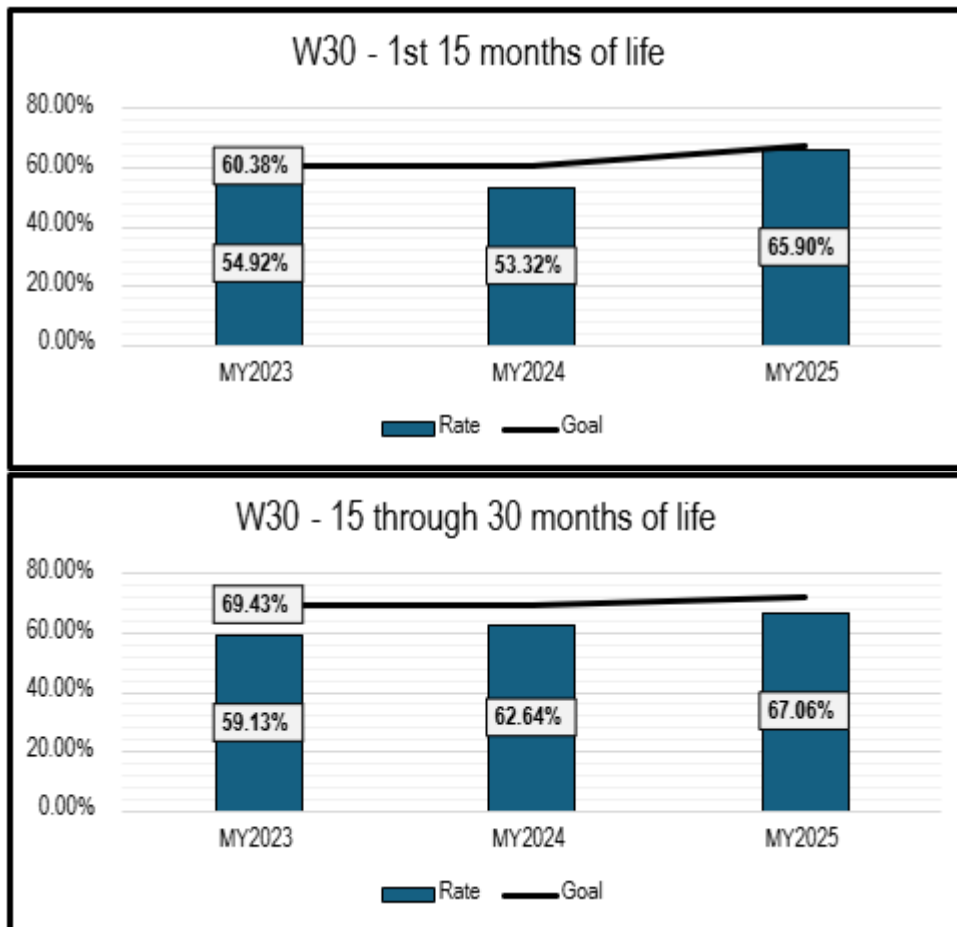
MEASUREMENT:

Overall effectiveness is measured through the annual HEDIS® reporting process; measure performance is monitored monthly.

FINDINGS:

Graph 5: W30-15 and W30-30





**Data as of January 16, 2026.

Graph 5 above demonstrates the plan's rates for the W30-15 and W30-30 measures. W30 performance in MY2025 demonstrates overall improvement, with gains observed across both age bands, indicating that outreach and care coordination efforts are supporting increased well-child visit completion in early childhood. While W30-15 met goal, W30-30 remained below target, suggesting ongoing challenges with visit continuity and completion of recommended visits beyond the first year of life.

BARRIERS:

- Convenient, timely access to high-quality, coordinated care
- Identifying and addressing member barriers
- Member education, awareness, and understanding of importance of annual well car visits



INTERVENTIONS IN MY2025:

- Member outreach (e.g., telephonic, text, mail, and/or IVR)
- Local Health Dept. (MDHHS) Collaboration
- Provider Partnership Expansion, 3-way warm handoff appointment scheduling
- Community Clinic/Mobile Events
- Vaccination BINGO
- School-based Health Centers
- Adolescent Score Card
- MOSAIC CIN
- Partnership with FQHCs

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Continue with successful strategies from 2025 while enhancing access points and engagement strategies by age cohort.
- Provider education and strategy discussions regarding plan services and benefits, best practices, gap-in-care closure strategies and tools, and operational strategies conducted during Partnership Oversight Committee (POC) meetings.

Child and Adolescents Well-Care Visits (WCV)

OBJECTIVE:

The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the MY.

GOAL:

To reach 65.39% in MY2025 for 3-11 years, 55.01% in MY2025 for 12-17 years, and 33.78% for MY2025 for 18-21 years.

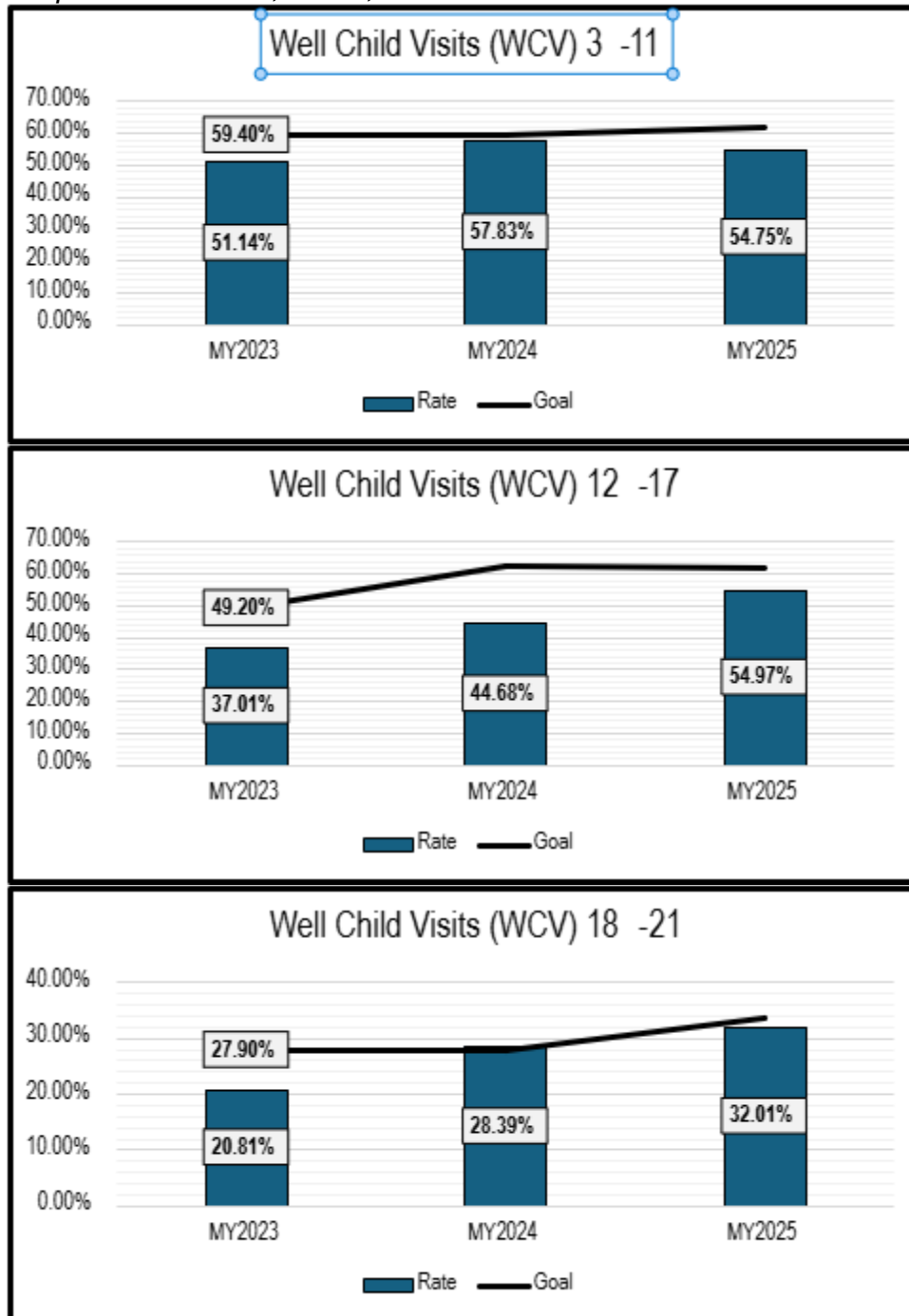
MEASUREMENT:

Overall effectiveness is measured through the annual HEDIS® reporting process; measure performance is monitored monthly.



FINDINGS:

Graph 6: WCV 3-11, 12-17, and 18-21



**Data as of January 16, 2026.



The plan's rate for the WCV HEDIS® measure is noted in Graph 6. WCV 3-11 goal was not met by 10.64 percentage points. WCV performance in MY2025 remained below goal across all age bands, indicating ongoing challenges with annual well-care visit completion among children, adolescents, and young adults. While some age groups demonstrated modest improvement compared to prior years, persistent gaps suggesting targeted opportunities particularly among older adolescents and young adults. Significant denominator increases year over year.

BARRIERS:

- Convenient, timely access to high-quality, coordinated care
- Identifying and addressing member barriers
- Member education, awareness, and understanding of importance of annual well car visits

INTERVENTIONS IN MY2025:

- Member outreach (e.g., telephonic, text, mail, and/or IVR)
- Local Health Dept. (MDHHS) Collaboration
- Provider Partnership Expansion, 3-way warm handoff appointment scheduling
- Community Clinic/Mobile Events
- Vaccination BINGO
- School-based Health Centers
- Adolescent Score Card
- MOSAIC CIN
- Partnership with FQHCs

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Continue with successful strategies from 2025 while enhancing access points and engagement strategies by age cohort.
- Provider education and strategy discussions regarding plan services and benefits, best practices, gap-in-care closure strategies and tools, and operational strategies conducted during Partnership Oversight Committee (POC) meetings.

Prenatal and Post-Partum Care – Timeliness of Prenatal Care (PPC-PN)

OBJECTIVE:



The percentage of live births on or between October 8 of the year prior to the MY and October 7 of the MY that received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment in the plan.

GOAL:

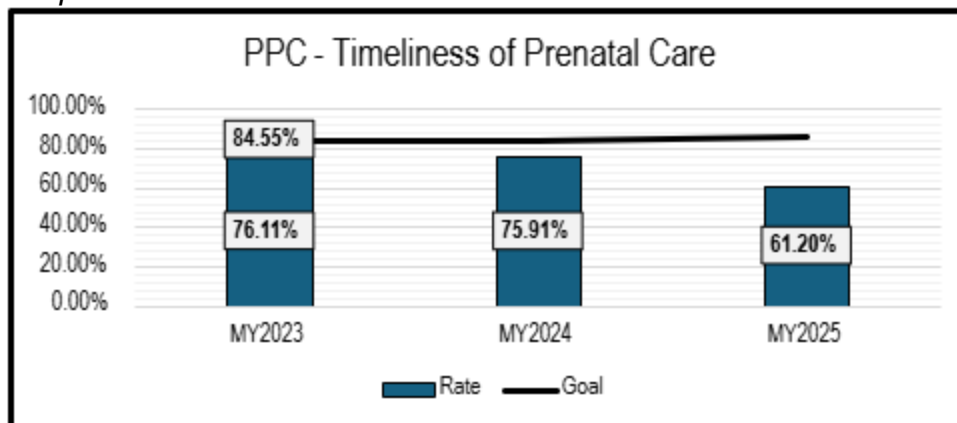
To reach 86.24% in MY2025.

MEASUREMENT:

Overall effectiveness is measured through the annual HEDIS® reporting process; measure performance is monitored monthly.

FINDINGS:

Graph 7: PPC – Timeliness of Prenatal Care



**Hybrid measure – results may continue to shift as additional clinical data are submitted and validated. Data as of January 16, 2026.

Graph 7 demonstrates the 2025 administrative rate for completed PPC – timeliness of prenatal care. The administrative rate is trending below the final hybrid rates for timeliness of prenatal care in 2023 and 2024 as expected. The final hybrid rate for 2025 will not be known until July 2026. At that time, a final year-over-year performance analysis will be conducted against the 2023 and 2024 rates, and strategy updates will be made as appropriate. 20+% denominator increases year over year.

BARRIERS:

- Accurate and timely data to identify pregnant members
- Convenient, timely access to high-quality, coordinated care
- Identifying and addressing member barriers



INTERVENTIONS IN MY2025:

- Member outreach (e.g., telephonic, text, mail, and/or IVR)
- Food Service Programs (i.e., ILOS In-lieu of services, Moms Meals)
- Partner with FQHCs

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Improve early identification of pregnant members through stronger data capture, referral pathways, and cross-functional coordination to minimize delays in initiating prenatal care.
- Reduce access and social barriers by continuing integrated transportation, food services, and care coordination for members with identified needs.
- Enhance documentation and data completeness through focused provider education and improved supplemental data collection for accurate measure capture.

Prenatal and Post-Partum Care – Post Partum Care (PPC-PP)

OBJECTIVE:

The percentage of live births on or between October 8 of the year prior to the MY and October 7 of the MY that had a postpartum visit on or between seven (7) and 84 days after delivery.

GOAL:

To reach 81.84% in MY2025.

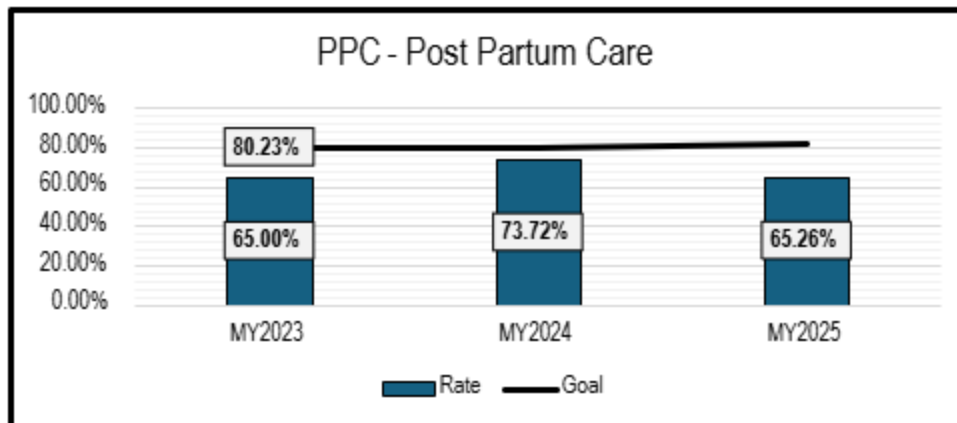
MEASUREMENT:

Overall effectiveness is measured through the annual HEDIS® reporting process; measure performance is monitored monthly.

FINDINGS:

Graph 8: PPC – Post Partum Care





**Hybrid measure – results may continue to shift as additional clinical data are submitted and validated. Data as of January 16, 2026.

Graph 8 demonstrates the 2025 administrative rate for completed PPC – timeliness of post partum care. The administrative rate is trending below the final hybrid rates for timeliness of post partum care in 2023 and 2024 as expected. The final hybrid rate for 2025 will not be known until July 2026. At that time, a final year-over-year performance analysis will be conducted against the 2023 and 2024 rates, and strategy updates will be made as appropriate.

BARRIERS:

- Accurate and timely data to identify pregnant members
- Convenient, timely access to high-quality, coordinated care
- Identifying and addressing member barriers

INTERVENTIONS IN MY2025:

- Member outreach (e.g., telephonic, text, mail, and/or IVR)
- Food Service Programs (i.e., ILOS In-lieu of services, Moms Meals)
- Partner with FQHCs
- Doula Referrals
- Mom and Baby Beginnings Program

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Strengthen early post-partum engagement.
- Enhance access to post-partum visits by continuing warm-handoff scheduling and collaboration with OB/GYN, FQHC, and maternal health providers.



- Improve documentation and data completeness through provider education and focused monitoring of supplemental data to support accurate capture of post-partum care services.

Breast Cancer Screening (BCS-E)

OBJECTIVE:

The percentage of members 40-74 years of age who completed a routine breast cancer screening.

GOAL:

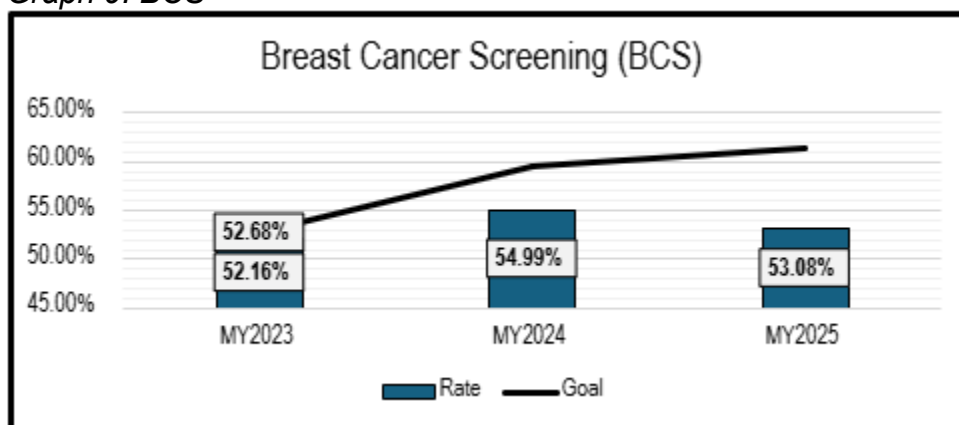
To reach 60.70% in MY2025.

MEASUREMENT:

Overall effectiveness is measured through the annual HEDIS® reporting process; measure performance is monitored monthly.

FINDINGS:

Graph 9: BCS



**Data as of January 16, 2026.

The plan's rate for the BCS HEDIS® measure is noted in Graph 9. Graph 9 shows that breast cancer screening performance remained relatively stable but declined slightly in MY2025 compared to prior years, with rates continuing to fall below the established goal. This pattern suggests persistent challenges in screening uptake and highlights an opportunity to strengthen outreach, provider



engagement, and member education to improve preventive screening compliance.

BARRIERS:

- Convenient, timely access to high-quality, coordinated care
- Identifying and addressing member barriers
- Member education and awareness of recommendation schedules

INTERVENTIONS IN MY2025:

- Member outreach (e.g., telephonic, text, mail, and/or IVR)
- Community Clinic Events
- Provider Education via JOC meetings and HCS Newsletters
- Care Management

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Strengthen targeted member outreach to increase awareness of recommended screening intervals
- Expand community-based screening opportunities
- Enhance provider engagement and education

Cervical Cancer Screening (CCS)

OBJECTIVE:

The percentage of members 21-64 years of age who were recommended for routine cervical cancer screening.

GOAL:

To reach 58.32% in MY2025

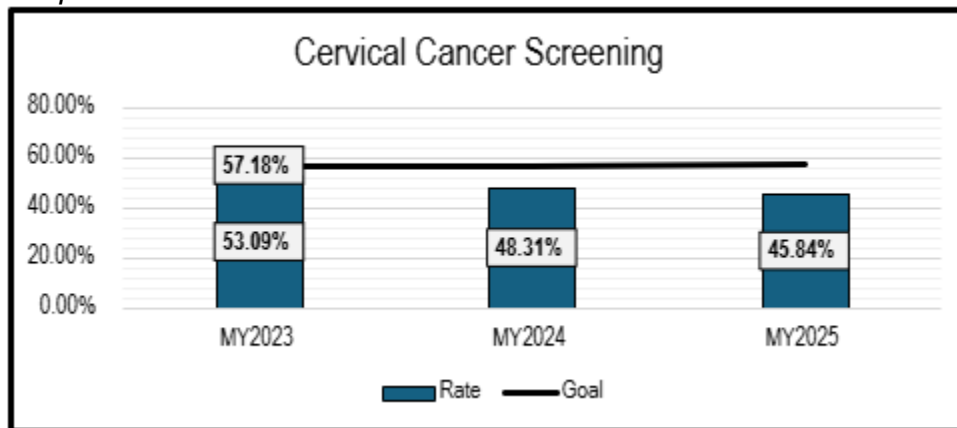
MEASUREMENT:

Overall effectiveness is measured through the annual HEDIS® reporting process; measure performance is monitored monthly.

FINDINGS:



Graph 10: CCS



**Hybrid measure – results may continue to shift as additional clinical data are submitted and validated. Data as of January 16, 2026.

Graph 10 demonstrates the 2025 administrative rate for completed cervical cancer screenings. The administrative rate is trending below the final hybrid rates for cervical cancer screenings in 2023 and 2024 as expected. The final hybrid rate for 2025 will not be known until July 2026. At that time, a final year-over-year performance analysis will be conducted against the 2023 and 2024 rates, and strategy updates will be made as appropriate.

BARRIERS:

- Convenient, timely access to high-quality, coordinated care
- Identifying and addressing member barriers
- Member education and awareness of recommendation schedules

INTERVENTIONS IN MY2025:

- Member outreach (e.g., telephonic, text, mail, and/or IVR)
- Community Women's Health Clinic Events
- Provider Education via JOC meetings and HCS Newsletters
- Care Management
- MOSAIC CIN

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Strengthen targeted member outreach and education
- Enhance provider engagement and education
- Expand access to women's health screening opportunities



Chlamydia Screening (CHL)

OBJECTIVE:

The percentage of members 16-24 years of age who were identified as sexually active and who completed at least one (1) test for chlamydia during the MY2025.

GOAL:

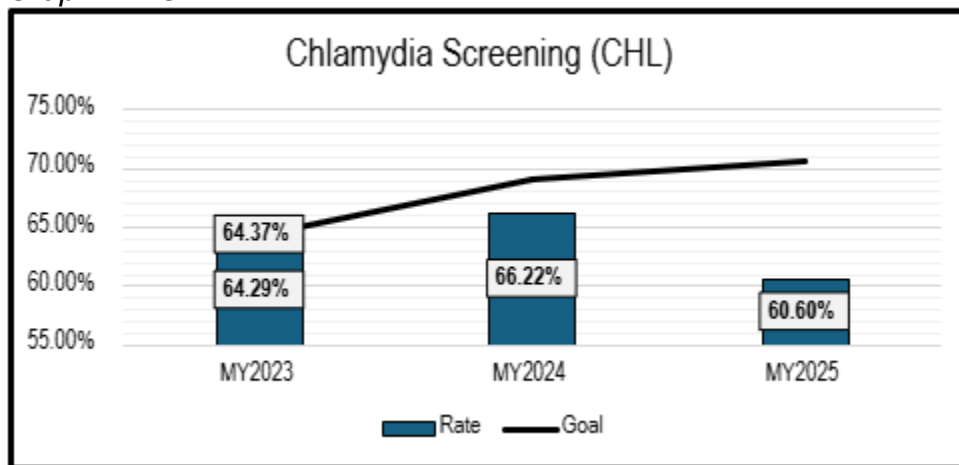
To reach 70.45% in MY2025

MEASUREMENT:

Overall effectiveness is measured through the annual HEDIS® reporting process; measure performance is monitored monthly.

FINDINGS:

Graph 11: CHL



**Data as of January 16, 2026.

The plan's rate for the CHL HEIDS® measure is noted in Graph 11. Chlamydia screening performance in MY2025 declined compared to prior years and remained below the established goal, indicating ongoing challenges with screening uptake among eligible members.

BARRIERS:

- Convenient, timely access to high-quality, coordinated care
- Identifying and addressing member barriers



- Missed screening opportunities

INTERVENTIONS IN MY2025:

- Community Women's Health Clinic Events
- Provider Education via JOC meetings and HCS Newsletters
- Care Management
- Mom and Baby Beginnings Program
- MTL Vendor

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Strengthen targeted member outreach and education
- Identify opportunities to increase returned MTL vendor kits
- Expand access to screening opportunities

Asthma Medication Ratio (AMR)

OBJECTIVE:

The percentage of members 6-64 years of age who were identified as having persistent asthma and who had a ratio of controlled medications to total asthma medications of 0.50 or greater during the MY.

GOAL:

To reach 70.39% in MY2025

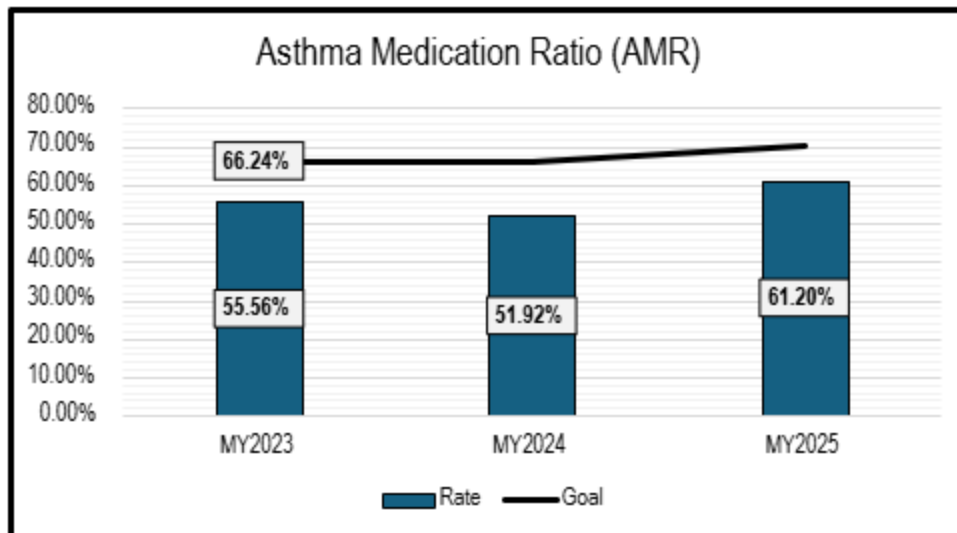
MEASUREMENT:

Overall effectiveness is measured through the annual HEDIS® reporting process; measure performance is monitored monthly.

FINDINGS:

Graph 12: Asthma Medication Ratio





**Data as of January 16, 2026.

The plan's rate for the AMR HEDIS® measure is presented in Graph 12. AMR performance in MY2025 improved compared to MY2024 but remained below the established goal, indicating progress in asthma medication management alongside ongoing opportunities for improvement. The upward trend suggests that medication adherence initiatives and pharmacy-focused interventions are beginning to positively influence controller medication use; however, persistent gaps highlight continued challenges related to medication adherence, refill behavior, and consistent engagement among members with persistent asthma. Progressive denominator increase year over year.

BARRIERS:

- Convenient, timely access to high-quality, coordinated care
- Identifying and addressing member barriers
- Medication adherence and refill behavior

INTERVENTIONS IN MY2025:

- AMR Provider Pharmacy Letters
- Pharmacy Text Message Adherence Reminder
- Disease Management Asthma Newsletters

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Strengthen medication adherence support



- Improve member education and engagement by reinforcing asthma self-management, medication purpose, and the importance of adherence through targeted outreach and disease management materials.
- Address access and refill barriers

Blood Pressure Control for Patients with Diabetes (BPD)

OBJECTIVE:

The percentage of members 18-75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the MY.

GOAL:

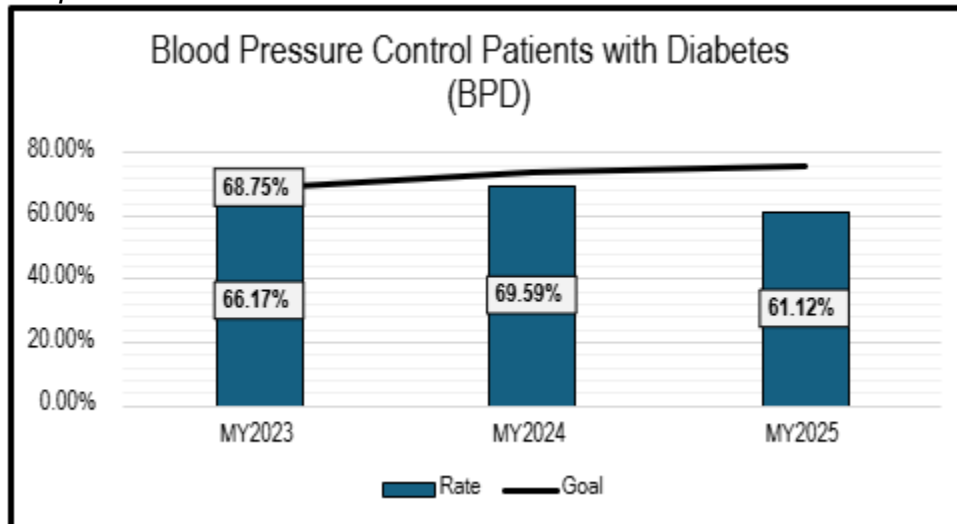
To reach 75.43% in MY2025

MEASUREMENT:

Overall effectiveness is measured through the annual HEDIS® reporting process; measure performance is monitored monthly.

FINDINGS:

Graph 13: BPD



**Hybrid measure – results may continue to shift as additional clinical data are submitted and validated. Data as of January 16, 2026.



Graph 13 demonstrates the 2025 administrative rate for completed blood pressure control patients with diabetes. The administrative rate is trending below the final hybrid rates for blood pressure control patients with diabetes in 2023 and 2024 as expected. The final hybrid rate for 2025 will not be known until July 2026. At that time, a final year-over-year performance analysis will be conducted against the 2023 and 2024 rates, and strategy updates will be made as appropriate. Denominator increases of 30% impacting rate.

BARRIERS:

- Medication adherence challenges
- Gaps in accurate and compliant blood pressure measurement
- Social needs impacting access-related barriers

INTERVENTIONS IN MY2025:

- Member outreach (e.g., telephonic, text, mail, and/or IVR)
- Community Clinic Events
- Diabetic Adherence Reminder Report Card Provider Letters
- Care Management
- Diabetic Prevention Program Provider Partnership
- Disease Management Diabetic Newsletters

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Strengthen medication adherence support
- Improve accuracy and consistency of blood pressure measurement
- Address social and access-related barriers impacting chronic disease management

Eye Exam for Patients with Diabetes (EED)

OBJECTIVE:

The percentage of members 18-75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.

GOAL:

To reach 59.41% in MY2025

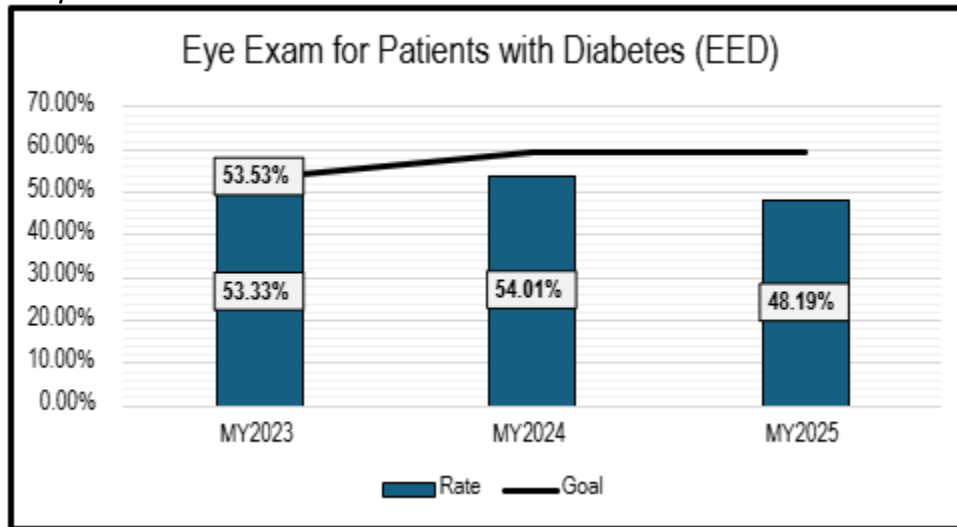
MEASUREMENT:



Overall effectiveness is measured through the annual HEDIS® reporting process; measure performance is monitored monthly.

FINDINGS:

Graph 14: EED



**Data as of January 16, 2026.

The plan's rate for the EED HEDIS® rate is noted in Graph 14. EED performance in MY2025 declined compared to MY2024 and remained below the established goal, indicating ongoing challenges in completing recommended retinal eye exams among members with diabetes. The decline suggests persistent barriers related to access to eye care services, coordination between medical and vision providers, and limitations in the availability and utilization of teleretinal screening and remote reading services. Continued below-goal performance highlights the need for strengthened care coordination, improved access options, and enhanced documentation to support timely and complete eye exam screening. Denominator increases of roughly 15% year over year.

BARRIERS:

- Convenient, timely access to high-quality, coordinated Caresource
- Identifying and addressing member barriers
- Limited availability and utilization of tele-retinal screening and remote reading services

INTERVENTIONS IN MY2025:



- Member outreach (e.g., telephonic, text, mail, and/or IVR)
- Community Clinic Events
- Diabetic Adherence Reminder Report Card Provider Letters
- Care Management
- Diabetic Prevention Program Provider Partnership
- Disease Management Diabetic Newsletters

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Improve access to retinal eye exams
- Enhance care coordination between medical and vision providers
- Strengthen member outreach and education

Glycemic Status Assessment for Patients with Diabetes – Glycemic Status <8% (GSD)

OBJECTIVE:

The percentage of members 18-75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c) was <8% during the MY.

GOAL:

To reach 60.58% in MY2025

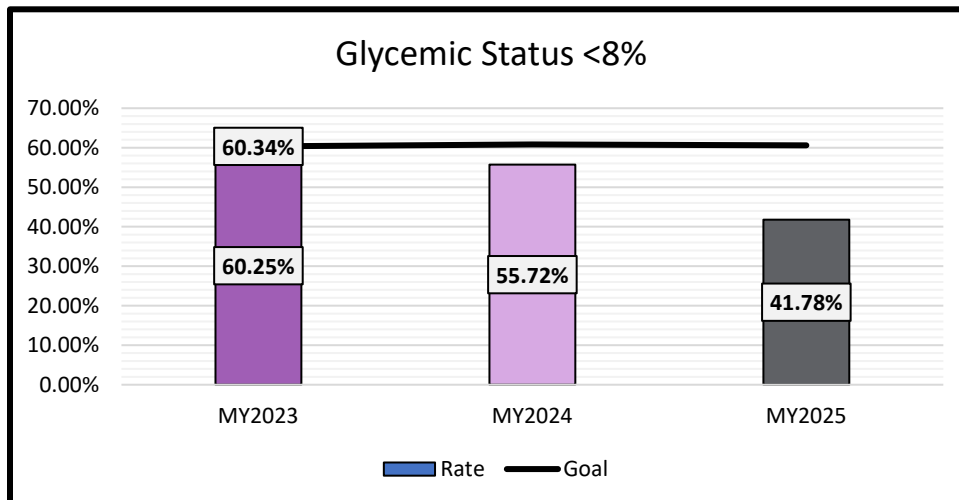
MEASUREMENT:

Overall effectiveness is measured through the annual HEDIS® reporting process; measure performance is monitored monthly.

FINDINGS:

Graph 15: Glycemic Status <8%





**Hybrid measure – results may continue to shift as additional clinical data are submitted and validated. Data as of January 16, 2026.

Graph 15 demonstrates the 2025 administrative rate for completed glycemic status <8%. The administrative rate is trending below the final hybrid rates for glycemic status <8% in 2023 and 2024 as expected. The final hybrid rate for 2025 will not be known until July 2026. At that time, a final year-over-year performance analysis will be conducted against the 2023 and 2024 rates, and strategy updates will be made as appropriate. Denominator increases of roughly 30% year over year.

BARRIERS:

- Missing clinical readings
- Medication adherence challenges
- Social and access-related barriers impacting diabetes care

INTERVENTIONS IN MY2025:

- Member outreach (e.g., telephonic, text, mail, and/or IVR)
- Community Clinic Events
- Diabetic Adherence Reminder Report Card Provider Letters
- Care Management
- Diabetic Prevention Program Provider Partnership
- Disease Management Diabetic Newsletters

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:



- Identify opportunities to close the “missing clinical readings” gap/hybrid measure lift
- Continue to offer and provide scheduling support during member engagement
- Further strengthen medication adherence interventions using pharmacy + care management together:

Kidney Health Evaluation for Patients with Diabetes (KED)

OBJECTIVE:

The percentage of members 18-85 years of age with diabetes (types 1 and 2) who received a kidney health evaluation during the MY.

GOAL:

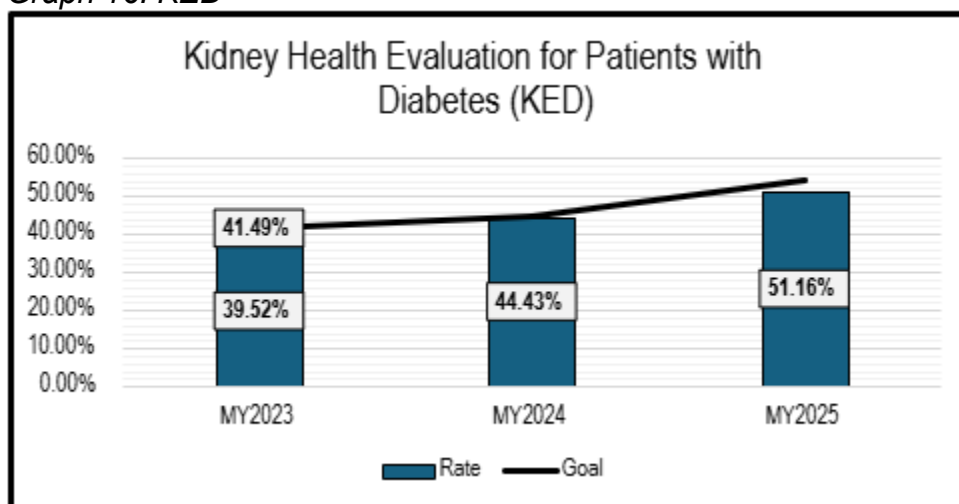
To reach 54.15% in MY2025

MEASUREMENT:

Overall effectiveness is measured through the annual HEDIS® reporting process; measure performance is monitored monthly.

FINDINGS:

Graph 16: KED



**Data as of January 16, 2026.



Graph 16 demonstrates the plan's rate for the HEDIS® KED measure. KED performance in MY2025 remained below the established goal, indicating ongoing challenges with completion of recommended kidney health evaluations among members with diabetes. Continued gaps suggest barriers related to timely screening completion, care coordination, and documentation of laboratory services.

BARRIERS:

- Convenient, timely access to high-quality, coordinated care
- Identifying and addressing member barriers
- Gaps in screening completion

INTERVENTIONS IN MY2025:

- Member outreach (e.g., telephonic, text, mail, and/or IVR)
- Community Clinic Events
- Diabetic Adherence Reminder Report Card Provider Letters
- Care Management
- Diabetic Prevention Program Provider Partnership
- MTL Vendor
- Disease Management Diabetic Newsletters

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Increase completion of kidney health screenings
- Enhance provider engagement and education
- Strengthen member outreach and engagement

Controlling Blood Pressure (CBP)

OBJECTIVE:

The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the MY.

GOAL:

To reach 71.34% in MY2025

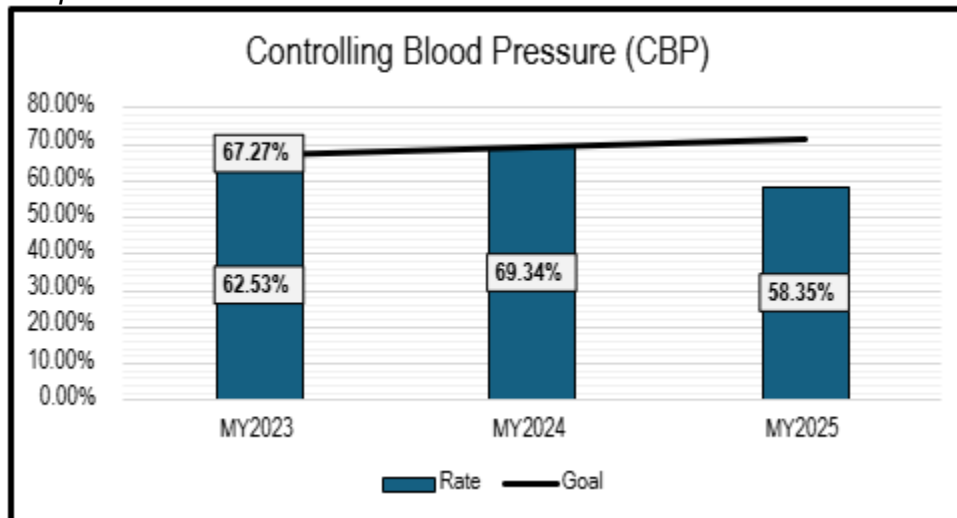


MEASUREMENT:

Overall effectiveness is measured through the annual HEDIS® reporting process; measure performance is monitored monthly.

FINDINGS:

Graph 17: CBP



**Hybrid measure – results may continue to shift as additional clinical data are submitted and validated. Data as of January 16, 2026.

Graph 17 demonstrates the 2025 administrative rate for completed controlling blood pressure. The administrative rate is trending below the final hybrid rates for controlling blood pressure in 2023 and 2024 as expected. The final hybrid rate for 2025 will not be known until July 2026. At that time, a final year-over-year performance analysis will be conducted against the 2023 and 2024 rates, and strategy updates will be made as appropriate. Denominator increases of approximately 15% year over year.

BARRIERS:

- Medication adherence challenges
- Gaps in accurate and compliant blood pressure measurement
- Social and access-related barriers affecting hypertension management

INTERVENTIONS IN MY2025:

- Member outreach (e.g., telephonic, text, mail, and/or IVR)
- Community Clinic Events



- Care Management
- Disease Management Hypertension Newsletters

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Strengthen medication adherence
- Improve accuracy and consistency of blood pressure measurement
- Enhance provider engagement and education

Follow-Up After Hospitalization for Mental Illness within 30 days (FUH-30)

OBJECTIVE:

The percentage of discharges for members 6 years of age and older who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service within 30 days after discharge.

GOAL:

To reach 70.59% in MY2025

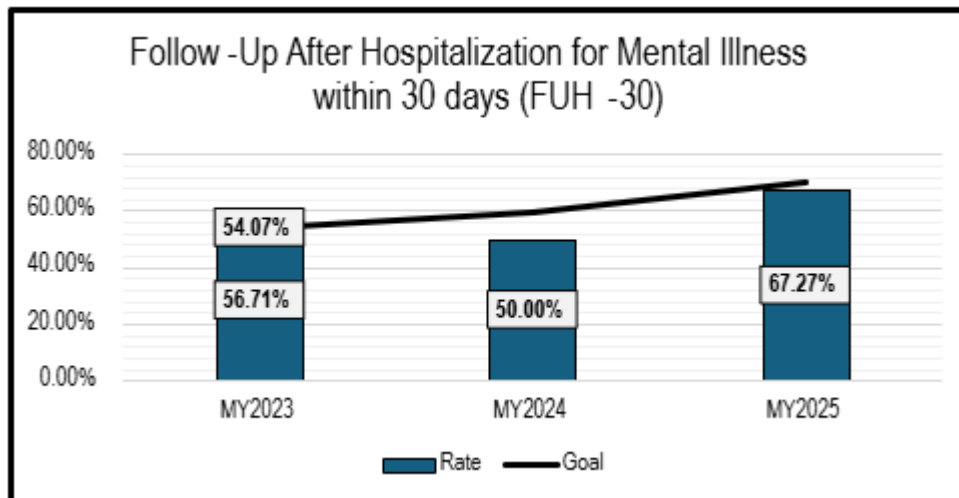
MEASUREMENT:

Overall effectiveness is measured through the annual HEDIS® reporting process; measure performance is monitored monthly.

FINDINGS:

Graph 18: FUH-30





**Data as of January 16, 2023.

The rate for the FUH-7 HEDIS® measure is noted in Graph 18. Graph 18 shows that FUH-30 performance in MY2025 remained below goal, reflecting ongoing challenges with timely outpatient behavioral health follow-up after inpatient discharge. This pattern suggests continued gaps in care transitions and access to follow-up services, underscoring the need to further strengthen post-discharge coordination and member engagement.

BARRIERS:

- Challenges with timely access to outpatient behavioral health follow-up services
- Care transition and care coordination gaps following inpatient discharge
- Social barriers impacting post-discharge follow-up

INTERVENTIONS IN MY2025:

- Care Management & Members Engaged in Foster Care
- Increase BH Referrals
- Enhance PIHP Collaboration & Establish Process Standardization
- Raise Awareness to BH Tool Kit
- Vital Data Technologies

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Strengthen post-discharge care coordination with PIHP partners
- Identify any opportunities to improve timeliness and completeness of discharge data



- Explore use of technology-enabled outreach

Initiation and Engagement of Substance Use Disorder Treatment – Engagement of SUD treatment (IET-E)

OBJECTIVE:

The percentage of new SUD episodes that result in treatment engagement within 34 days of treatment initiation.

GOAL:

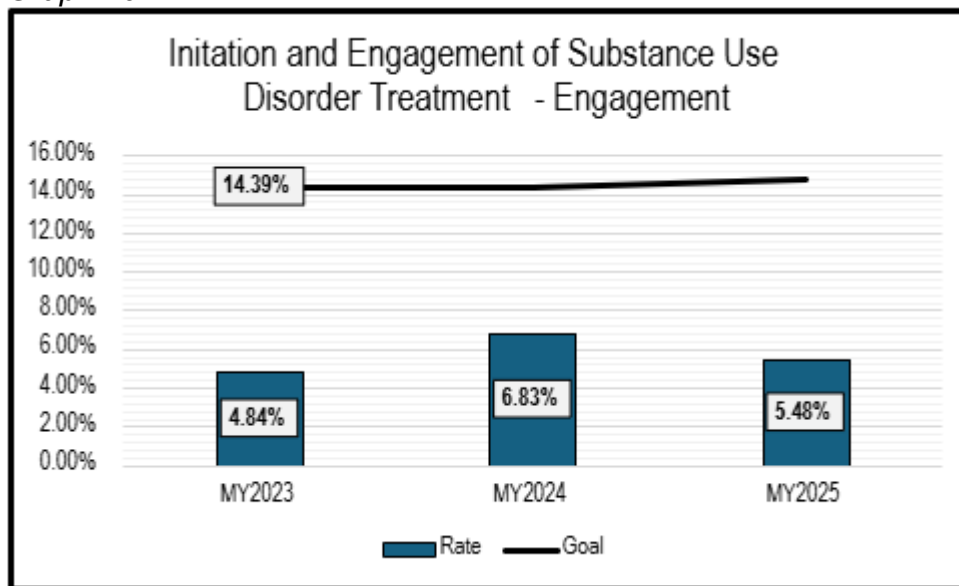
To reach 14.80% in MY2025

MEASUREMENT:

Overall effectiveness is measured through the annual HEDIS® reporting process; measure performance is monitored monthly.

FINDINGS:

Graph 19: IET-E



**Data as of January 16, 2026.

Rate for IET-E for the plan is presented in Graph 19. Graph 19 shows that IET-E performance in MY2025 remained well below the established goal, indicating that



while some members initiated substance use disorder treatment, sustained engagement within the required timeframe was limited. This pattern highlights ongoing challenges with continuity of care following treatment initiation and the need for enhanced reporting and engagement strategies.

BARRIERS:

- Challenges engaging members in timely initiation and continuation of SUD treatment
- Limited access to timely, appropriate substance use disorder treatment services
- Social, behavioral, and stigma-related barriers impacting treatment participation

INTERVENTIONS IN MY2025:

- Increase BH Referrals
- Enhance PIHP Collaboration & Establish Process Standardization
- Raise Awareness to BH Tool Kit

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Strengthen continuity of care following treatment initiation
- Enhance member engagement strategies to reduce drop-off after initiation
- Improve data capture for IET engagement services

B. Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

On an annual basis HAP CareSource administers, through a third-party and approved vendor, a CAHPS® survey. The CAHPS survey results inform the plan of the ongoing performance in various categories and helps design improvement strategies for the following year.

OBJECTIVE:

To objectively measure members' experience with access to care and health plan operations.

GOAL:



To improve by one STAR level for the following CAHPS composites and measures:

- Getting Needed Care (GNC)
- Getting Care Quickly (GCQ)
- Customer Service (CS)
- Care Coordination (CC)
- Rating of Health Plan
- Rating of Health Care
- Rating of Personal Doctor
- Rating of Specialist
- How Well Doctors Communicate

MEASUREMENT:

Administration and assessment of the CAHPS survey occurs annually.

FINDINGS:

Table 15: CAHPS results

CAHPS Composite Measures (MCD)	MY2023	MY2024	MY2025	Goal	Goal Met Y/N
Getting Needed Care (GNC) Composite	80.5	83.6	82.6	61.5	Y
Getting Care Quickly (GCQ) Composite	78.7	83.0	81.7	80.4	Y
Customer Service (CS) Composite	90.3	92.1	91.5	89.1	Y
Care Coordination (CC)	86.7	79.2	86.9	85.6	Y
Rating of Health Plan	63.9	59.8	60.8	61.5	N
Rating of Health Care	57.1	64.6	56.1	56.8	N
Rating of Personal Doctor	71.0	72.1	70.4	69.2	Y
Rating of Specialist	63.1	70.0	59.9	67.7	N
How Well Doctors Communicate Composite	93.3	92.1	94.7	93.0	Y

Table 15. In 2025, six of nine measures met the established goals including all four composites plus Rating of Personal Doctor and Care Coordination. The three measures that did not meet their established goals are as follows: Rating of Health Plan, Rating of Health Care, and Rating of Specialist.

Measures 3-12 Medicaid Adult CAHPS

Rating of Health Plan



- In 2025, the goal of 50th percentile was met by 0.8 percentage points, which is 4 percentage points higher than 2024 and 0.1 percentage points higher than 2023.

Rating of Health Care

- In 2025, the goal of 50th percentile was not met by 0.9 percentage points, which is 8.5 percentage points lower than 2024 and 1 percentage point lower than 2023.

Rating of Personal Doctor

- In 2025, the goal of 50th percentile was not met by 0.6 percentage points, which is 1.7 percentage points lower than 2024 and 0.6 percentage points lower than 2023.

Rating of Specialist

- In 2025, the goal of 50th percentile was not met by 7.8 percentage points, which is -10.1 percentage points lower than 2024 and -3.2 percentage points lower than 2023.

Care Coordination

- In 2025, the goal of 50th percentile was met by +1.3 percentage points, which is 7.7 percentage points higher than 2024 and -0.2 percentage points higher than in 2023.

Getting Needed Care

- In 2025, the goal of 50th percentile was met by +21.1 percentage points, which is -1 percentage point lower than in 2024 and 2.1 percentage points higher than in 2023.

Getting Care Quickly

- In 2025, the goal of 50th percentile was met by +1.3 percentage points, which is -1.3 percentage points lower than in 2024 and

How well doctors communicate

- In 2025, the goal of 50th percentile was

Customer Service

- In 2025, the goal of 50th percentile was

Analysis:

The data demonstrates operational experience is strong. Provider communication exceeded goal and improved versus MY2024. Perception-based



ratings have the biggest opportunities. The most concerning change is the year over year decline in Rating of Health Care and Rating of Specialist from MY2024 to MY2025. Care coordination improved sharply.

BARRIERS:

- Having difficulty getting timely appointments, limited in-network specialist availability, long wait times, and/or challenges with referrals can directly depress Rating of Specialist and impact Rating of Health Care.
- Despite improved Care Coordination scores, members may still experience friction navigating referrals, prior authorizations, follow-up after visits, and transitions between PCP/specialists/hospitals—hurting overall member experience.
- “Unable to reach” members, communication gaps, and limited understanding of how to use plan benefits (how to find the right provider, when/how referrals work, what services are covered) can negatively affect Rating of Health Plan and broader member experience.

INTERVENTIONS IN MY2025:

- Address health-related social needs
- Improve metric performance
- Improve provider involvement

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Rating of Health Plan
- Rating of Health Care
- Rating of Specialist

C. Provider Satisfaction Survey

On an annual basis HAP CareSource administers the Provider Satisfaction Survey to its contracted providers through a third-party vendor.

OBJECTIVE:

To objectively evaluate providers’ experience/satisfaction with HAP CareSource.

GOAL:



To meet or exceed the vendor's Book of Business (BoB) benchmark for the following categories:

- Overall Satisfaction with HAP CareSource
- Utilization Management
- HCS Care Management Programs
- Pharmacy Services
- Provider Inquiry
- Provider Services

MEASUREMENT:

Survey is administered annually; however, provider experience is measured ongoing through various other measurements such as provider grievances and/or disputes.

FINDINGS³:

Table 16: Provider Experience Survey Results

Provider Experience Measure (MCD)	MY2023 (n=111)	MY2024 (n=77)	MY2025 (N=117)	Recent Change
Overall Satisfaction with HAP CareSource	33%	45%	30%	-15%
Utilization Management	24%	31%	25%	-6%
HCS Care Management Programs	28%	38%	19%	-19%
Pharmacy Services	20%	30%	26%	-4%
Provider Inquiry	24%	35%	30%	-5%
Provider Services	27%	34%	32%	-2%

The plan performance specific to Michigan provider experience is noted in Table 16 above. Across all Provider Experience Survey domains, MY2025 results declined year-over-year compared to MY2024, with the sharpest drops in HCS Care Management Programs (38% to 19%, -19 points) and Overall Satisfaction with HAP CareSource (45% to 30%, -15 points). Smaller but consistent decreases were also seen in Utilization Management (-6 points), Provider Inquiry (-5 points), Pharmacy Services (-4 points), and Provider Services (-2 points). Notably, MY2025 had a higher response count (n=117 vs n=77), suggesting the

³ Plan performance rates are reflective of the plan's Top Two Box Score (TSB) capturing responses of (1) Well above average; and (2) Somewhat above average



lower scores may reflect broader provider feedback rather than a narrow respondent group.

BARRIERS:

- Specialist access friction and downstream capacity constraints.
- Care navigation gaps for high-touch populations.
- Lower member-perceived health care quality/experience creating additional pressure on provider offices.

INTERVENTIONS IN MY2025:

- Expand provider partnership support and further strengthen care management collaboration to better coordinate services for high-touch members.
- Continue multi-channel outreach (calls/text/mail/IVR) plus community-based care gap closure events (transportation support, on-site scheduling, benefit education, immediate incentives) to drive completion of needed services.
- Partner with MDHHS/local health departments, FQHCs, school-based health centers, and community clinics/mobile events—paired with incentive programs—to improve access and close preventive care gaps.

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Discover potential opportunities for improving specialty access
- Identify opportunities to expand care navigation for high-touch members
- Improve the “member experience of care”

D. Behavioral Health (BH) Member Satisfaction Survey

To better understand member experience with behavioral healthcare, counseling or treatment received HAP CareSource contracted with a vendor to administer and report the annual BH member survey. Questions relating to member satisfaction:

- Rate all your/your child’s counseling, treatment, or medication services in the last 6 months on a 0 to 10 scale where 0 is very unsatisfactory and 10 is the most satisfactory.
- Compared to before you received counseling, treatment, or medication how much were you/your child helped? Response options: Not at all, A little, Somewhat, A lot.



OBJECTIVE:

To objectively evaluate members' experience/satisfaction with behavioral health services.

GOAL:

To have year over year improvement.

MEASUREMENT:

Survey is administered annually; however, member experience is measured ongoing through various other measurements such as member grievances and/or disputes.

FINDINGS:

Table 17 Behavioral Health Member Survey

Behavioral Health (BH) MBR Survey Measures	2024	2025
Percentage who rated their counseling, treatment, or medication rating 8, 9, or 10	81%	77.1%
Percentage that rated their services helpful rating 8, 9, or 10	88%	77.7%

Represents trended Behavior Health Member Satisfaction data. Based on Press Ganey Survey for HAP CareSource Michigan Medicaid *Data as of 2025. **HAP did not report BH CAHPS in 2023 therefore 2024 is baseline year.

Analysis:

In 2025, the Behavioral Health (BH) Satisfaction Member Survey response rate increased significantly from (33) in 2024 to 4.65% (159) in 2025.

BARRIERS:

- Timely access to outpatient behavioral health services (capacity constraints)
- Care navigation and transitions gaps for high-touch populations
- Social/operational barriers that disrupt engagement and continuity

INTERVENTIONS IN MY2025:



- Increase BH Referrals
- Enhance PIHP Collaboration & Establish Process Standardization
- Raise Awareness to BH Tool Kit

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Strengthen continuity of care following treatment initiation
- Enhance member engagement strategies to reduce drop-off after initiation
- Improve data capture for IET engagement services

E. Network Adequacy

To ensure that Health Plan Alliance (HAP) maintains an adequate network of primary, specialty and behavioral health care practitioners, HAP conducts an annual availability assessment against established standards for numbers and geographic distribution. The analysis includes the HAP CareSource (formerly HAP Empowered) legal entity, which includes Medicaid HMO, Marketplace HMO and MMP HMO.

Practitioner Type	High Volume	High Impact	Ratio	Geographic distribution (100% of members) Distance in miles / Time in minutes	
				Medicaid HMO	
				Non-Rural*	Rural
General Practice			1:500	30/30	40/40
Family Practice			1:500	30/30	40/40
Pediatrics			1:500	30/30	40/40
Internal Medicine			1:500	30/30	40/40
OB/GYN	X		1:4,000	30/30	40/40
Oncology		X	1:4,000	40/40	60/60
Behavioral Health	X		NA	NA	NA



Geographic Distribution

Practitioner Type	Access Standard	Reporting Year/Trend	Non-Rural (Urban/Suburban Zips)		Percent Meeting Standard	Meets Standard (Y/N)
			Miles	Minutes		
Internal Medicine	30 miles /30 minutes	2024	1.1	2.1	100	Y
		2025	1.1	2.0	100	Y
		Trend	No change	decrease		
Family/General Practice	30 miles /30 minutes	2024	1.0	1.9	100	Y
		2025	1.0	1.9	100	Y
		Trend	No change	No change		
Pediatricians	30 miles /30 minutes	2024	1.7	3.1	100	Y
		2025	1.6	3.0	100	Y
		Trend	decrease	decrease		

Practitioner Type	Access Standard	Reporting Year/Trend	Rural (Rural Zips)		Percent Meeting Standard	Meets Standard (Y/N)
			Miles	Minutes		
Internal Medicine	40 miles /40 Minutes	2024	4.3	4.8	100	Y
		2025	4.2	4.7	100	Y
		Trend	decrease	decrease		
Family / General Practice	40 miles /40 Minutes	2024	3.3	3.6	100	Y
		2025	3.3	3.6	100	Y
		Trend	No change	No change		
Pediatricians	40 miles/40 minutes	2024	6.5	7.3	100	Y
		2025	6.4	7.2	100	Y
		Trend	decrease	decrease		

In 2025, HAP CareSource met its established goal and standards for driving distance and driving time with 100% of members having appropriate access to all primary care practitioner types in non-rural and rural zip codes.

- For Internal Medicine, HAP CareSource saw no change in driving distance and a slight decrease in driving time in non-rural zip codes in 2025. For non-rural zip codes, the driving distance and driving time decreased from 4.3 miles and 4.8 minutes in 2024 to 4.2 miles and 4.7 minutes in 2025.
- For Family Practice, HAP CareSource saw no change in driving distance and driving time in non-rural and rural zip codes in 2025. The driving distance and driving time stayed the same at 1.0 miles and 1.9 minutes in 2025 for non-rural counties. For rural counties, the driving distance and driving time stayed the same at 3.3 miles and 3.6 minutes in 2025.



HAP CareSource also saw decreases in both driving distance and driving time in 2025 for Pediatrics in non-rural and rural zip codes. In 2025, the driving distance and driving time decreased from 1.7 miles and 3.1 minutes to 1.6 miles and 3.0 minutes in 2024. In rural zip codes, the driving distance and driving time decreased from 6.5 miles and 7.3 minutes in 2024 to 6.4 miles and 7.2 minutes in 2025.

Ratio

Specialty	Number of Practitioners	Number of Applicable Members	Standard	Reporting Year/ Trend	Ratio of Providers to Members	Meets Standard (Y/N)
Internal Medicine	1,778	27,362	1:500	2024	1:21	Y
				2025	1:15	Y
				<i>Trend</i>	decrease	
Family/General Practice	1,756	27,362	1:500	2024	1:22	Y
				2025	1:16	Y
				<i>Trend</i>	decrease	
Pediatrics	774	14,585	1:500	2024	1:22	Y
				2025	1:19	Y
				<i>Trend</i>	decrease	

For practitioner numbers in 2024, HAP CareSource met its established practitioner to member ratios for all primary care practitioner types.

- For Internal Medicine, HAP CareSource had one practitioner for every 21 members in 2024, slightly improving in 2025 to one practitioner for every 15 members.
- For Family/General Practice, the 2024 ratio of practitioner to members was one practitioner for every 22 members, improving in 2025 to one practitioner for every 16 members.
- For Pediatrics, HAP CareSource also saw a slight increase in practitioner availability with one practitioner for every 22 members in 2024 to one practitioner for every 19 members in 2025.



Geographic Distribution

Practitioner Type	Access Standard	Reporting Year/Trend	Non-Rural (Urban/Suburban Zips)		Percent Meeting Standard	Meets Standard (Y/N)
			Miles	Minutes		
OB/Gyn	30 miles /30 minutes	2024	1.6	2.9	100	Y
		2025	1.5	2.8	100	Y
		Trend	Decrease	decrease		
Oncologists	40 miles/40 minutes	2024	2.7	5.2	100	Y
		2025	2.7	5.2	100	Y
		Trend	No change	No change		

Practitioner Type	Access Standard	Reporting Year/Trend	Rural (Rural Zips)		Percent Meeting Standard	Meets Standard (Y/N)
			Miles	Minutes		
OB/Gyn	40 miles /40 Minutes	2024	5.6	6.3	100	Y
		2025	5.9	6.6	100	Y
		Trend	Increase	increase		
Oncologists	60 miles/60 minutes	2024	8.0	9.3	100	Y
		2025	8.0	9.3	100	Y
		Trend	No change	No change		

HAP CareSource met its established standards for driving distance and driving time with 100% of members having appropriate access to each identified high-volume and high-impact specialty care practitioner type in 2025.

- For OB/GYN, HAP CareSource saw a decrease in both driving distance and driving time in non-rural zip codes and an increase in both time and distance for rural zip codes in 2025. The driving distance and driving time in non-rural zip codes decreased from 1.6 miles and 2.9 minutes in 2024 to 1.5 miles and 2.8 minutes in 2025. In rural zip codes, the driving distance and driving time increased from 5.6 miles and 6.3 minutes in 2024 to 5.9 miles and 6.3 minutes in 2024.
- For Oncology, HAP CareSource experienced no change in driving distance and driving time in 2025 in both non-rural and rural zip codes. In 2024 and 2025, the driving distance and driving time stayed the same at 2.7 miles and 5.2 minutes for non-rural zip codes. In rural zip codes, the driving distance and driving time remained steady at 8.0 miles and 9.3 minutes for both 2024 and 2025.



Ratio

Specialty	Number of Practitioners	Number of Applicable Members	Standard	Reporting Year/ Trend	Ratio of Providers to Members	Meets Standard (Y/N)
Obstetrics/Gynecology	1,135	21,081	1:4,000	2024	1:23	Y
				2025	1:19	Y
				<i>Trend</i>	decrease	
Oncology	399	41,864	1:4,000	2024	1:129	Y
				2025	1:105	Y
				<i>Trend</i>	decrease	

For practitioner numbers, HAP CareSource met the established practitioner to member ratios for each high-volume and high-impact specialty care practitioner type in 2025.

- The availability for OB/GYN increased with one practitioner for every 23 members in 2024 to one practitioner for every 19 members in 2025.
- For Oncology, HAP CareSource saw an improvement going from one practitioner for every 129 members in 2024 to one practitioner for every 105 members in 2025.

HAP CareSource met its established standards and goals for the geographic distribution and practitioner numbers for each identified high-volume and high-impact specialty type; therefore, no additional analysis was conducted.

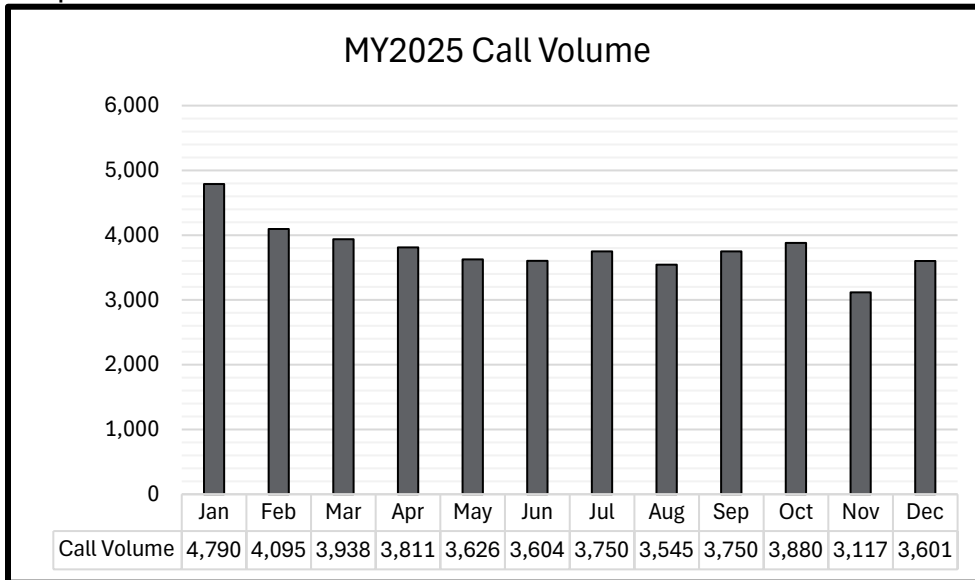
HAP CareSource met all established standards and goals for the geographic distribution and practitioner numbers for all primary care practitioner types; therefore, no additional analysis was conducted.

F. Customer Care

It is HAP CareSource's Goal to provide high quality services to its members and providers which includes accessibility to knowledgeable staff to offer information, clarification(s), and guidance on how to access and/or navigate a complex healthcare system and benefits. Member Services team evaluates its performance on an ongoing basis to ensure efficient and effective access to health plan staff.



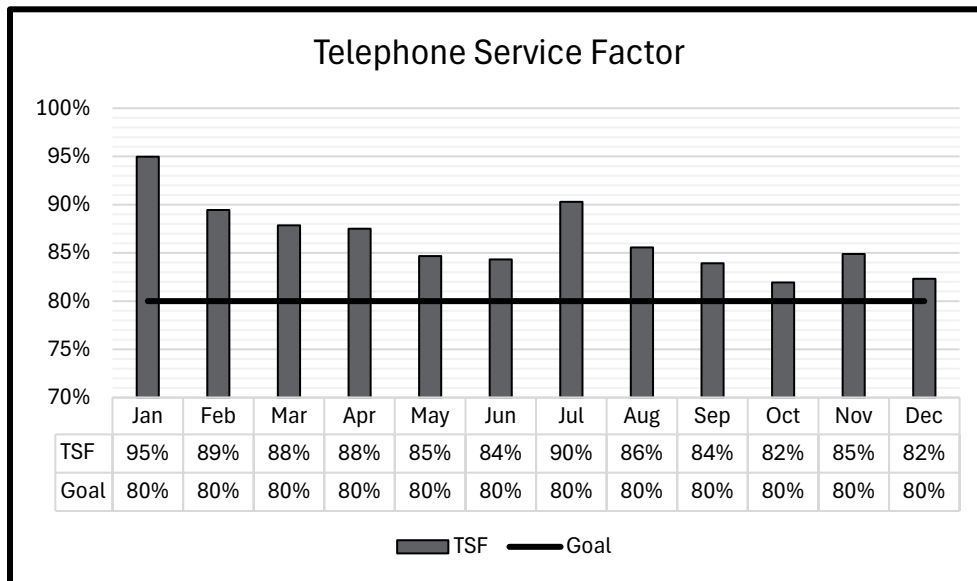
Graph 20: MY2025 call volume



The plan's call volume is noted in Graph 20. Graph 20 shows MY2025 call volume peaked in January (4,790) and generally declined through mid-year, stabilizing in the mid-3,500s to upper-3,800s from May through October. The lowest volume occurred in November (3,117), followed by a rebound in December (3,601). Overall, the pattern suggests seasonal and/or event-driven spikes early in the year and late-year variability, highlighting the need to align staffing and member communications with anticipated peak periods to minimize service disruption and protect member experience.

Graph 21: MY2025 Telephone Service Factor

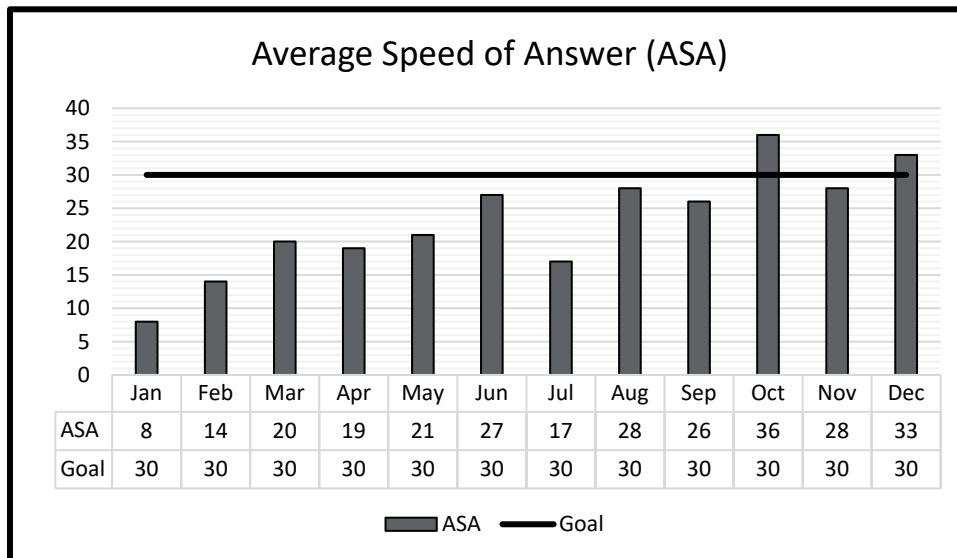




Telephone Service Factor (TSF) evaluates the plan’s ability to answer incoming calls within the threshold of average speed of answer (ASA). The plan’s TSF goal is 80%. Graph 21 shows MY2025 call volume peaked in January (4,790) and generally declined through mid-year, stabilizing in the mid-3,500s to upper-3,800s from May through October. The lowest volume occurred in November (3,117), followed by a rebound in December (3,601). Overall, the pattern suggests seasonal and/or event-driven spikes early in the year and late-year variability, highlighting the need to align staffing and member communications with anticipated peak periods to minimize service disruption and protect member experience.

Graph 22: MY2025 ASA

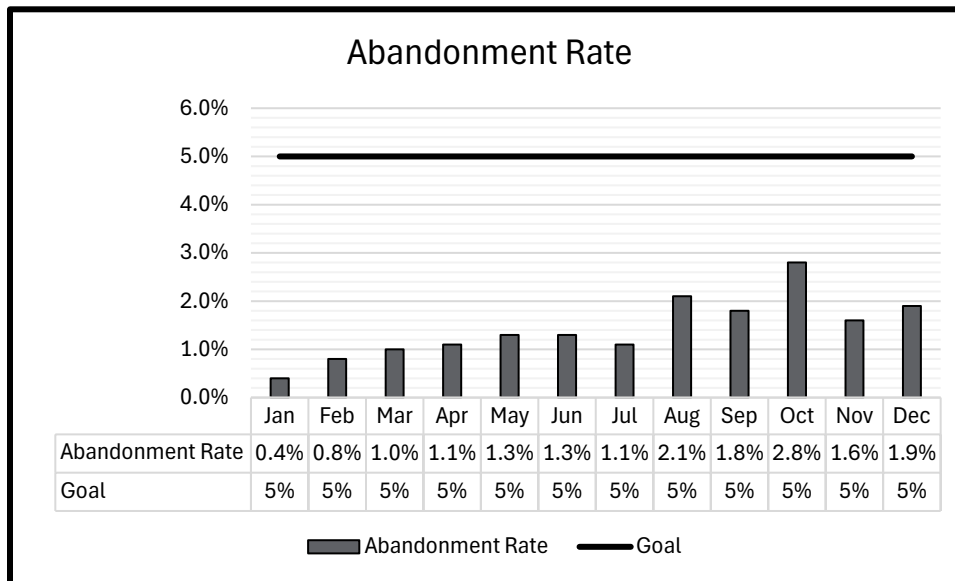




The plan's ASA goal is <30 seconds. Graph 22 presents the plan's ASA performance during the MY. As the data presents, the plan met the established goal in most months, with particularly strong performance early in the year and continued compliance through much of the mid-year despite fluctuations in call volume. Brief exceedances of the goal occurred in October and December, aligning with known peak and year-end demand periods. Overall, ASA performance demonstrates effective call center responsiveness, with opportunities to further align staffing and operational resources during predictable seasonal spikes to sustain optimal performance.

Graph 23: MY2025 Abandonment Rate





Graph 23 presents the plan’s abandonment rate during MY2025. The plan’s goal for abandonment rate is <5%. The plan consistently met the established goal in all months, with abandonment rates remaining well below the threshold throughout the year. Modest increases were observed during late-year peak periods; however, performance remained within acceptable limits and did not exceed the goal. Overall, abandonment rate performance reflects effective call center capacity management and supports timely member access to customer service.

G. Other processes and outcome measures

Maternity Management Program

The HAP CareSource Maternity Management program ensures members have a healthy pregnancy by:

- Connecting members with a Provider, an OB/Gyn or CNM.
- Educating the member about Douglas and the important supportive role they offer. (reword as needed)
- 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 and their potential health impacts on pregnancy
- 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 our MyLife™ 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 CareSource.

HAP CareSource continues to refer all pregnant members and infants to MIHP. MIHP helps pregnant members and infants get the proper food, support, and transportation for all health services. It also helps emphasize the importance of getting prenatal care, childcare, and immunizations or vaccines 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.

Low Birth Weight (LBW)

In 2025, HAP CareSource implemented the following to improve outcomes for LBW measure:

- Increasing member engagement through marketing to HAP CareSource members and HAP CareSource providers to ensure awareness of the Maternity Care Management Program resulting in early prenatal care to decrease pregnancy risks and promote healthy birthweight.



- Early identification of social needs impacting a healthy pregnancy and associated interventions to overcome the following: transportation barriers; food insecurity; mental health needs; medication/supply expenses; tobacco, alcohol, or substance use; cultural considerations; language barriers, etc.
- Educating members on and connecting with programs like MIHP, Women, Infants and Children (WIC) nutrition program, smoking cessation, drug and alcohol treatment programs, Mom and Baby Beginnings, etc.
- Early and frequent assessment of Behavioral Health needs and referral to services as appropriate.
- Informing members of the incentive program for maternity services; A member is eligible to receive a \$50 gift card for timely prenatal care.
- A provider toolkit is available on the website that includes resources for providers to utilize with members. This includes mental health, MIHP, tobacco cessation, health equity training, MC3 perinatal program.
- Advanced the plan's health opportunity strategy through targeted chronic disease management initiatives designed to reduce disparities among priority populations, supporting improved maternal and birth outcomes.

Lessons learned include the below which will impact the FY25 improvement plans:

- Increasing member outreach through multiple channels (telephonic, print, mail, text, app) is key to ensuring member engagement in programs.
- Early identification of social needs impacting a healthy pregnancy such as transportation barriers, food insecurity, mental health needs, tobacco cessation, substance abuse disorders, language barriers will assist in care plan development and eliminating the barriers can help member focus on medical care needs while building trust.
- Ongoing assessment of behavioral health needs is needed.
- Continuation of incentive programs to encourage and engage members to obtain prenatal care.

Data related to 2025 measurement year:

- 362/1,253 (29%) members enrolled in the Mom and Baby Beginning case management program
- 377/616 (61.20%) members received timely prenatal care
- 402/616 (65.26%) members received timely postpartum care
- 345/616 (56.0%) members earned the prenatal incentive
- 213/616 (34.58%) members earned the postpartum incentive
- 1,193/1,253 (95%) members enrolled in the MIHP program



Pediatric Sickle Cell Quality Collaborative

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

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

Preventive Care Outcome Measures for Children who have Sickle Cell Anemia

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

Below HAP CareSource data shows measurement period performance for 7/1/24 – 6/30/25 for Region 10:

Region 10 Only Pediatric Members with SCA	Numerator	Denominator	Rate
Transcranial Doppler	6	7	85.71
Appropriate Antibiotic Prophylaxis	0	2	0.00
Use of Hydroxyurea	0	10	0.00



Oral Health

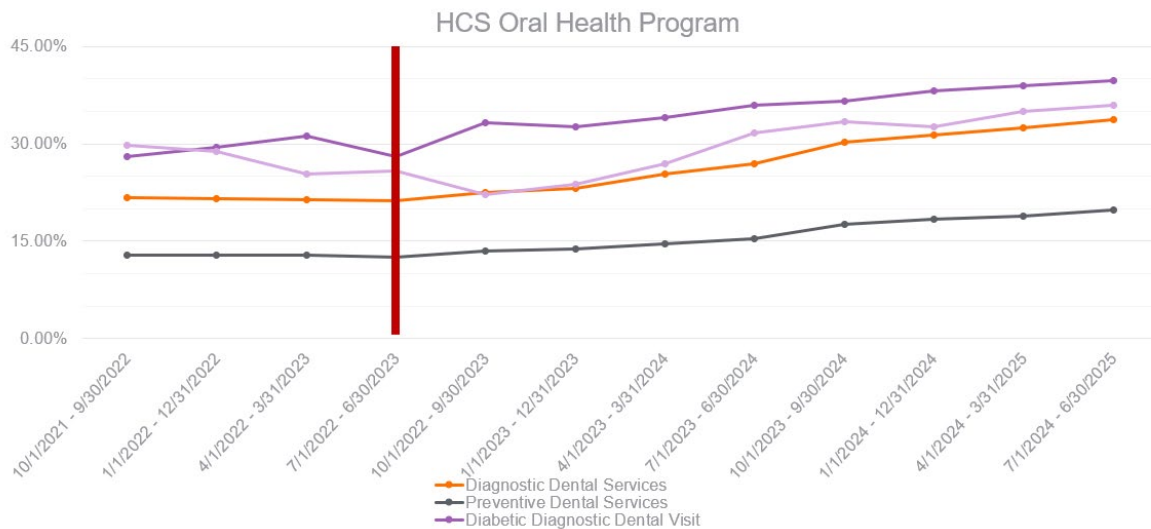
Our HAP CareSource Oral Health Program is designed to improve access to, utilization of, and outcomes related to dental services for Michigan Medicaid members. The program emphasizes whole-person care, recognizing oral health as a critical component of overall health, chronic disease management, maternal health, and health equity. Dental services were delivered through the plan's contracted dental provider network and integrated with broader quality improvement and population health strategies.

The Oral Health Program focuses on increasing preventive, diagnostic, and restorative dental service utilization, with targeted improvement goals for high-risk populations, including members with chronic conditions such as diabetes and pregnant members. Program objectives include improving preventive dental visit rates, reducing avoidable emergency department utilization for non-traumatic dental conditions, and strengthening care continuity through interprofessional collaboration between medical and dental providers.

Quality improvement activities were guided by a QIC-approved 2025 Oral Health Work Plan, which established measurable SMART Aims and ongoing monitoring of performance. These activities included data-driven analysis of dental utilization trends, collaboration with dental vendors and stakeholders, and focused workgroups to identify barriers to care, and implement mitigation strategies. Continuous performance monitoring supported targeted interventions to address disparities and improve oral health outcomes across our population.

The program aligns to our HAP CareSource's broader Quality Improvement and Health Opportunity strategies by emphasizing access to care. Evaluation of program effectiveness occurred through routine performance measurement, trend analysis, and integration with Enterprise Quality reporting to inform of ongoing improvement opportunities.





VII. Delegation Oversight

HAP CareSource has policies, procedures, and a dedicated team to provide delegation oversight. The oversight of delegates and vendors (all FDRs) is an ongoing activity at HAP CareSource. Oversight activities include quarterly Delegation Oversight Committee (DOC) meetings, Vendor and Delegate meetings reviewing key performance indicators, compliance with regulatory and contractual requirements. HAP CareSource evaluates potential delegates through the process of a pre-delegation audit prior to entering into a service agreement with the entity. For FDRs that are in existence during measurement periods, the health plan completes annual delegation audits which informs the plan on the recommendations to continue services, develop a CAP or terminate contractual agreement (if warranted).

During CY2025 HAP CareSource completed 12 audits on all its delegates and vendors. The plan identified four performance deficiencies with zero vendors/delegates requiring a CAP.



Table 18: Delegates and Vendors

Vendor Name	Product Line(s)	# Regulatory Deficiencies	Type of Audit
Braille Works	MI Medicaid	0	Annual Attestation of Compliance/RAM
Delta Dental	MI Medicaid	1	Annual Audit
ESI	MI Medicaid	1	Annual Audit
Evolent	MI Medicaid	2	Annual Audit
EyeMed	MI Medicaid	0	Annual Audit
Joint Venture Hospital Laboratories (JVHL)	MI Medicaid	0	Annual Audit
MTM	MI Medicaid	0	Annual Audit
NationsBenefit/ NationsHearing	MI Medicaid	0	Annual Audit
O'Neil	MI Medicaid	0	Annual Audit
Solutran	MI Medicaid	0	Annual Audit
TurningPoint	MI Medicaid	0	Annual Audit
United Direct Solutions	MI Medicaid	0	Annual Audit

VIII. Overall Effectiveness and Adequacy of QI program, Resources, Staffing, and Committee Structure

Overall, Michigan QI program remained effective across all involved departments in meeting the quality and safety of clinical care and services goals based on performance in all aspects of the QI Program as evidenced by:

- Adequacy of QI Program resources



- QI Committee and subcommittee structure
- Practitioner participation and leadership involvement in the QI Program

MAJOR ACCOMPLISHMENTS:

- Maintained an effective and fully operational Quality Improvement (QI) Program, supported by an established committee structure, adequate staffing, and active leadership and practitioner participation, with all required committees meeting prescribed frequencies throughout MY2025.
- Demonstrated year-over-year improvement across multiple HEDIS® measures, including gains in early childhood well-care visits (W30-15), asthma medication management (AMR), and select preventive care measures, reflecting the impact of targeted outreach, provider engagement, and care coordination strategies.
- Successfully met or exceeded CAHPS® performance goals for six of nine measures, including all composite measures (Getting Needed Care, Getting Care Quickly, Customer Service, and Care Coordination), with notable improvement in provider communication and care coordination scores.
- Achieved consistent compliance with Customer Care performance standards, meeting established goals for Telephone Service Factor (TSF), Average Speed of Answer (ASA) in most months, and Abandonment Rate throughout MY2025, supporting timely member access to services.
- Implemented effective Performance Improvement Projects (PIPs), including measurable improvement in Well-Child Visits in the First 15 Months of Life (W30-15), exceeding the established MY2025 goal and demonstrating successful application of rapid-cycle quality improvement methodologies.
- Strengthened member engagement and care gap closure efforts through multi-channel outreach and community-based “white glove” events, resulting in the closure of hundreds of care gaps and improved access to preventive and screening services.
- Advanced population health and health equity initiatives, including expanded Health-Related Social Needs (HRSN) screening, integration of digital engagement tools (MyLife app), and targeted interventions addressing social determinants of health.
- Maintained network adequacy standards across primary care and high-volume specialty providers, meeting established driving distance, driving time, and practitioner-to-member ratio requirements for all reviewed service categories.
- Successfully completed delegation oversight activities, including annual audits of all delegated entities and vendors, with no corrective action plans



required, demonstrating effective compliance monitoring and oversight processes.

- Sustained NCQA accreditation readiness and compliance, with ongoing monitoring, reporting, and integration of accreditation standards across QI program activities.

BARRIERS:

- Access to care challenges
- Member engagement and reachability barriers
- Social and health-related social needs
- Provider experience and operational opportunities
- Behavioral health care transition and coordination gaps
- Preventive care utilization declines among adolescents, young adults, and older EPSDT cohorts
- Seasonal and volume-driven pressure on customer service operations

OPPORTUNITIES FOR IMPROVEMENT:

- Enhance access to care across the continuum
- Strengthen member engagement and outreach effectiveness
- Further address health-related social needs
- Improve data timeliness, completeness, and hybrid measure capture
- Focus on provider experience and operational efficiency
- Enhance care transitions and post-discharge follow-up
- Increase preventive care utilization
- Optimize customer service performance during peak demand periods

RESOURCES/STAFFING:

- The HAP CareSource of Michigan Quality Improvement (QI) Program was supported by adequate and appropriately structured resources and staffing throughout MY2025. The program benefited from dedicated market and enterprise leadership, including medical directors, quality leadership, population health, behavioral health, dental, analytics, and regulatory compliance staff, ensuring comprehensive oversight across clinical quality, member experience, provider experience, and accreditation activities.
- Multidisciplinary teams with clinical, operational, and analytical expertise supported the execution of the QI Work Plan, Performance Improvement Projects (PIPs), HEDIS® reporting, delegation oversight, customer care



monitoring, and population health initiatives. Staffing resources were sufficient to support ongoing performance monitoring, implementation of targeted interventions, evaluation of outcomes, and timely reporting to internal governance committees and external stakeholders.

- Leadership engagement and practitioner participation were sustained across required QI committees and workgroups, supporting effective decision-making, accountability, and continuous quality improvement. Based on MY2025 performance and oversight outcomes, existing resources and staffing were determined to be adequate, and no additional staffing or structural changes were identified as necessary for MY2026.

There is no need to restructure or change the QI Program for 2026.



IX. Acknowledgement and Approval

The 2025 QI Program Evaluation was reviewed and approved by:

Brittnee S. Berry, MSN, RN

03/19/2026

Brittnee Berry, MSN, RN

HAP CareSource of Michigan Quality Improvement
and Population Health, Senior Director

Date

Lori Billis, M.D.

03/19/2026

Lori Billis, M.D.

HAP CareSource of Michigan Medical Director

Date

Lori Billis, M.D.

HAP CareSource of Michigan QIC Approval

03/19/2026

Date



X. Appendix A: Accomplished MY2025 Goals and Objectives

Implement the 2025 QI program that effectively promotes and builds quality into the organization landscape through appropriate structure and processes.	
Goals	Objectives
CMS/MDHHS Quality Withhold performance	Meet CMS-core and MDHHS priority measure requirements under the MY2025 Quality Withhold methodology.
QI program governance / committee oversight structure	Maintain an effective QI committee structure and meet prescribed meeting frequencies to support monitoring and oversight.
Improve enrollees' health outcomes.	
HEDIS® performance improvement / preventive health & chronic condition management	Improve clinical quality outcomes and preventive health activities as measured through HEDIS® and required reporting.
Performance Improvement Projects (PIPs)	1. Blood Lead Screening in Children - Improve the percentage of children two years old who have received at least one blood lead screening by 2nd birthday. Improve the percentage of children who have received one blood lead screening at age one and age two. (Stratification of LSC) 2. Increase the percentage of new and existing members who are 18 years of age and older who have been screened for Health-Related Social Needs during the remeasurement year.



	New Member Screening Rate: 28% Existing Member Screening Rate: 20% 3. W30 Rate 1 (6+ visits) in the first 15 months of Life Improve well child visits in the first 15 months of life from 53.32% to 61.59% during the reported measurement period. 4. Improve Adult Dental Utilization by 5% Improve adult dental utilization for eligible member population 19 to 64 years of age overall by 5% 5. Follow-up after hospitalization for mental illness within 30 days - Adults Improve FUH 30 day adult rate from 2024 baseline rate of 59.72% to 61.51% during the reported measurement year.
Improve enrollee and provider experience with healthcare services	
Improve enrollee and provider experience with healthcare services	Improve members' experience with services offered by the company and its provider network, with emphasis on timely access to care and care coordination.
Improve enrollee and provider experience with healthcare services	Increase overall member experience performance as measured by CAHPS® (e.g., Getting Care Quickly and Care Coordination) and improve provider satisfaction results related to administrative processes (e.g., claims/prior authorization and provider support) compared to the prior measurement year.



Ensure network adequacy, access and availability of care and services.	
Network adequacy (access and availability)	Meet established network adequacy standards for driving time/distance and practitioner-to-member ratios (primary care and key specialties).
Ensure adequate and timely access to primary, specialty, and behavioral health services by monitoring appointment availability and addressing identified access gaps across the service area.	Meet network adequacy and access standards across the service area by completing CY2025 availability and accessibility analysis, implementing corrective actions for any identified deficiencies, and reporting results through established QI governance committees.
Ensure programs of care and services meet the culturally and linguistically diverse needs of the served membership	
Improve collection and use of Race/Ethnicity/Language (REL) data	Increase completeness/accuracy of member race, ethnicity, and preferred language data and use it to identify and monitor disparities.
Ensure timely access to language assistance and culturally appropriate member communications	Ensure members can access interpreter services and receive key materials in a language and format they understand (e.g., translated, accessible formats).
Improve member experience for diverse populations (including “getting needed care quickly”)	Improve member-reported experience of access and care coordination, with monitoring for disparity patterns where possible.
Strengthen culturally responsive care coordination and outreach	Implement outreach strategies that account for cultural/linguistic needs and reduce unable-to-reach (UTR), especially for high-risk members.
Maintain network adequacy that supports equitable access	Ensure provider network adequacy meets standards to support access for the served membership (including diverse communities).
Develop, implement, and continually improve programs and services to meet the complex health needs of the population as a whole.	
Strengthen population health and chronic condition management for the medically complex Medicaid population	Improve performance on priority chronic-condition HEDIS® measures (e.g., diabetes and hypertension-related measures) through targeted



	outreach, care coordination, and provider engagement interventions.
Develop, implement, and continually improve programs and services to meet the complex health needs of the population as a whole.	Strengthen population health management by expanding member identification, stratification, and engagement for high-risk and rising-risk members to support integrated care management and improved outcomes.
Maintain a robust population health strategy.	
Maintain and strengthen a data-driven Population Health Management (PHM) strategy aligned to the Medicaid population profile	Monitor and report PHM performance routinely through the QI governance structure (e.g., QIC/JOC oversight), using process/outcome/utilization measures and member experience feedback to adjust interventions.
Maintain a robust, integrated PHM program portfolio that addresses prevention, emerging risk, transitions of care, and multiple chronic conditions	Implement and maintain PHM programs across key domains reflected in your document (e.g., “Keeping Members Healthy,” “Managing Members with Emerging Risk,” “Member Safety/Transitions of Care,” “Managing Members with Multiple Chronic Conditions”), ensuring each has a defined target population and program focus.
Maintain Health Plan Accreditation with NCQA.	
Maintain compliance with NCQA Health Plan Accreditation standards and requirements throughout MY2025	Monitor and report NCQA-related requirements through established QI governance (e.g., QEC/JOC oversight) and ensure applicable standards (including Member Experience requirements) are reviewed and acted on as needed.
Maintain accreditation readiness by continually evaluating and improving infrastructure, documentation, and operational performance aligned to NCQA “best practice” expectations	Use annual program evaluation and work plan processes to identify strengths/opportunities and implement corrective actions that sustain accreditation readiness (e.g., incorporating regulator/EQRO recommendations into QAPI/QI documentation where applicable).



Promote members' health, safety, and welfare.	
Maintain a robust Member Safety & Welfare (Health, Safety and Welfare) program with active detection, reporting, and oversight	Provide routine governance oversight and trending of member safety and welfare activity through the QI committee structure (e.g., QEC oversight of Health, Safety and Welfare; PAC/QIC review as applicable), using findings to drive corrective actions and prevent recurrence.
Strengthen safe transitions of care and coordination for members with complex needs (including LTSS), to reduce safety risks across settings	Ensure care coordination supports member safety across care settings, including monitoring that services/supports delivered align with the person-centered/service plan and that members have access to needed resources (e.g., transportation, follow-up appointments) to safely remain in the community.
Maintain compliance with state, federal, regional, local and accreditation requirements.	
Maintain a comprehensive compliance program that ensures timely identification, monitoring, and implementation of applicable regulatory and accreditation requirements	Monitor, track, and respond to applicable requirements (state, federal, regional/local, and accreditation) through established oversight structures (e.g., Enterprise Compliance Committee (ECC), QI committees, and functional workgroups), including maintaining an issue log and documenting decisions/actions.
Demonstrate operational compliance through successful execution of required oversight, reporting, and corrective action processes across delegated and internal functions	Ensure QI program documentation and reporting remain audit-ready and compliant by completing the annual QI Program Evaluation and Work Plan review/approval and incorporating external oversight recommendations (e.g., EQRO/HSAG recommendations) into QAPI/QI documentation and follow-up actions.



XI. Appendix B: Definitions

Acronym	Definition
<ABD>	Aged, Blind, and Disabled
ADT	Admissions-Transfers-Discharges
AMR	Asthma Medication Ratio
ASA	Average Speed of Answer
AVP	Associate Vice President
BCS-E	Breast Cancer Screening – ECDS
BH	Behavioral Health
BMI	Body Mass Index
BoB	Book of Business
BoD	Board of Directors
BP	Blood Pressure
BPD	Blood Pressure Control for Patients with Diabetes
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CBP	Controlling Blood Pressure
CC	Care Coordination
<CHIP>	Children’s Health Insurance Program
CHL	Chlamydia Screening
CIS-E	Childhood Immunization Status – ECDS
CM	Care Management
CMO	Chief Medical Officer
CMS	Center for Medicare and Medicaid Services
COL-E	Colorectal Cancer Screening – ECDS
CPG	Clinical Practice Guidelines
CPGC	Clinical Policy Governance Committee
CQI	Continuous Quality Improvement
CS	Customer Service
CSMGB	HAP CareSource Management Group Board
CSMS	HAP CareSource Management
CX	Consumer Experience
CY	Calendar Year
DOC	Delegation Oversight Committee
DTaP	Diphtheria, Tetanus, and aCellular Pertussis
ECC	Enterprise Compliance Committee
ECDS	Electronic Clinical Data Systems
ED	Emergency Department
EED	Eye Exam for Patients with Diabetes
EHR	Electronic Health Record



EPAC	Enterprise Provider Advisory Committee
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQRO	External Quality Review Organization
EVP	Executive Vice President
FDR	First Tier, Downstream, and Related Entities
Flu	Influenza
FUA-7	Follow-Up After ED visit for Substance Use within 7 days
FUH-7	Follow-Up After Hospitalization for Mental Illness within 7 days
FUI-7	Follow-Up After High-Intensity Care for Substance Use Disorder within 7 days
FUM-7	Follow-Up After ED Visit for Mental Illness within 7 days
FWA	Fraud, Waste, and Abuse
GCQ	Getting Care Quickly
GNC	Getting Needed Care
GSD	Glycemic Status Assessment for Patients with Diabetes – Glycemic Status <8%
HEDIS®	Healthcare Effectiveness Data and Information Set
HepA	Hepatitis A
HepB	Hepatitis B
Hib	Haemophilus influenza type b
HIE	Health Information Exchange
HIS	Health Information Systems
HPR	Health Plan Ratings
HTN	Hypertension
IET-E	Initiation and Engagement of Substance Use Disorder Treatment – Engagement of SUD treatment
IMA-E	Immunizations for Adolescents – ECDS
IPV	Inactivated Polio Vaccine
KED	Kidney Health Evaluation for Patients with Diabetes
LTSS	Long-term Services and Supports
MAC	Member Advisory Committee
MCO	Managed Care Organization
MMR	Measles, Mumps, and Rubella
MRR	Medical Records Review
MY	Measurement Year
NCQA	National Committee for Quality Assurance
OB/GYN	Obstetrics/Gynecology
P&TC	Pharmacy & Therapeutics Committee
PAC	Provider Advisory Committee
PCP	Primary Care Provider
PCV	Pneumococcal Conjugate Vaccine



PH	Physical Health
PIP	Performance Improvement Project
PPC-PN	Prenatal and Post-Partum Care – Timeliness of Prenatal Care
PPC-PP	Prenatal and Post-Partum – Post Partum Care
PQoC	Potential Quality of Care
PSG	Preventive Service Guideline
QAPI	Quality Assessment and Performance Improvement
QEC	Quality Enterprise Committee
QI	Quality Improvement
QIP	Quality Improvement Project
QM	Quality Management
QoC	Quality of Care
Quality Improvement Committee	Quality Improvement Committee
RN	Registered Nurse
RV	Rotavirus
SAA	Adherence to Antipsychotic Medication for Individuals with Schizophrenia
SUD	Substance Use Disorder
<TANF>	Temporary Assistance for Needy Families
TSF	Telephone Service Factor
UM	Utilization Management
UM/CM	Utilization Management/Care Management
UMCMC	Utilization Management/Care Management Committee
VBR	Value-based Reimbursements
VP	Vice President
VZV	Varicella-Zoster Vaccine (Chickenpox)
W30-15	Well-Child Visits in the First 30 months of life – First 15 months of life
W30-30	Well-Child Visits in the First 30 months of life – 15 months through 30 months of life
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
WCV	Child and Adolescents Well-Care Visits
YoY	Year over Year



