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Quality Improvement

Program Evaluation
Michigan Medicare-Medicaid Plan
MY 2025



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I. Executive Summary

Strategies to Improve Quality

HAP CareSource MI Health Link 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.
- Enhance the quality of Long-Term Services and Supports (LTSS) by improving access to services, fostering care coordination, increasing member satisfaction, promoting independence and quality of life, and ensuring compliance with regulatory requirements through continuous quality improvement efforts.

Progress towards Quality Improvement (QI) Goals in CY2025:

HAP CareSource's 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:



Priority Measures

HAP CareSource MI Health Link aligned its efforts to meet the priorities set forth by CMS and State of Michigan through the process of Quality Withhold methodology on Centers for Medicare & Medicaid Services (CMS) and state select measures. HAP CareSource MI Health Link accomplished the following goals in MY2025:

- Michigan MI Health Link is projected to have met at least nine out of twelve measures for Measurement Year 2025.

MY2025 goal attainment was based on a tiered scale aligning the percentage of performance measures met against the percent of quality withhold. The MY2025 HAP CareSource quality withhold earnings percentage met of the MDHHS and CMS priority measures will be determined at a later date.

HEDIS®

In CY2025 efforts to improve HEDIS® scores supported HAP CareSource MI Health Link's goal to demonstrate QI and preventive health activities. The health plan demonstrated a year over year (YoY) improvement in most of the required Medicare reporting measures 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:

- Adult Access to Preventive/Ambulatory Health Services, AAP
- Care for Older Adults, COA
- Osteoporosis Management in Women Who Had a Fracture, OMW
- Glycemic Status Assessment for Patients with Diabetes, GSD >9%
- Transitions of Care, TRC
- Plan All-Cause Readmissions, PCR
- Breast Cancer Screening, BCS
- Colorectal Screening, COL
- Blood Pressure Control for Patients with Diabetes, BPD
- Eye Exam for Patients with Diabetes, EED
- Glycemic Status Assessment for Patients with Diabetes, GSD <8%
- Controlling Blood Pressure, CBP
- Follow-Up After Hospitalization for Mental Illness within 30 Days, FUH-30
- Follow-Up After Hospitalization for Mental Illness within 7 Days, FUH-7

Ongoing Improvement Activities in support of HEDIS®



HAP CareSource MI Health Link made it a priority for the organization to improve HEDIS® rates in CY2025 and beyond. To continuously improve performance, the plan will continue to improve its data collection methodologies, processes and procedures. HAP CareSource MI Health Link is transitioning to a Highly Integrated Dually Eligible Special Needs Plan (HIDE-SNP) effective 01/01/2026 and will align its efforts to drive improvement in alignment with State of Michigan and CMS priorities for the served population.

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 Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey which demonstrated the following:

- HAP CareSource received an overall score of 4 out of 5 on the CAHPS survey reporting
- HAP CareSource saw increases from 2024 in 5 subcategories
- Hap CareSource received a score of 5 in getting appointments & Care Quickly this is an overall 3 point increase

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.

During CY2025, the HAP CareSource MI Health Link (MMP) Quality Improvement Program implemented targeted initiatives to strengthen member experience, access, and care coordination for the dual-eligible population. Efforts focused on proactive care gap closure through community-based outreach events that coordinated scheduling, transportation, incentives, and education, while multidisciplinary collaboration across Quality Improvement, Population Health, Care Management, Network, and Consumer Experience teams addressed access barriers and transitions of care. Member feedback and CAHPS® results informed ongoing improvement strategies, and continued emphasis on network adequacy and integrated medical, behavioral health,



maternal, and oral health services supported person-centered, whole-person care delivery.

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 MI Health Link 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 CareSource MI Health Link¹ is a nonprofit, mission driven managed care organization (MCO) in the state of Michigan. HAP CareSource provides an innovative approach to managed care through personalized services and value-added benefits to its dual-eligible members and network providers. 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 by integrating Medicare and Medicaid services into a single, seamless plan to reduce administrative hurdles.

HAP CareSource began serving the Medicare-Medicaid Plan (MMP) members on January 1, 2024, under CMS contract # H9712. Currently the health plan is serving resident of three counties of Michigan serving members that are dual-eligible (Medicare & Medicaid) who may also receive 1915(c) home and community based service(s) (HCBS) waiver benefits or have long-term services and supports (LTSS) needs.

HAP CareSource 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 our 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) 2025², 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's 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) Improving member experience; (4) Improving provider experience and; (5) Advancing Health Equity."*¹

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.

¹ Institute for Healthcare Improvement: Quintuple Aim. www.ihl.org



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 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
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.

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 MI



Health Link 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.

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 Consumer Advisory Committee (CAC/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 MI Health Link 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 Michigan 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 the 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 improvements 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.

Vice President (VP), Care Management (CM)

The VP of CM provides clinical expertise and oversight to CM activities, inclusive of Long-term Services and Supports (LTSS) management. This individual oversees CM caseloads, ensures compliance with all regulatory requirements, works collaboratively with quality partners in advancing health equity and drives performance improvement through CM activities.

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

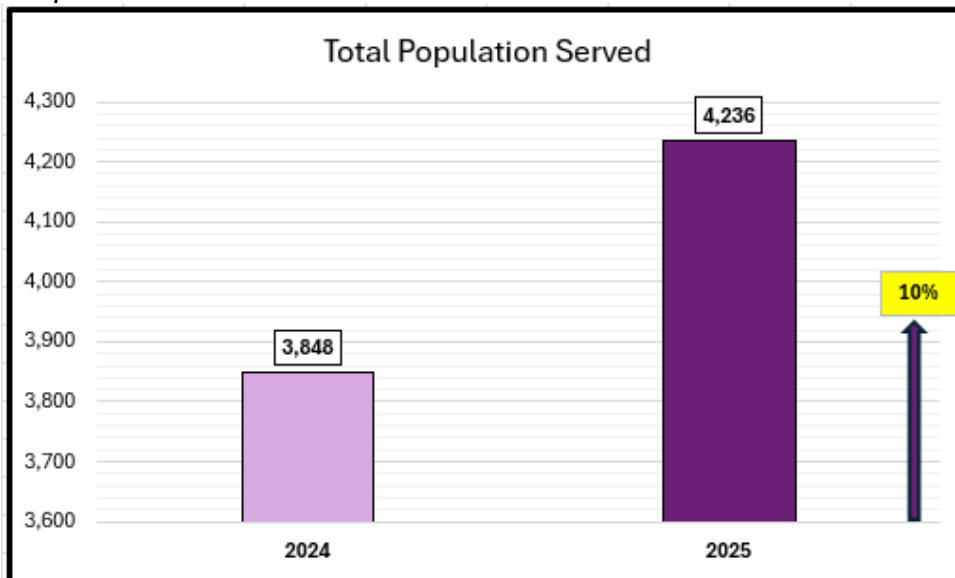


programs, value-based reimbursements (VBR) and other QI -related activities and initiatives.

- 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



MI Health Link served a total of 4,236 members in CY2025 (see Graph 1) which demonstrates a 10% YoY increase compared to CY2024 (prior year).

Table 2: Age & Gender Distribution



Age Band and Gender Matrix

Gender AgeBand	Female		Male		Total	
	Unique Members	%GT Unique Members	Unique Members	%GT Unique Members	Unique Members	%GT Unique Members
20-29	45	1.06%	59	1.39%	104	2.46%
30-39	145	3.42%	160	3.78%	305	7.20%
40-49	172	4.06%	175	4.13%	347	8.19%
50-59	296	6.99%	189	4.46%	485	11.45%
60-74	1,096	25.87%	787	18.58%	1,883	44.45%
75+	733	17.30%	379	8.95%	1,112	26.25%
Total	2,487	58.71%	1,749	41.29%	4,236	100.00%

Age and gender distribution is noted in Table 2 above. Table 2 demonstrates that the MI Health Link population is predominantly older and female, with females representing 57.3% of members and approximately 80% of the population aged 50 years and older. The largest age cohort is 60–69 years (41.5%), highlighting the need for continued focus on chronic disease management, preventive care, and coordinated services tailored to an aging, medically complex population.

Table 3: Race, Ethnicity and Language

Race/Ethnicity

Ethnicity_Race	Unique Members	Percent of Total
Caucasian	1,859	43.89%
Black	1,710	40.37%
Other Race or Ethnicity	428	10.10%
Asian or Pacific Islander	135	3.19%
Unknown	79	1.86%
Native American	14	0.33%
Native Hawaiian	11	0.26%
Hispanic		
Mutually Defined		
Total	4,236	100.00%

Language

Language	Unique Members	Percent of Total
English	4,060	95.85%
Other	91	2.15%
Arabic	64	1.51%
Spanish	21	0.50%
Somali		
Unknown		
Total	4,236	100.00%

Data reported 02/16/2026.

Table 3 presents the served membership Race, Ethnicity and Language profiles for CY2025. Table 3 indicates that the MI Health Link population is racially diverse, with Black/African American (40.4%) and Caucasian (43.9%) members comprising the largest groups. The population is predominantly English-speaking (95.9%); however, the presence of members with other primary languages



underscores the continued need for culturally and linguistically appropriate services to support equitable access and care delivery.

Table 4: CY2025 prevalence of chronic conditions

Data reported 02/16/2026.

All Chronic Conditions

EDCDesc	Unique_CC_Members	% Condition_Prevalence
Hypertension, w/o major complications	2,532	59.77%
Disorders of lipid metabolism	2,220	52.41%
Type 2 diabetes, w/ complication	1,188	28.05%
Degenerative joint disease	1,097	25.90%
Obesity	1,054	24.88%
Nonspecific signs and symptoms	867	20.47%
Hypertension, with major complications	843	19.90%
Anxiety, neuroses	812	19.17%
Ischemic heart disease (excluding acute m...	812	19.17%
Chronic renal failure	803	18.96%
Emphysema, chronic bronchitis, COPD	781	18.44%
Peripheral vascular disease	671	15.84%
Peripheral neuropathy, neuritis	598	14.12%
Congestive heart failure	593	14.00%
Cardiac arrhythmia	555	13.10%
Asthma, w/o status asthmaticus	526	12.42%
Major depression	523	12.35%
Hypothyroidism	476	11.24%
Cardiovascular disorders, other	442	10.43%
Neurologic disorders, other	429	10.13%
Depression	417	9.84%
Inherited metabolic disorders	410	9.68%
Cerebrovascular disease	407	9.61%

Data reported 02/16/2026.

Table 4 demonstrates the prevalence of chronic conditions for the members served in CY2025. Table 4 demonstrates a high burden of chronic disease within the MI Health Link population, with hypertension (59.8%) and disorders of lipid metabolism (52.4%) being the most prevalent conditions, followed by type 2 diabetes (28.1%) and obesity (24.9%). This chronic disease profile underscores the need for sustained focus on cardiovascular risk reduction, diabetes management, and integrated, multidisciplinary care coordination for this medically complex population.

Table 5: Inpatient Utilization Management



Top 20 IP Discharge Diagnosis					
EDCDescription	MemCnt	ClmCnt	% of Total Claims	Util per 1,000	PMPM
Septicemia	53	66	8.75%	21.91	\$32.66
Hypertension, with major complications	43	45	5.97%	14.94	\$15.02
Complications of mechanical devices	27	30	3.98%	9.98	\$15.92
Cerebrovascular disease	25	27	3.58%	8.98	\$9.63
Acute lower respiratory tract infection	25	25	3.32%	8.30	\$5.63
Acute renal failure	21	21	2.79%	6.97	\$5.39
Cardiac arrhythmia	20	21	2.79%	6.97	\$7.69
Gastrointestinal obstruction/perforation	18	20	2.65%	6.64	\$8.28
Musculoskeletal disorders, other	19	20	2.65%	6.64	\$13.13
Acute myocardial infarction	18	18	2.52%	6.31	\$9.90
Fluid/electrolyte disturbances	17	19	2.52%	6.31	\$7.62
Type 2 diabetes, w/o complication	18	19	2.52%	6.31	\$7.15
Seizure disorder	14	17	2.25%	5.54	\$4.31
Hypertension, w/o major complications	16	16	2.12%	5.31	\$2.92
Schizophrenia and affective psychosis	10	15	1.99%	4.98	\$5.55
Acute respiratory failure	12	13	1.72%	4.32	\$3.62
Emphysema, chronic bronchitis, COPD	12	13	1.72%	4.32	\$10.26
Chronic renal failure	11	12	1.59%	3.98	\$3.57
Peptic ulcer disease	11	11	1.46%	3.65	\$2.40
Cardiovascular signs and symptoms	10	10	1.33%	3.32	\$1.89
Pregnancy and delivery with complications	10	10	1.33%	3.32	\$1.82

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

Data reported 02/16/2026.

Table 5 visually depicts the inpatient utilization trend for the HAP CareSource of Michigan during CY2025. Table 5 indicates that inpatient utilization in CY2025 was concentrated among a relatively small subset of members, with the number of inpatient claims exceeding the number of unique members represented, suggesting repeat inpatient use for certain conditions. The associated utilization rate and PMPM highlight the impact of inpatient admissions on overall cost of care and underscore opportunities to further strengthen care management, improve transitions of care, and reduce potentially avoidable hospitalizations through earlier intervention and coordinated outpatient follow-up. The top three inpatient diagnosis in 2025 were septicemia at 8.75%, hypertension without major complications at 5.97%, and complications of mechanical devices at 3.98%.

Table 6: ED utilization trends for CY2025

Top 20 ED Discharge Diagnosis					
EDCDescription	MemCnt	ClmCnt	% of Total Claims	Util per 1,000	PMPM
Chest pain	81	91	5.51%	30.21	\$1.58
Lacerations	60	67	4.08%	22.25	\$0.90
Acute upper respiratory tract infection	54	62	3.78%	20.59	\$0.97
Abdominal pain	53	60	3.63%	19.92	\$1.37
Neurologic signs and symptoms	52	60	3.63%	19.92	\$0.71
Contusions and abrasions	53	57	3.45%	18.93	\$0.75
Musculoskeletal signs and symptoms	52	56	3.39%	18.59	\$0.63
Urinary tract infections	42	45	2.73%	14.94	\$0.84
Headaches	28	36	2.18%	11.95	\$0.61
Administrative concerns and non-specific laboratory abno...	28	35	2.12%	11.62	\$0.28
Nonspecific signs and symptoms	31	34	2.06%	11.29	\$0.42
Vertiginous syndromes	30	33	2.00%	10.96	\$0.53
Nausea, vomiting	30	32	1.94%	10.62	\$0.60
Schizophrenia and affective psychosis	19	32	1.94%	10.62	\$0.40
Fractures (excluding digits)	26	29	1.78%	9.83	\$0.39
Viral syndromes	23	29	1.78%	9.83	\$0.49
Acute sprains and strains	26	28	1.70%	9.30	\$0.34
Respiratory signs and symptoms	22	28	1.70%	9.30	\$0.49
Nonfungal infections of skin and subcutaneous tissue	25	27	1.64%	8.95	\$0.38
Hypertension, with major complications	18	25	1.51%	8.30	\$0.49

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

Data reported 02/16/2026.

Table 6 demonstrates the trends of Emergency Department (ED) utilization in CY2025 for HAP CareSource of Michigan members. Table 6 indicates that Emergency Department utilization in CY2025 was concentrated among a



relatively small subset of members, with repeat ED use evident as the number of claims exceeded the number of unique members represented. This pattern, along with the associated PMPM and utilization rate, highlights opportunities to further strengthen care coordination, improve access to timely outpatient services, and reduce potentially avoidable ED utilization while maintaining appropriate access to emergent care. The top three emergency department diagnosis in 2025 were chest pain at 5.56%, lacerations second at 4.09%, and acute upper respiratory tract infections at 3.79%.

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:

- 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
- Pharyngitis - Acute Pharyngitis in Children (3 years and older), Adolescents and Adults
- Pregnancy - Routine Prenatal and Postnatal Care, Prevention of Unintended Pregnancy in Adults 18 Years and Older
- Preventative Services - Adult Preventive Services (Age $\geq$ 50), Adult Preventive Services (Ages 18-49)
- 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. 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 State of Michigan's contracted External Quality Review Organization (EQRO) and CMS designated Quality Improvement Organization (QIO) and/or other Michigan Department of Health & Human Services (MDHHS) approved activities deemed necessary. On at least tri-annual basis, HAP CareSource complies with the comprehensive EQR



compliance with standards set forth in 42 CFR §438 subpart D, the disenrollment requirements and limitations described in 42 CFR §438.56, the member rights requirements described in 42 CFR §438.100, the emergency and post-stabilization services requirements described in 42 CFR §438.114 and the quality assessment and performance improvement requirements described in 42 CFR §438.330. HAP CareSource addresses any external quality review (EQR) findings through the QAPI program process through the development and implementation of performance improvement goals, objectives and activities.

During CY2025 the plan cooperated with all EQRO activities and addressed received CY2023 and CY2024 EQRO recommendations for improvement:

- While the ICO sought input from members during the MMP Advisory Council meetings, the minutes provided did not capture on which topics members provided feedback or the actual feedback provided. HSAG recommends that the ICO ensure thorough documentation within the minutes to properly track and follow up on feedback provided.
- Although ICO staff members indicated that the ICO manages continuity and coordination of care through the care coordination process, HSAG recommends that the ICO add information about continuity and coordination of care across all care and services settings, including transitions in care, to its quality assessment and performance improvement (QAPI) program documents.
- During the site review, ICO staff members described several initiatives related to social determinants of health and health disparity reduction; however, these initiatives were not clearly outlined in the QAPI work plan. HSAG strongly recommends all activities related to social determinants of health and health disparity reduction be added to the QAPI work plan, specifically activities that focus on the MI Health Link population.
- While sub-element c is not being scored during SFY 2022 due to MDHHS not directing a process for a customized medical record review to monitor the assessment for and provision of LTSS, after consultation with MDHHS, moving forward, it is the expectation of MDHHS that the ICO will develop its own medical review process. As such, HSAG strongly recommends that the ICO proceed with developing its own internal medical record review process to comply with this requirement.
- HSAG strongly recommends that the ICO ensure it uses and analyzes its MI Health Link program specific Healthcare Effectiveness Data and Information Set (HEDIS®), A-1 Consumer Assessment of Healthcare Providers and Systems (CAHPS®), A-2 and Health Outcomes Survey (HOS) data to develop initiatives to improve health outcomes for the MI Health Link program. HSAG further recommends that the ICO include



- these specific activities, particularly those using social determinants of health and health disparity data, within its QAPI work plan to monitor and track the progress of these activities.
- While the ICO included its MI Health Link members in its Medicaid performance improvement projects (PIPs), HSAG strongly recommends that the ICO also evaluate its MI Health Link membership for potential PIPs to improve overall outcomes specifically for this population. Additionally, HSAG recommends separating the MI Health Link population from its Medicaid population in the documentation and data reporting of its PIPs for ease of understanding the true impact of the PIP on the MI Health Link population.
 - The ICO did not establish a medical record review process for monitoring provider network compliance with policies and procedures, specifications, and appropriateness of care consistent with the utilization control requirements of 42 CFR Part 456. Since MDHHS has not requested the ICO's process for conducting medical record reviews and the results of these reviews, sub-element a was not considered as part of the scoring for this element.
 - While most activities addressed in the QAPI evaluation included quantitative and qualitative analysis, HSAG recommends that the ICO include all quality activities to ensure it is a robust evaluation of all quality improvement initiatives, including those handled in other departments, with thorough quantitative and qualitative analysis for each activity.
 - The 2022 HAP Empowered MI Health Link Quality Program Evaluation did not include the performance on all measures on which it is required to report (e.g., MI Core Measures), the outcomes and trended results of each PIP, or the results of any efforts to support community integration for members using LTSS. Although the ICO submitted separate reports, including the Reducing Unplanned Transitions Report, the intent of this element is to include all QAPI activities within the QAPI program evaluation.
 - HSAG recommends that the ICO update its standard operating procedure to include the credentials of the medical record reviewers (e.g., clinicians, coders).
 - After the site review, the ICO demonstrated that it had Michigan Core measures scattered throughout the QAPI evaluation and in an appendix to the QAPI report. However, HSAG strongly recommends that the ICO include sections in its QAPI evaluation narrative that specifically outline each measure set required to be reported by the ICO to MDHHS and/or CMS, and a detailed assessment of the measures within each measure set (e.g., the Healthcare Effectiveness Data and Information Set [HEDIS®], A-2 Michigan Core, CMS Core Set) so that the information is



clearly documented. Additionally, although the ICO included attachments that related to LTSS and supported the ICO's efforts to support community integration for members using LTSS, the ICO should strongly consider adding specific information in the QAPI evaluation narrative that addresses LTSS, including an assessment of all activities related to LTSS that have been implemented over the prior year, any barriers to implementation, and outcomes from the initiated activities.

C. Quality Improvement Projects and Chronic Care Improvement Programs

In accordance with the requirements of the Managed Care Manual Chapter 5, "Quality Assessment," and in accordance with 42 CFR §422.152(a)(2), and contractual requirements, HAP CareSource develops and implements Quality Improvement Projects (QIP) and Chronic Care Improvement Programs (CCIP) that focus on clinical and non-clinical areas of improvement. Per CMS guidelines and re-designation of the QIP, HAP CareSource aligns its improvement efforts by combining QIP and CCIP to promote effective chronic disease management and improvement of care and health outcomes for members with chronic conditions.

HAP CareSource also 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 of Michigan and EQRO on potential topics and adheres to state of Michigan and EQRO reporting requirements.

PIP #1

OBJECTIVE:

Do focused interventions improve the rate of members with controlled blood pressure, and reduce the disparity between the White/Caucasian and Black/African American populations without a decline in performance for the White/Caucasian population

GOAL:

By 12/31/2024, improve Controlling High Blood Pressure (CBP) performance for HAP CareSource MI Health Link members ages 18–85 by increasing the CBP rate for Black/African American members from the baseline 51.50% (MY2021) to at least 65.00%, while maintaining the White/Caucasian CBP rate at or above the baseline 74.24% (MY2021).



MEASUREMENT:

Measurement Period	Black/African American CBP Rate	White/Caucasian CBP Rate
MY2021 Baseline	51.50%	74.24%
MY2022 Remeasurement 1	63.83%	67.41%
MY2023 Remeasurement 2	70.83%	78.29%
MY2024 Remeasurement 3	68.75%	76.97%

FINDINGS:

Compared to the MY2021 baseline, CBP performance improved for both populations by MY2024 Remeasurement 3. The Black/African American rate increased from 51.50% to 68.75%, while the White/Caucasian rate improved from 74.24% to 76.97%. The disparity gap narrowed substantially from 22.74 to 8.22 percentage points, indicating progress toward more equitable blood pressure control outcomes.

BARRIERS:

- System Level Barriers:
 - *Barrier #1:* While healthcare access has normalized, member utilization continues to lag behind pre pandemic patterns.
 - *Barrier #2:* Racial disparities between Caucasian and African American populations in hypertension control are well-documented in the United States based on research.
- Business Level Barriers
 - *Barrier #3:* Delays in data availability hinder HAP CareSource's ability to identify real-time improvement opportunities, particularly for the African American population.
- Member Level Barriers
 - *Barrier #4:* Insufficient understanding of the importance of regular routine health care and medication compliance.
 - *Barrier #5:* Inability to secure timely appointments with PCPs based on member availability.
 - *Barrier #6:* SDoH barriers to include transportation continue to limit access to care in vulnerable communities.



- Care Coordination Barriers
 - *Barrier #7:* Care Coordinators and outreach team face challenges in reaching UTR members.

INTERVENTIONS IN MY2025:

- Targeted member outreach with no PCP visits
- Community outreach
- Member rewards
- Primary care incentive (Best Practice Program)
- Provider care in gaps report
- Adherence program through pharmacy benefit manager

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026

- Identify additional opportunities to improve timeliness/utility of data for intervention targeting
- Increase blood pressure capture + documentation reliability
- Strengthen member medication adherence supports with equity focus

PIP #2

OBJECTIVE:

Eye exam for patients with Diabetes

GOAL:

Increase eye exams for patients with Diabetes (EED) rate from 50.07% by 5% within the reporting measurement year. Explore racial disparity and decrease disparity if one exists.

MEASUREMENT:

	MY 2024 Baseline	MY 2025 Remeasurement 1	MY 2026 Remeasurement 2
Eye Exam for Patients with Diabetes (MMP)	50.07%	57.54% (Final rates TBD)	TBD



FINDINGS:

YTD rate of 57.54% reflects goal was met and exceeded the rate by 1.97%. MY 2025 is currently trending 7.47% percentage points higher than MY 2024 final rate.

BARRIERS:

- Lack of member engagement to provider systems and member awareness of the importance of receiving annual Diabetic Retinal Eye Exam.
- Lack of transportation for HCS disparate population has made it challenging for members to go in for an eye exam.
- Limited supplemental data from eye care providers.

INTERVENTIONS IN MY2025

- Member outreach (Telephonic, Text, Mailings, and Email Campaigns)
- Best Practice Program (i.e.: EED Provider Incentives)
- Community Outreach (i.e.: Vision Clinic Events)
- Reminders through Customer Service and Care Coordination interactions
- Promote transportation benefits more broadly and provide education to improve member engagement
- Promote provider education to ensure servicing providers are utilizing the correct LOINC codes, to help accurately capture diabetic retinal eye exam data.

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026

- Continue with successful strategies from 2025 while enhancing access points and engagement strategies.
- Provider education
- Enhance data analysis to include data heat mapping to strategically support 2026 QI and PH improvement efforts.

PIP #3

OBJECTIVE:

Increase completion of Health Risk Assessments

GOAL:



HAP CareSource MI Health Link aims to improve the percentage of eligible members who have a health risk assessment completed from 23.2% to 85% by 09/30/2025.

MEASUREMENT:

HRA Completion increased from 23.2% to 49% in MY2025.

FINDINGS:

23% of members who were successfully reached declined and 21% were unable to be reached. 89% of members who were successfully reached and did not decline to be assessed successfully completed the HRA.

BARRIERS:

HCS MI Health Link identified that some members did not see the value in having an assessment. Our PIP evaluation revealed several contributing factors:

- Some care coordinators lacked caller IDs displaying 'HAP CareSource' discouraging members from answering calls.
- Members did not recognize the importance of completing a health risk assessment.
- Staffing challenges limited care coordinators' capacity to effectively complete HRAs.
- Data analysis revealed that the process of locating hard-to-reach members consumed considerable time and resources, hindering care coordinators' ability to efficiently complete assessments and provide timely support.

INTERVENTIONS IN MY2025:

- Caller ID Enhancement
- Optimizing Staffing and Caseload Management
- Care Coordinator Training
- Utilizing Community Health Workers for Outreach Support

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026



- Incentive program – introduce incentive program to motivate members to complete the assessment.
- Ongoing training for care coordinators to equip them with effective communication scripts to highlight the benefits of completing the HRAs.
- Continuous staffing and caseload management.

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 7: PQoC referrals

PQoC Level	Leveling Data Definition		Measurement Periods	
	Standard of Care Met/Not Met	Outcome	MY24	MY25
N/A	Not Investigated	Not clinical in nature; not eligible at time of service.	4	6
Level 0	Met	No untoward outcome.	11	5
Level 1	Met	Minor adverse outcome.	2	7
Level 2a	Met	Moderate adverse outcome, disability or death.	0	0
Level 2B	Not Met	No untoward outcome/No documentation submitted.	2	2
Level 3	Not Met	Minor Injury	0	0
Level 4	Not Met	Moderate Injury	0	0
Level 5	Not Met	Death or Disability	0	0



Indeterminate	Insufficient Documentation - cannot be determined or leveled.	5	3
Total		24	23

Table 6 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.

HAP CareSource has systems in place to assess the quality and appropriateness of care provided to members with complex healthcare needs, inclusive of LTSS members. Processes include, but are not limited to: assessment of care between care settings; comparison of services and supports received with those set forth in members' service plan, person-centered care plan, services in the plan and actual delivery, coordinated services (including health services) and provider responsiveness to members' changing needs and circumstances.

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 8: 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. MDHHS and CMS Priority Focus



a. Quality Withhold

MMP model focused on improving care for the dual-eligible members in service area states by testing person-centered, integrated care models that provide a more easily navigable and seamless path to Medicare and Medicaid benefits. To support the MMP priorities, both Medicare (CMS) and Medicaid (MDHHS) withhold a percentage of the plan's capitation rate which are repaid retrospectively subject to HAP CareSource's performance consistent with established quality requirements that include a combination of CMS-core performance measures and goals as well as MDHHS specific measures and goals.

The following CMS-core and MDHHS measures comprised the quality withhold dataset for MY2025:

- Plan-All-Cause Readmissions: Observed/Expected Ratio (HEDIS®)
- Annual Flu Vaccination (MCAHPS®)
- Follow-Up After Hospitalization for Mental Illness within 30 days (HEDIS®)
- Controlling Blood Pressure (HEDIS®)
- Medication Adherence for Diabetes Medications (Prescription Drug Event [PDE])
- Encounter Data Frequency and timeliness (Encounter Data)
- Care Transition Record Transmitted to Health Care Professional (MDHHS)
- Medication Review (HEDIS® like)
- Annual Dental Visit (MDHHS)
- Minimizing Facility Length of Stay (CMS)
- Colorectal Cancer Screening (HEDIS®)
- Medication Reconciliation Post Discharge (HEDIS®)

Detailed analysis of the HEDIS® and MCAHPS® (as applicable) measures noted above can be found in the HEDIS® section noted below with an asterisk (*) denotation identifying the priority focus measures discussed above.

B. 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 MI Health Link required measures which included the following priority measures based on contractual priority and/or accreditation/HPR NCQA STAR ratings:

- Prevention and population HEDIS® measures:
 - Adults' Access to Preventive Services (AAP)
 - Annual Dental Visit
- Cancer Screenings HEDIS® measures:
 - Breast Cancer Screening (BCS-E)
 - Colorectal Screening (COL-E)
 - Care for Older Adults (COA)
 - Osteoporosis Management in Women Who Had a Fracture (OMW)
- Management of Chronic Conditions HEDIS® measures:
 - Controlling Blood Pressure (CBP)
 - 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)
 - Glycemic Status Assessment for Patients with Diabetes – Glycemic Status >9% (GSD)
 - Transitions of Care – Medication Reconciliation Post Discharge (TRC)
 - Plan All Cause Readmission (PCR)
- BH HEDIS® measures:
 - Follow-Up After Hospitalization for Mental Illness within 7 and 30 days - (FUH)

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 56.70% in MY2025.

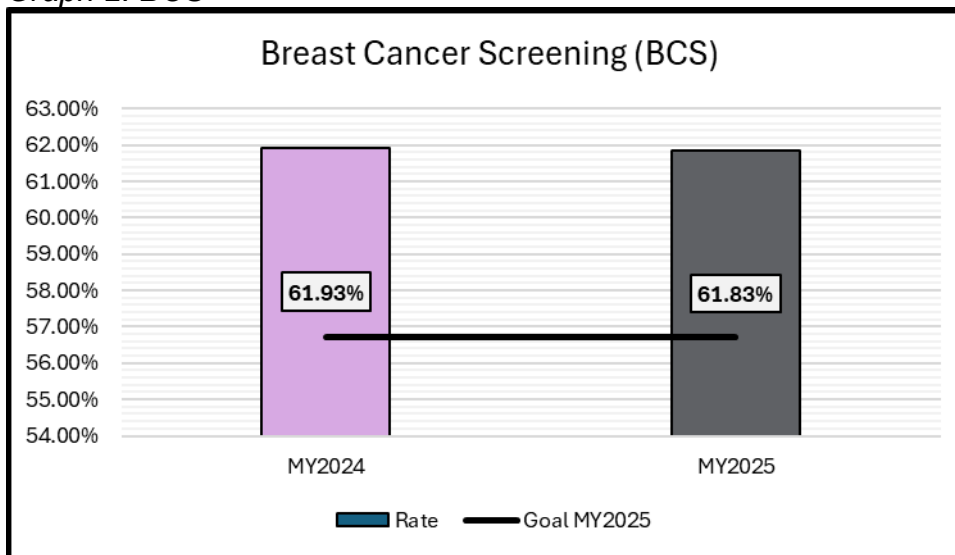


MEASUREMENT:

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

FINDINGS:

Graph 2: BCS



**Data as of January 16, 2026.

Graph 2 indicates the Breast Cancer Screening (BCS-E) rate improved from MY2024 to MY2025, reaching 61.83% in MY2025 (meeting the stated goal). Qualitatively, the year-over-year increase suggests that care coordination, member outreach, and community-based screening efforts helped close screening gaps; however, continued focus on timely access, barrier mitigation (e.g., transportation/scheduling), and member education is needed to sustain and further improve performance.

BARRIERS:

- Identifying and addressing member barriers
- Convenient, timely access to high-quality, coordinated care
- Missed screening opportunities during routine visits

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 Coordination

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

Colorectal Cancer Screening (COL)

OBJECTIVE:

The percentage of members 45-75 years of age who has appropriate screening for colorectal cancer.

GOAL:

To reach 42.80% in MY2025

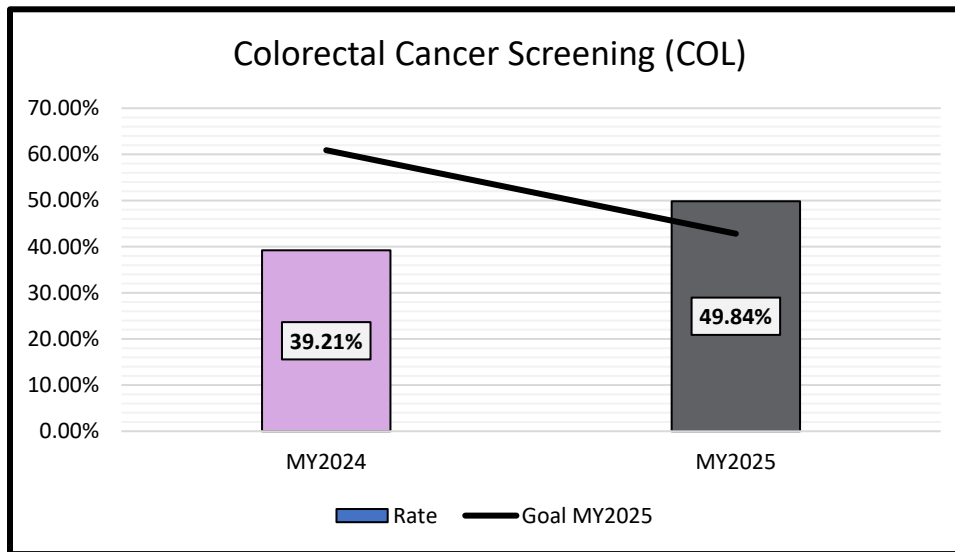
MEASUREMENT:

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

FINDINGS:

Graph 3: COL





**Data reported 01/16/2026.

Graph 3 indicates the Colorectal Cancer Screening (COL-E) rate improved from MY2024 to MY2025 and met the MY2025 goal of 42.80%. Qualitatively, the year-over-year increase suggests that continued member outreach, care management engagement, and community-based screening events supported gap closure; to sustain improvement, continued focus on timely access, addressing member barriers (including completion of mailed/at-home screening workflows such as FIT), and provider engagement is recommended.

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 Health Clinic Events
- Provider Education via JOC meetings and HCS Newsletters
- Care Management

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Strengthen targeted member outreach and education
- Enhance provider engagement and education



- Evaluate opportunity to offer more FIT kits to support member modality preference

Care for Older Adults (COA)

OBJECTIVE:

The percentage of members 66+ years of age who had both the following during MY2025.

GOAL:

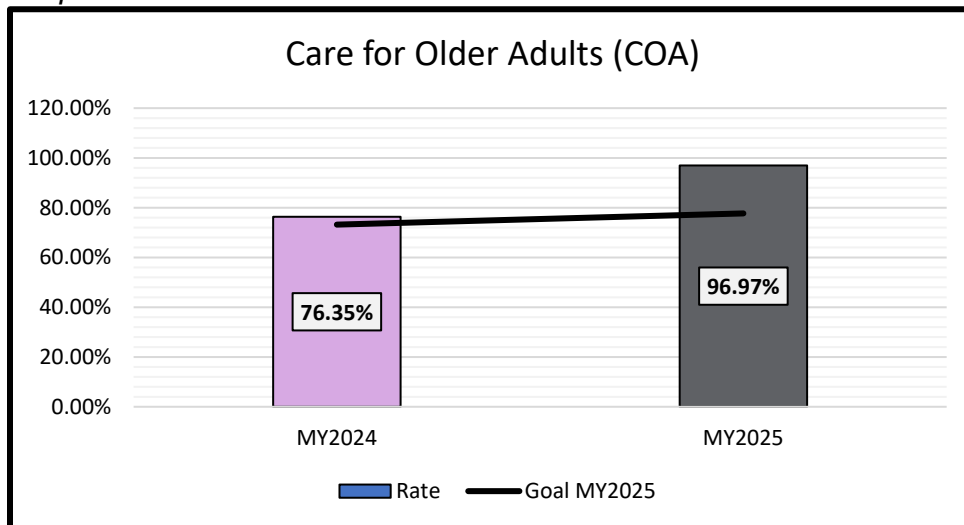
To reach 77.70% in MY2025

MEASUREMENT:

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

FINDINGS:

Graph 4: COA



**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 completed care for older adults. The administrative rate is trending above the final hybrid rates for care for older adults in 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 2024 rates, and strategy updates will be made as appropriate.

BARRIERS:

- Convenient, timely access to high-quality, coordinated care
- Identifying and addressing member barriers
- Documentation gaps and inconsistent capture of required COA components

INTERVENTIONS IN MY2025:

- Care Management engagement
- Pharmacy-led medication review outreach/closure efforts (targeted gap closure to improve COA medication review completion)

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Strengthen targeted member outreach and education
- Further strengthen pharmacy-led medication review outreach
- Further strengthen care management engagement and outreach

Osteoporosis Management in Women Who Had a Fracture (OMW)

OBJECTIVE:

The percentage of members 66-85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the 180 days (6 months) after the fracture during MY2025.

GOAL:

To reach 11.20% in MY2025

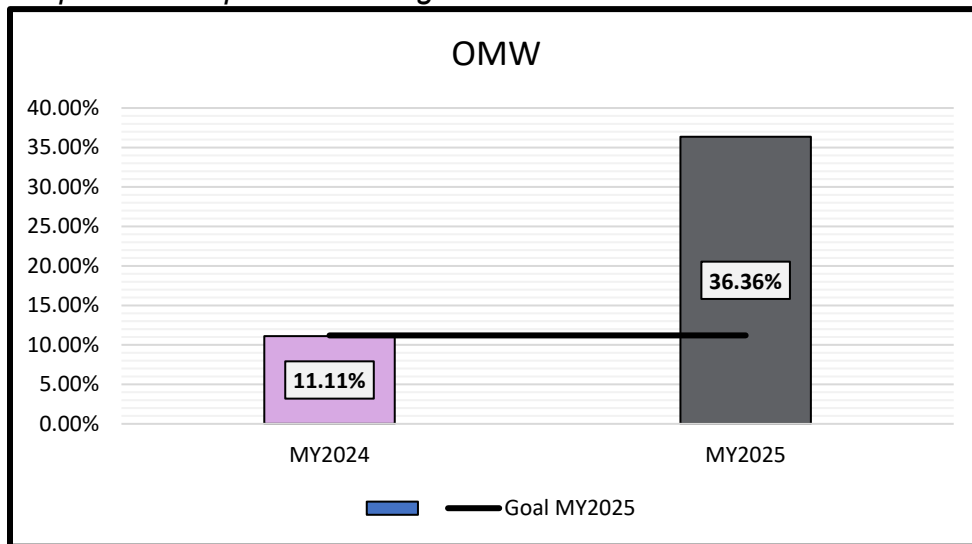
MEASUREMENT:

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

FINDINGS:



Graph 5: Osteoporosis Management in Woman



**Data reported 01/16/2026.

Graph 5 indicates the plan's Osteoporosis Management in Women Who Had a Fracture (OMW) rate improved from MY2024 to MY2025 and met the MY2025 goal of 11.20% (see Graph 12). Qualitatively, the year-over-year increase suggests progress in post-fracture follow-up and treatment initiation; continued focus on timely access to bone density testing and medication initiation, closing care coordination gaps after fracture events, and supporting medication adherence is needed to sustain and accelerate improvement.

BARRIERS:

- Convenient, timely access to high-quality, coordinated care
- Identifying and addressing member barriers
- Claims lag / fracture identification delays
- Provider documentation/coding gaps new fracture versus history of fracture

INTERVENTIONS IN MY2025:

- Provider education (ongoing)
- Care coordination gap-in-care workflows
- Community-based outreach / clinic event model

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Look for opportunities to reduce fracture-to-outreach time



- Identify opportunities to close the “coding gap”
- Review current OMW post-fracture pathway to identify additional opportunities

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 MY2025.

GOAL:

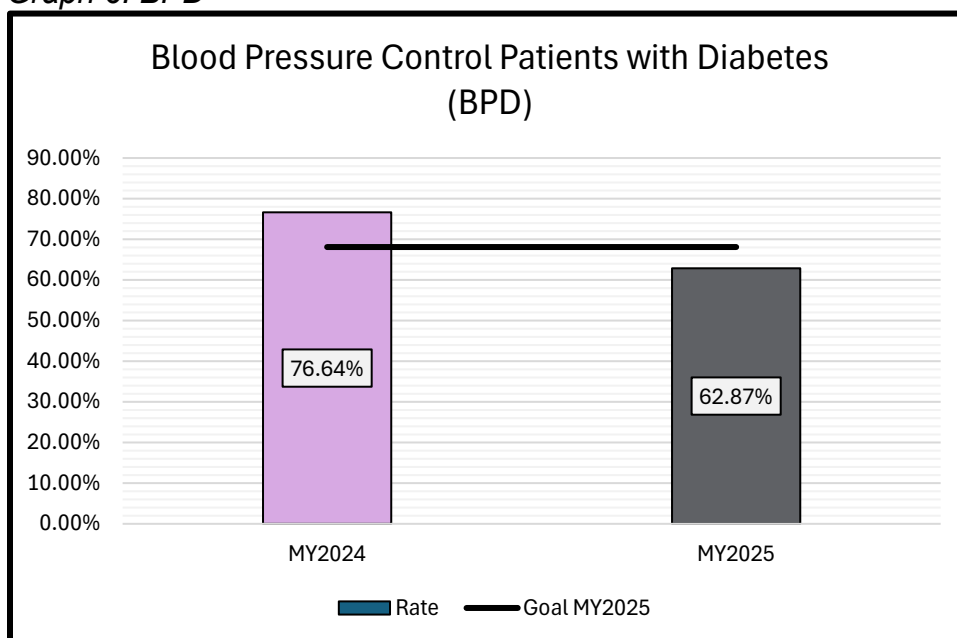
To reach 68.10% in MY2025

MEASUREMENT:

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

FINDINGS:

Graph 6: BPD



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

Graph 6 demonstrates the 2025 administrative rate for completed blood pressure control for patients with diabetes. The administrative rate is trending below the final hybrid rates for blood pressure control for patients with diabetes in 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 2024 rates, and strategy updates will be made as appropriate.

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:



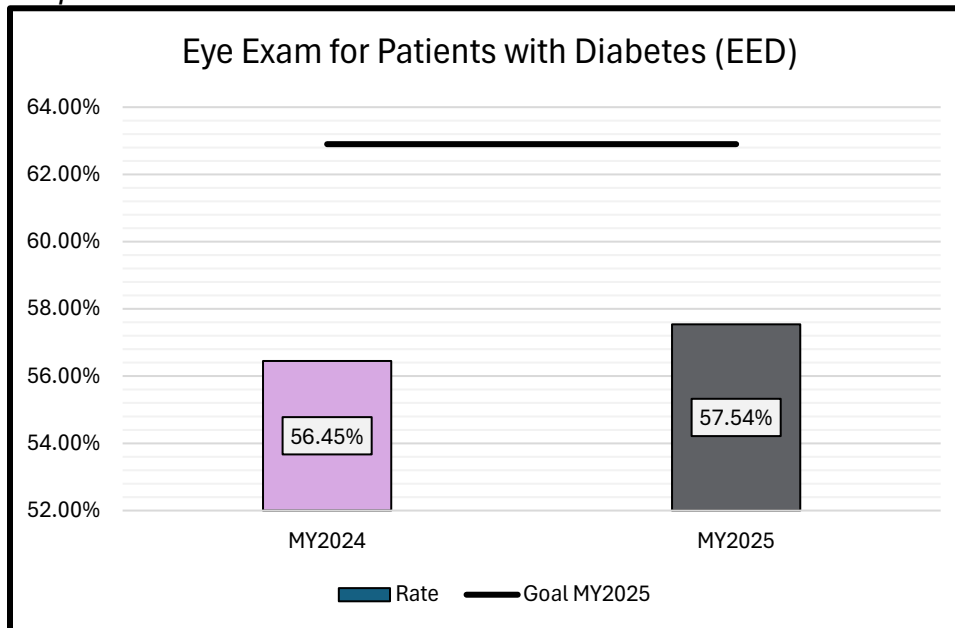
To reach 62.90% in MY2025

MEASUREMENT:

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

FINDINGS:

Graph 7: EED



**Data as of January 16, 2026.

Graph 7 indicates the plan's Eye Exam for Patients with Diabetes (EED) rate improved from 50.07% in MY2024 to 57.54% in MY2025 (+7.47 percentage points). Despite the year-over-year improvement, MY2025 performance remained below the MY2025 goal of 62.90% by 5.36 percentage points (final rates may continue to shift as additional clinical data are submitted and validated). Qualitatively, the increase suggests progress from member outreach, provider incentives, and community vision clinic events, with continued opportunity to reduce access and transportation barriers and strengthen supplemental/clinical data captured from eye care providers.

BARRIERS:

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



- Limited supplemental/clinical data capture from eye care providers (including limited availability of tele-retinal devices)

INTERVENTIONS IN MY2025:

- Vision clinic/community events increase access points and can also support data capture.
- Outreach + care management reminders + transportation benefit promotion directly address engagement/access barriers.
- Diabetic Adherence Reminder Report Card Provider Letters
- Diabetic Prevention Program Provider Partnership
- Disease Management Diabetic Newsletters

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Look for opportunities to improve access to retinal eye exams
- Strengthen 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 58.50% in MY2025

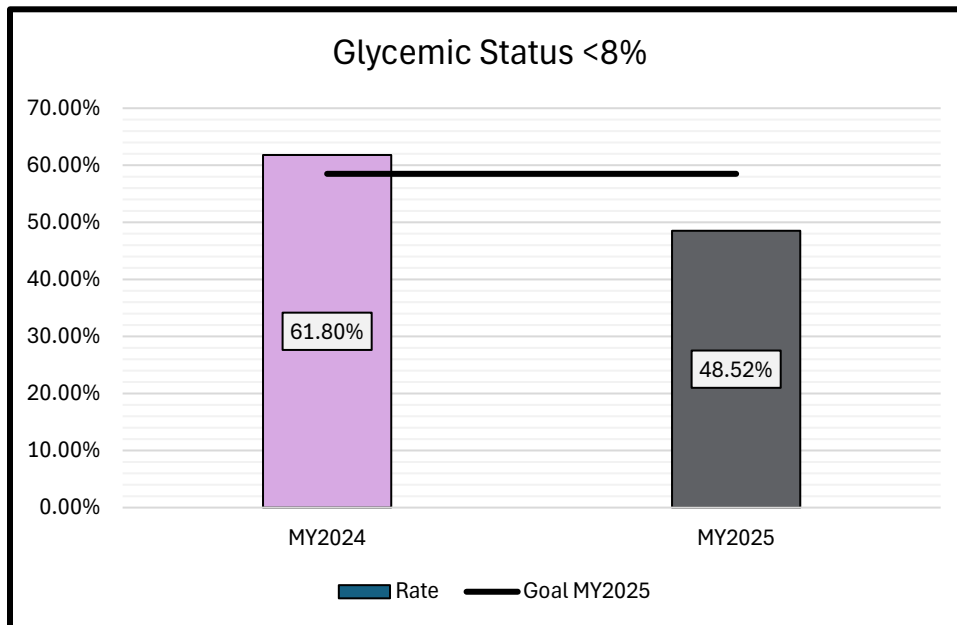
MEASUREMENT:

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

FINDINGS:

Graph 8: 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 8 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 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 2024 rates, and strategy updates will be made as appropriate.

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 Coordination using gap in care reporting during contacts
- Diabetic Prevention Program Provider Partnership
- Disease Management Diabetic Newsletters
- Member Rewards



OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Member rewards & incentives tied to gap closure
- Further strengthen Care Coordination gap in care reporting
- Examine opportunities for home testing vendor partnerships

Glycemic Status Assessment for Patients with Diabetes – Glycemic Status >9% (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 >9% during the MY.

GOAL:

To reach 34.10% in MY2025

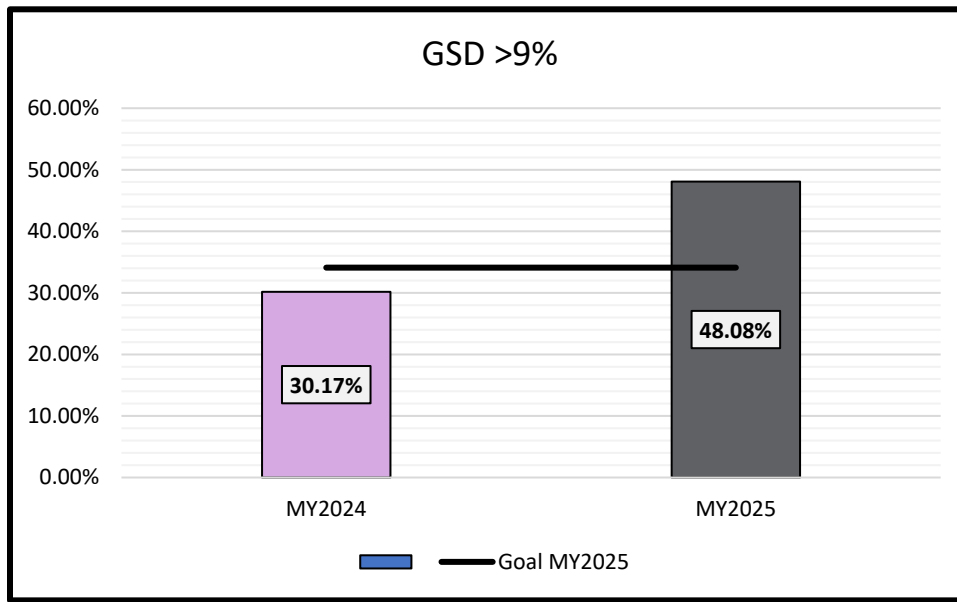
MEASUREMENT:

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

FINDINGS:

Graph 9: Glycemic Status >9%





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

Graph 9 demonstrates the 2025 administrative rate for completed glycemic status assessment for patients with diabetes >9%. The administrative rate is trending above the final hybrid rates for glycemic status assessment for patients with diabetes >9% in 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 2024 rates, and strategy updates will be made as appropriate.

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:

- Further strengthen community event strategies
- Identify opportunities to add/expand vision clinics
- Continue to address diabetes equity

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 71.00% in MY2025

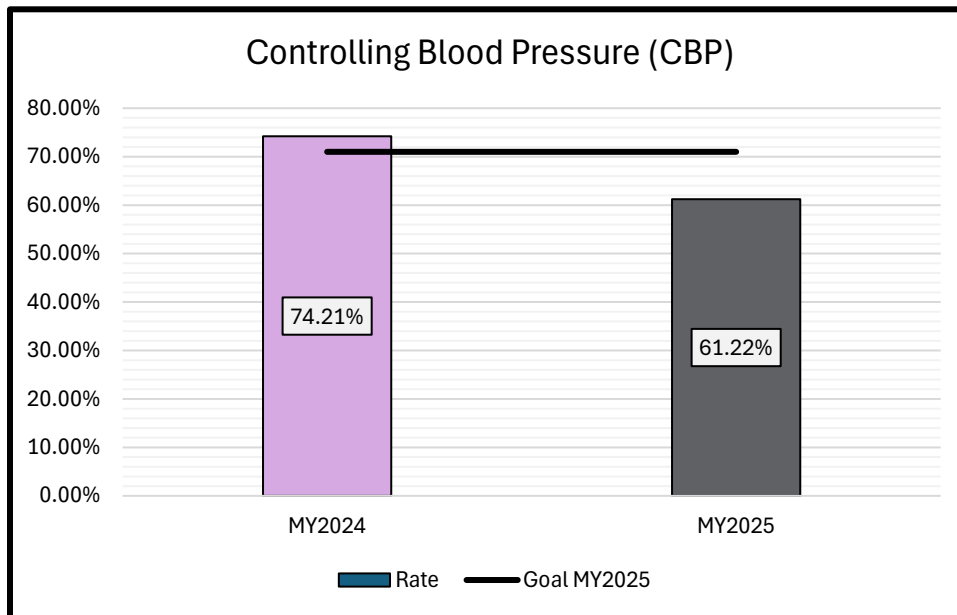
MEASUREMENT:

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

FINDINGS:

Graph 10: CBP





**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 controlling blood pressure. The administrative rate is trending below the final hybrid rates for controlling blood pressure in 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 2024 rates, and strategy updates will be made as appropriate.

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
- Further strengthen community event strategies
- Continue to address diabetes equity

Transitions of Care (TRC)

OBJECTIVE:

The percentage of members 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the 180 days (6 months) after the fracture.

GOAL:

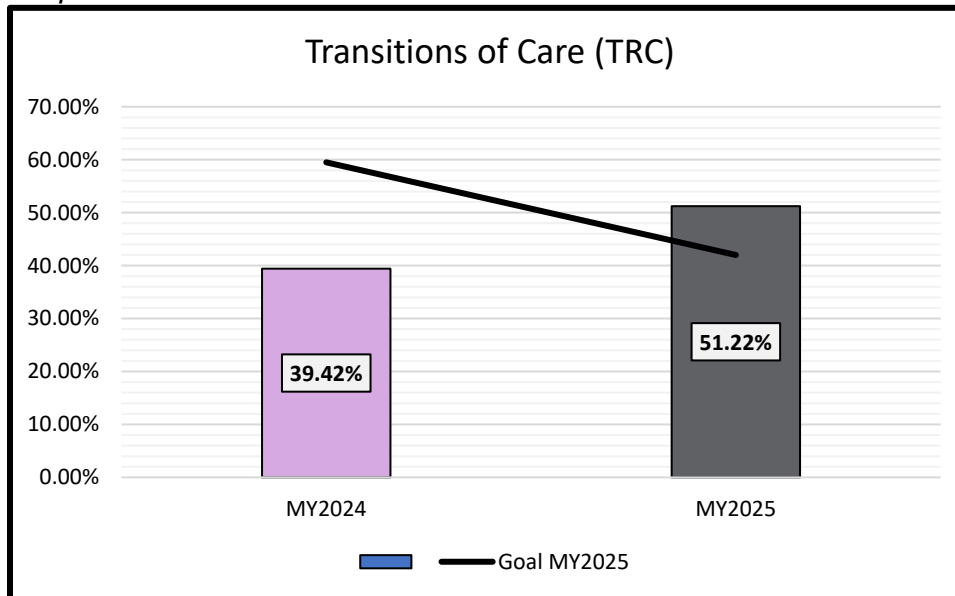
To reach 42.00% in MY2025

MEASUREMENT:

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

FINDINGS:

Graph 11: TRC



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

Graph 11 demonstrates the 2025 administrative rate for completed transitions of care. The administrative rate is trending below the final hybrid rates for transitions of care in 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 2024 rates, and strategy updates will be made as appropriate.

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
- BH Referrals
- PIHP Collaboration & Process Standardization
- BH Tool Kit
- Vital Data Technologies

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Continued focus on timely post-discharge outreach, care coordination, and addressing social/access barriers is recommended to sustain performance.
- Look for opportunities to further strengthen and scale timely post-discharge outreach workflows
- Identify opportunities to strengthen care transition partner coordination (hospital/SNF/PCP/pharmacy)

Plan All Cause Readmissions (PCR)

OBJECTIVE:

The percentage of members 18+ years the risk-adjusted ratio of observed-to-expected unplanned acute readmissions (inpatient and observation stays) for any



diagnosis within 30 days of an acute hospitalization (inpatient and observation stays).

GOAL:

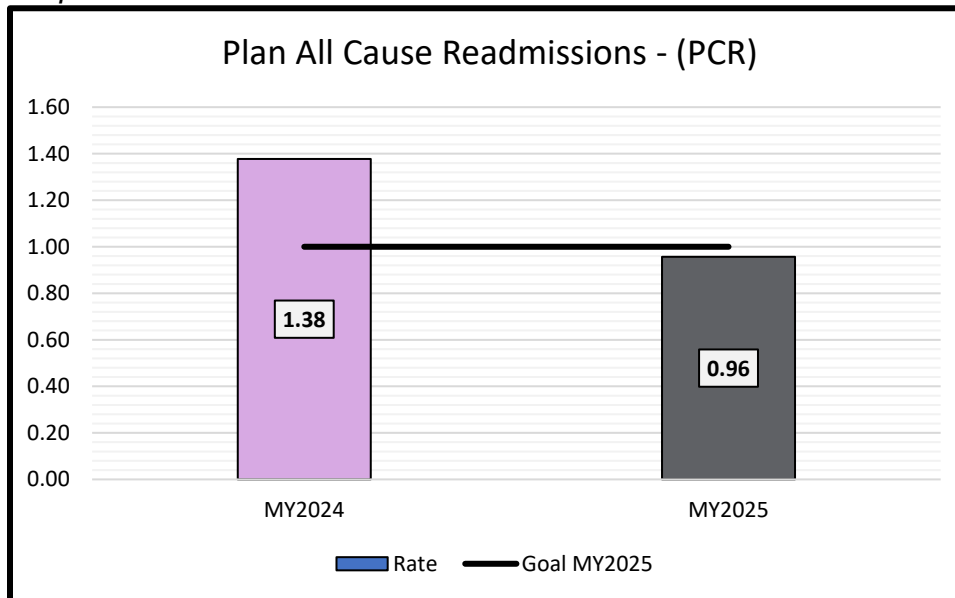
To reach 1.00% in MY2025

MEASUREMENT:

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

FINDINGS:

Graph 12: PCR



**Data as of January 16, 2026.

Graph 12 indicates improvement over MY2024 by 0.42 percentage points in 2025.

BARRIERS:

- Continued reporting/claims lag and delayed clinical performance reporting
- High unable-to-reach (UTR) rates

INTERVENTIONS IN MY2025:



- Daily Care Coordination inpatient reports to identify members experiencing a transition and prioritize outreach
- Post-discharge outreach to providers to obtain the transition record for sharing with the member's PCP
- Leveraged EPIC and CarePort to support transitions-of-care coordination and information exchange
- Gap-in-care report to prioritize outreach and gap-closure conversations during required member contacts
- Medication reconciliation process support

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Continue to look for opportunities to improve our PCR reporting to allow for us to adjust interventions faster
- Expand high-touch transition workflows
- Maintain dedicated resources for transition/readmission prevention workstreams

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 56.00% in MY2025

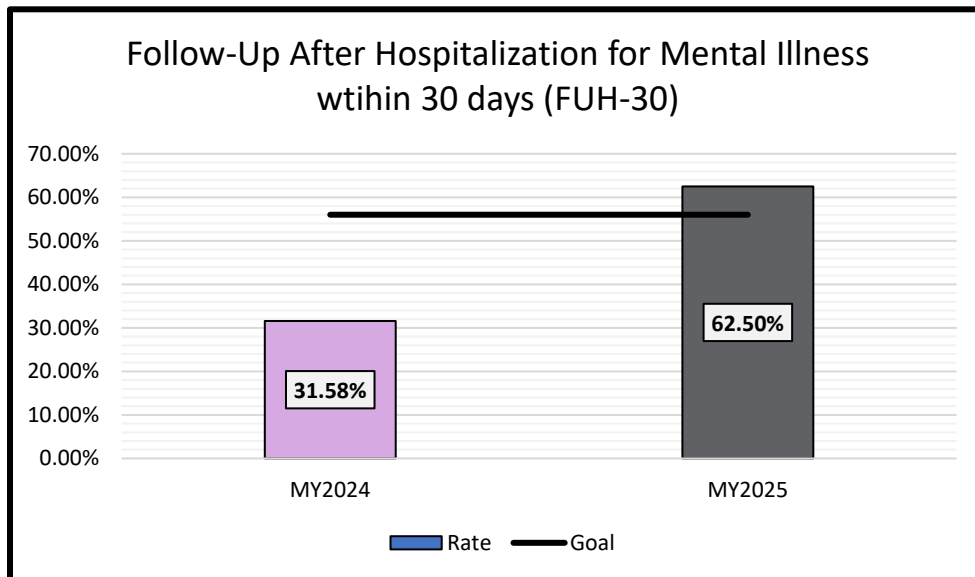
MEASUREMENT:

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

FINDINGS:

Graph 13: FUH-30





**Data as of January 16, 2026.

Based on Graph 13, FUH 30 improved by 30.92 percentage points in MY2025 over MY2024 performance. MY2025 met the goal of 56.00% in MY2025.

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
- BH Referrals
- PIHP Collaboration & Process Standardization
- BH Tool Kit
- Vital Data Technologies

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Strengthen timely outpatient behavioral health access post-discharge
- Review current transition workflows for opportunities to reduce handoff gaps



Follow-Up After Hospitalization for Mental Illness within 7 days (FUH-7)

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 7 days after discharge.

GOAL:

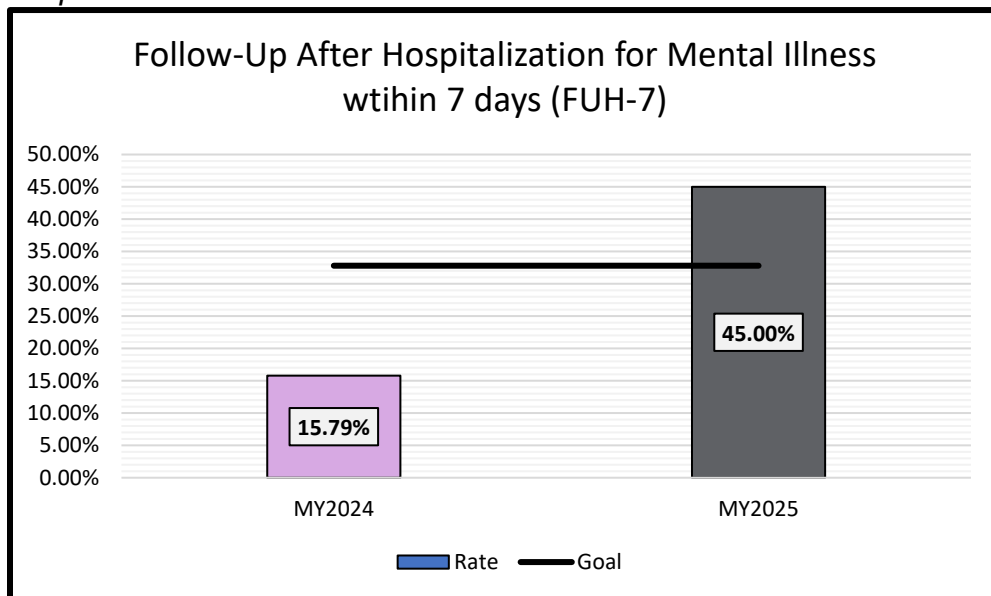
To reach 32.80% in MY2025

MEASUREMENT:

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

FINDINGS:

Graph 14: FUH-7



**Data as of January 16, 2026.

Based on Graph 14, FUH 7 improved by 29.21 percentage points in MY2025 over MY2024 performance. MY2025 met the goal of 32.80% in MY2025.

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
- BH Referrals
- PIHP Collaboration & Process Standardization
- BH Tool Kit
- Vital Data Technologies

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Strengthen timely outpatient behavioral health access post-discharge
- Review current transition workflows for opportunities to reduce handoff gaps

Adult Access to Preventive/Ambulatory Health Services (AAP)

OBJECTIVE:

The percentage of persons 20 years of age and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line.

GOAL:

To reach 94.40% in MY2025

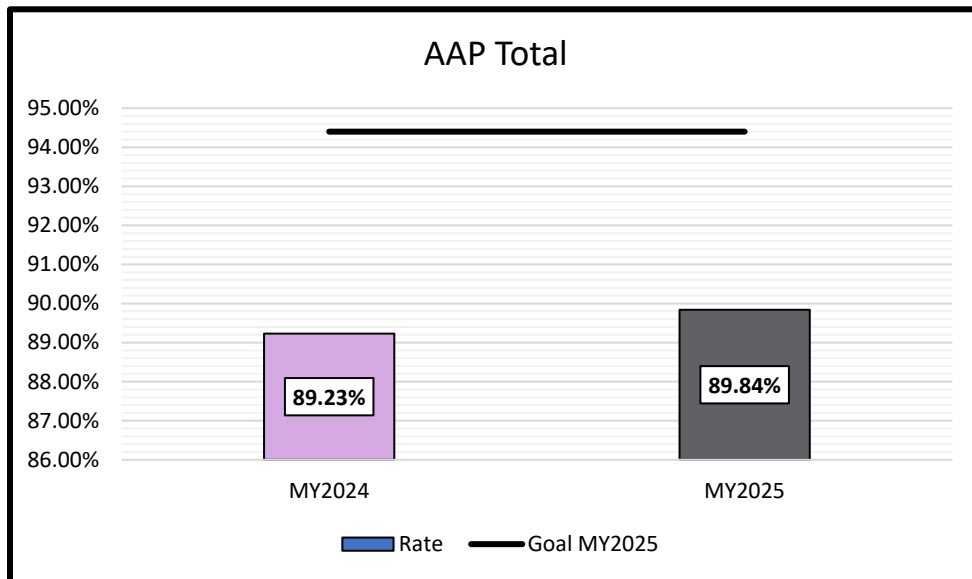
MEASUREMENT:

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

FINDINGS:

Graph 15: FUH-7





**Data as of January 16, 2026.

Based on Graph 15, AAP improved by 0.61 percentage points in MY2025 over MY2024 performance. MY2025 did not meet the goal of 94.40% in MY2025.

Barriers:

- Difficulty making contact with members/high UTR
- Member engagement challenges
- Access to care constraints

INTERVENTIONS IN MY2025:

- Care Coordination
- Targeted member outreach (telephonic, mail, text, and/or IVR)
- Member rewards

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Improve “visit conversion” for hard-to-reach members
- Continue to reduce access friction for preventive/ambulatory visits
- Further strengthen provider and data enablement for AAP closure

Annual Dental Visit days (ADV)

OBJECTIVE:



The percentage of persons 21 years of age and older with dental benefits, who had at least one dental visit during the year.

GOAL:

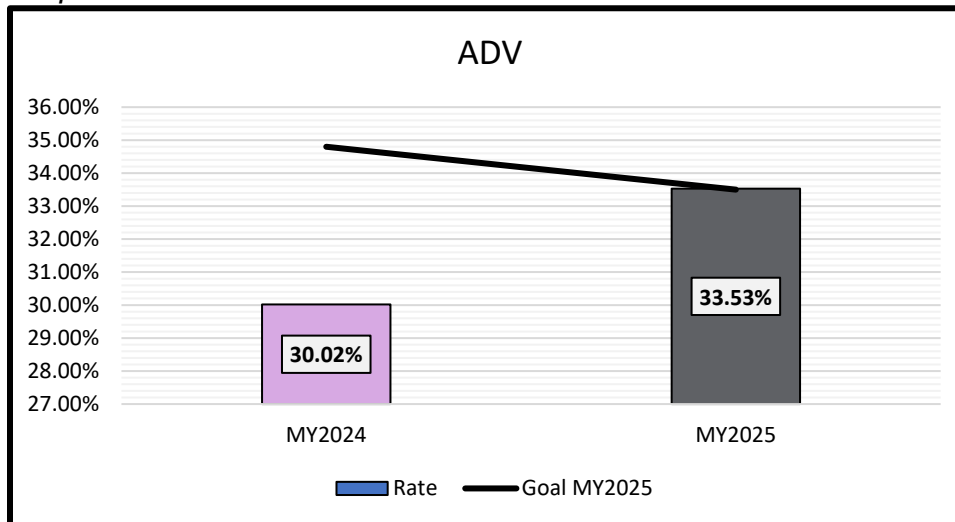
To reach 33.50% in MY2025

MEASUREMENT:

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

FINDINGS:

Graph 16: FUH-7



**Data as of January 16, 2026.

The rate for the ADV measure is noted in Graph 22. Based on Graph 16, AAP improved by 3.51 percentage points in MY2025 over MY2024 performance. MY2025 met the goal of 33.50% in MY2025.

BARRIERS:

- Transportation barriers and related no-show risk
- Difficulty reaching/engaging members (high UTR)
- Access to care constraints

INTERVENTIONS IN MY2025:



- Care Coordination gap closure during 1:1 outreach/contacts
- Targeted member outreach (telephonic, mail, text, and/or IVR)
- Member rewards

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Continue to improve “visit conversion” for hard-to-reach members
- Reduce transportation/no-show barriers
- Expand access points through mobile/community dental clinics and data-driven targeting

C. 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 reach a 4 STAR rating for the following composites and measures:

- Getting Needed Care (GNC)
- Getting Care Quickly (GCQ)
- Customer Service (CS)
- Care Coordination (CC)
- Rating of Health Care Quality
- Rating of Health Plan

MEASUREMENT:

Administration and assessment of the CAHPS survey occurs annually.

FINDINGS:

Table 9: CAHPS results



CAHPS Composite Measures (MMP)	MY2023	MY2024	MY2025	Goal	Goal Met Y/N
Getting Needed Care (GNC) Composite	86.3	83.3	87.3	86.5	Y
Getting Care Quickly (GCQ) Composite	90.5	89.1	91.5	87.3	Y
Customer Service (CS) Composite	95.3	91.8	94.2	92.9	Y
Care Coordination (CC) Composite	92.7	90.8	92.7	91.9	Y
Rating of Health Plan	76.4	72.5	71.1	72.7	N
Rating of Health Care Quality	62.9	60	63.9	62.6	Y
How Well Doctors Communicate Composite	97.2	95.5	95.2	94.7	Y
Rating of Personal Doctor	76.7	75.7	76.8	78.4	N
Rating of Specialist	73.6	71.3	71.8	72.3	N
Rating of Drug Plan	80.9	79.1	75.4	77.6	N
Getting Needed Prescription Drugs	95.1	93.7	96.0	94.5	Y
Annual Flu Vaccine	63.2	60.8	60.5	61.2	N

The plan's CAHPS scores are presented in Table 9. Quantitatively, the plan met the MY2025 goal for 7 of 11 reported CAHPS measures/composites (Goal Met = "Y"), with the strongest MY2025 performance observed in Getting Needed Care (87.3 vs. 86.5 goal, +0.8) and Getting Care Quickly (91.5 vs. 87.3 goal, +4.2). Opportunities remain in areas that did not meet goal, including Rating of Health Plan (71.1 vs. 72.7 goal, -1.6), Rating of Personal Doctor (76.8 vs. 78.4 goal, -1.6), Rating of Specialist (71.8 vs. 72.3 goal, -0.5), Rating of Drug Plan (75.4 vs. 77.6 goal, -2.2), and Annual Flu Vaccine (60.5 vs. 61.2 goal, -0.7).

Quantitative Analysis

Measures 3-12 MI Health Link Adult CAHPS

Rating of Health Plan

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

Rating of Health Care

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



Rating of Personal Doctor

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

Rating of Specialist

- In MY2025, Rating of Specialist (71.8) did not meet the goal of 72.3 (-0.5 points) but improved by 0.5 points from MY2024 (71.3) and declined by 1.8 points from MY2023 (73.6).

Care Coordination

- In MY2025, Care Coordination (92.7) met the goal of 91.9 (+0.8 points) and improved by 1.9 points from MY2024 (90.8); MY2025 performance matched MY2023 (92.7).

Getting Needed Care

- In MY2025, Getting Needed Care (87.3) met the goal of 86.5 (+0.8 points) and increased by 4.0 points from MY2024 (83.3), exceeding MY2023 (86.3) by 1.0 point.

Getting Care Quickly

- In MY2025, Getting Care Quickly (91.5) met the goal of 87.3 (+4.2 points) and increased by 2.4 points from MY2024 (89.1), exceeding MY2023 (90.5) by 1.0 point.

How well doctors communicate

- In MY2025, How Well Doctors Communicate (95.2) met the goal of 94.7 (+0.5 points) but decreased by 0.3 points from MY2024 (95.5) and by 2.0 points from MY2023 (97.2).

Customer Service

- In MY2025, Customer Service (94.2) met the goal of 92.9 (+1.3 points) and increased by 2.4 points from MY2024 (91.8); however, MY2025 remained 1.1 points below MY2023 (95.3).

BARRIERS:

- Low CAHPS response / engagement
- Access to care / appointment availability (real & perceived)
- Transportation barriers (network access/availability)
- Benefit understanding & “how to use benefits” confusion



- Grievances & Appeals operational issues (process-related)
- Care coordination stability / continuity

INTERVENTIONS IN MY2025:

- Help members understand their member benefits
- Early problem resolution during poor user experience
- Provider education

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Better understanding of “how” to use the benefit especially with the 2026 changes
- Appointment availability - real and perceived challenges
- Formulary education and adherence strategies from member to provider to pharmacy
- Provider education to ensure understanding of the care coordination elements and how important their role is
- More timely, accurate & streamlined problem-solving for member issues – first call resolution
- More personalized and real-time communications during relevant points of a member’s journey; leveraging strategic mix of email, text, and mail campaigns (right message at right time via optimal channels)

D. 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
- Finance Issues



- Utilization and Quality Management
- Network and Coordination of Care
- Pharmacy/Formulary
- Call Center/Service Staff
- Provider Relations

MEASUREMENT:

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

FINDINGS²:

Table 10: Provider Experience Survey Results

Provider Experience Measure (MMP)	MY2023 (n=66)	MY2024 (n=69)	MY2025 (N=108)	Recent Change
Overall Satisfaction with HAP CareSource	30%	44%	30%	-14%
Utilization Management	15%	29%	26%	-3%
HCS Care Management Programs	18%	33%	19%	-14%
Pharmacy Services	13%	26%	25%	-1%
Provider Inquiry	17%	31%	30%	-1%
Provider Services	20%	30%	33%	3%

Quantitatively, Table 10 indicates mixed results in provider experience from MY2024 (n=69) to MY2025 (n=108). Overall Satisfaction decreased from 44% in MY2024 to 30% in MY2025 (-14 percentage points), while Utilization Management decreased from 29% to 26% (-3 points) and HCS Care Management Programs decreased from 33% to 19% (-14 points). These results suggest opportunity to focus 2026 improvement efforts on provider support and experience with care management processes and day-to-day plan operations.

Table 11 Provider Experience Methodology

Methodology
August 18 and November 12, 2025

² 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



Patient Group	Sample Selected	Completed Surveys	Response Rate %
MMP	1479	108	7.30%

BARRIERS:

- UM processes remain a key experience pain point for providers
- Care Management program/process experience
- Operational “day-to-day” administrative friction that drives provider contacts

INTERVENTIONS IN MY2025:

- Provider call center performance monitoring + issue resolution
- Provider engagement and education mechanisms
- Network/operations “provider-facing infrastructure” work

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Identify Utilization Management opportunities for providers to understand requirements/decision communication
- Further strengthen provider-facing Care Management & provider coordination workflows

E. 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 12: Behavioral Health Member Satisfaction Survey

Behavioral Health (BH) Member Satisfaction Measures	MY2024 (n=4)	MY2025 (n=2)	75% Goal Met (Y/N)	Recent Change
Rating of Helpfulness	100.0%	100.0%	Y	0%
Able to Get Needed Services	100.0%	100.0%	Y	0%
Time spent with Practitioner	100.0%	0.0%	N	100%
Able to See Non-Prescribing Provider within Suggested Timeframe for Follow-Up	33.3%	50.0%	N	16.7%
Able to See Prescribing within Suggested Timeframe for Follow-Up	0.0%	100.0%	Y	0%

Quantitatively, MY2025 results (n=2) met the 75% threshold for 3 of 5 measures shown: Rating of Helpfulness (100%), Able to Get Needed Services (100%), and Able to See Prescribing Provider within Suggested Timeframe for Follow-Up (100%). Two measures did not meet the threshold: Time spent with Practitioner (0%) and Able to See Non-Prescribing Provider within Suggested Timeframe for Follow-Up (50%). Year-over-year changes should be interpreted with caution due to exceedingly small sample sizes (MY2024 n=4; MY2025 n=2).

BARRIERS:

- Exceedingly small sample size (MY2024 n=4; MY2025 n=2) limits interpretability, trend stability, and generalizability; single responses can shift results significantly.



- Access and timeliness appear variable across follow-up needs: “Able to see non-prescribing provider within suggested timeframe” improved from 33.3% to 50.0% (+16.7 pts) but remained below the 75% threshold.
- Time spent with practitioner declined from 100.0% to 0.0% (-100.0 pts), indicating potential opportunity to assess visit length, visit expectations, and/or question interpretation in the BH survey process.

INTERVENTIONS IN MY2025:

- Embedded gap-closure prompts into member-facing workflows (Care Coordination + customer service reminder tools).
- Improved access to behavioral health services by enhancing transportation options to allow for same-day services.
- Decreased UTR by raising awareness of the HAP CareSource free phone program through our Pulsewrx vendor.

OPPORTUNITIES FOR IMPROVEMENT FOR MY2026:

- Increase BH survey response volume (targeted outreach to members with recent BH utilization, multiple contact modes, and extended fielding window) to enable reliable year-over-year trending and subgroup review.
- Maintain strengths where MY2025 met the 75% threshold: Rating of Helpfulness (100%), Able to Get Needed Services (100%), and prescribing follow-up within suggested timeframe (100% vs. 0% in MY2024).
- Prioritize improvement on measures not meeting the 75% threshold in MY2025: time spent with practitioner (0%) and non-prescribing follow-up timeliness (50%); monitor quarterly with larger n before concluding sustained change.

F. Network Adequacy



Standards and Goals

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
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

* Non-Rural = Urban and Suburban

Assuming average miles per hour of Urban: 25 mph; Suburban: 40 mph; Rural: 55 mph

Primary Care Practitioners

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	2025	0.9	1.8	100	Y
Family/General Practice	30 miles /30 minutes	2025	0.8	1.7	100	Y

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	2025	2.8	3.2	100	Y
Family / General Practice	40 miles /40 Minutes	2025	2.3	2.6	100	Y

In 2025, HAP CareSource MMP 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 MMP met the goal for driving distance and driving time in non-rural and rural zip codes in 2025. For non-rural zip codes, the driving distance and driving time was 0.9 miles and 1.8 minutes in 2025. In rural zip codes, the driving distance and driving time was 2.8 miles and 3.2 minutes in 2025.
- For Family Practice, HAP CareSource MMP met the goal for driving distance and driving time in non-rural and rural zip codes in 2025. For non-rural zip codes, the driving distance and driving time was 0.8 miles and 1.7 minutes in 2025. In rural zip codes, the driving distance and driving time



- was 2.3 miles and 2.6 minutes in 2025.
- HAP CareSource MMP did not measure Pediatric availability as the member population did not contain pediatric members.

Ratio

Specialty	Number of Practitioners	Number of Applicable Members	Standard	Reporting Year/ Trend	Ratio of Providers to Members	Meets Standard (Y/N)
Internal Medicine	1,705	3,350	1:500			
				2025	1:2	Y
Family/General Practice	1,708	3,350	1:500			
				2025	1:2	Y

For practitioner numbers in 2025, HAP CareSource met its established practitioner to member ratios for all primary care practitioner types.

- For Internal Medicine, HAP CareSource MMP had one practitioner for every 2 members in 2025.
- For Family/General Practice, the HAP CareSource MMP 2025 ratio of practitioner to members was one practitioner for every two members.
- HAP CareSource MMP did not measure Pediatric Provider/Member ratios as the member population did not contain pediatric members.

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.



Specialty Care Practitioners

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					
		2025	1.3	2.7	100	Y
Oncologists	40 miles/40 minutes					
		2025	2.5	5.4	100	Y

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					
		2025	3.0	3.5	100	Y
Oncologists	60 miles/60 minutes					
		2025	8.2	10.5	100	Y

HAP CareSource MMP 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.

HAP CareSource MMP 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 MMP met the goal for driving distance and driving time in non-rural and rural zip codes in 2025. For non-rural zip codes, the driving distance and driving time was 1.3 miles and 2.7 minutes in 2025. In rural zip codes, the driving distance and driving time was 3.0 miles and 3.5 minutes in 2025.
- For Oncology, HAP CareSource MMP met the goal for driving distance and driving time in non-rural and rural zip codes in 2025. For non-rural zip codes, the driving distance and driving time was 2.5 miles and 5.4 minutes in 2025. In rural zip codes, the driving distance and driving time was 8.2 miles and 10.5 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)
Obstetrics/Gynecology	1,096	1,899	1:4,000			
				2025	1:2	Y
Oncology	385	3,350	1:4,000			
				2025	1:9	Y

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

- The ratio for OB/GYN was one practitioner for every two members in 2025.
- For Oncology, HAP CareSource MMP showed one practitioner for every nine members in 2025.

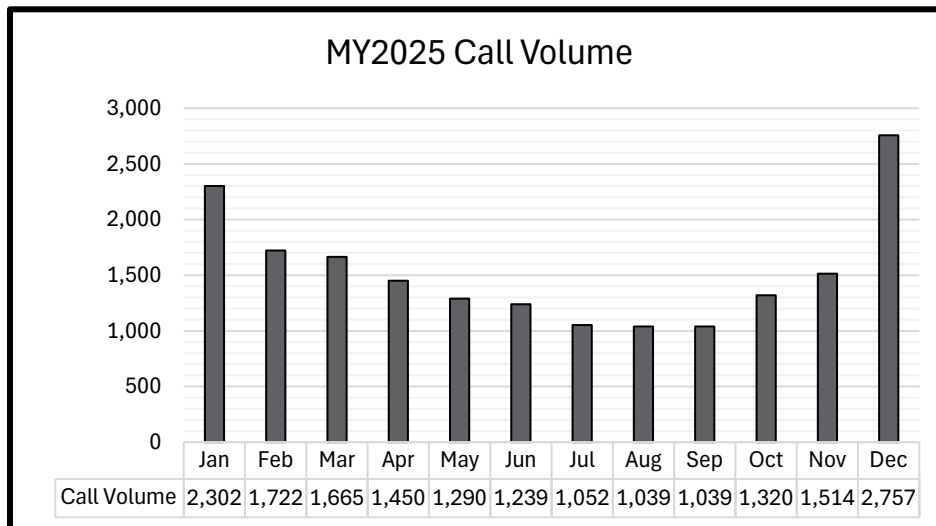
HAP CareSource met its established standards and goals for the geographic distribution and practitioner numbers for each identified high-volume and high-impact specialty type; therefore, no additional analysis was conducted.

G. 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.

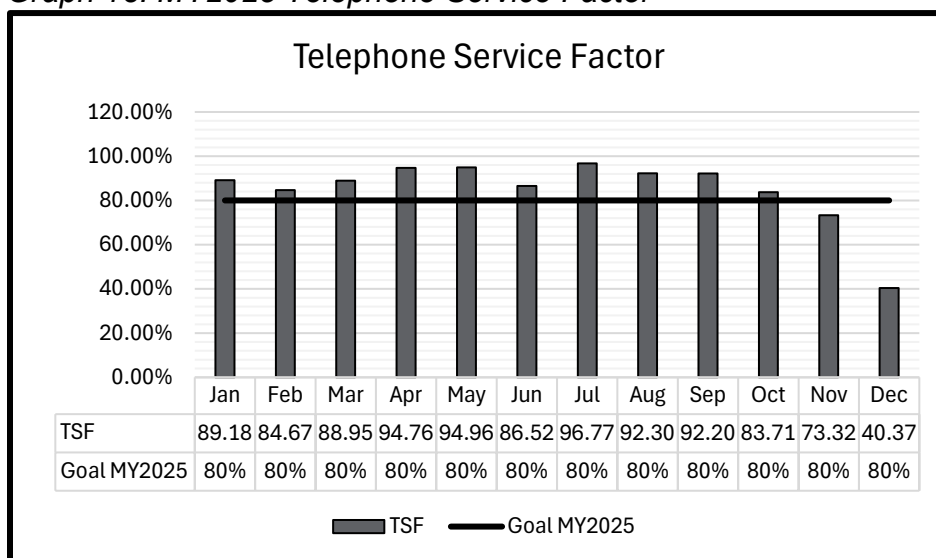
Graph 17: MY2025 call volume





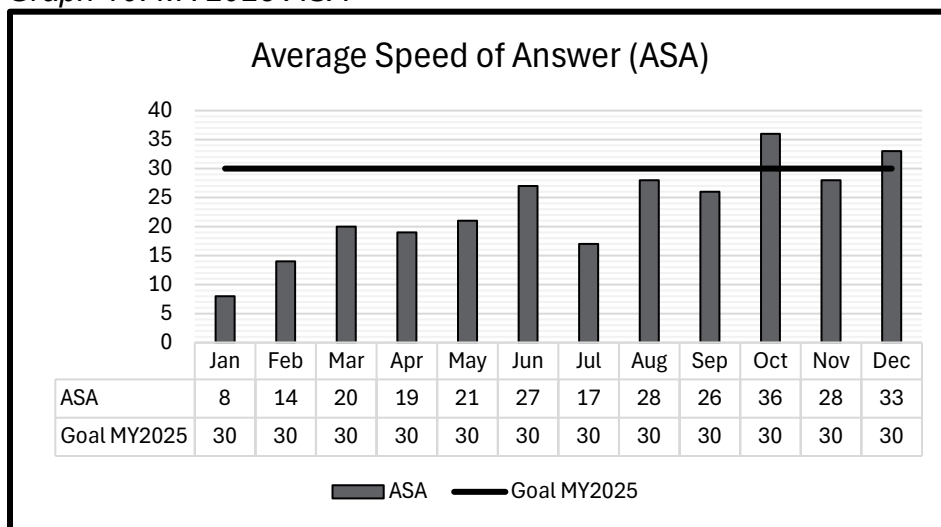
The plan's call volume is noted in Graph 17. Quantitatively, call volume fluctuated across MY2025 with a clear mid-year peak and lower volumes in the early and late months of the year. The highest monthly call volume occurred during the summer period (peak month), while the lowest volume occurred during the winter period (lowest month), indicating seasonal variability in member contact needs. Overall, the variability suggests opportunity to align staffing models and member communications to anticipated higher-volume months to maintain service levels and support timely issue resolution.

Graph 18: 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%. As shown in Graph 18, TSF performance varied across MY2025, with some months meeting or exceeding the 80% goal and other months falling below target. Periods of lower TSF align with higher operational demand and/or longer average speed of answer, indicating that staffing and call-routing capacity may not have been consistently matched to call volume. Overall, the pattern suggests opportunity to proactively align staffing, scheduling, and call-management strategies (e.g., forecasting, queue optimization, and targeted member communications during peak periods) to stabilize TSF at or above the 80% goal throughout the year.

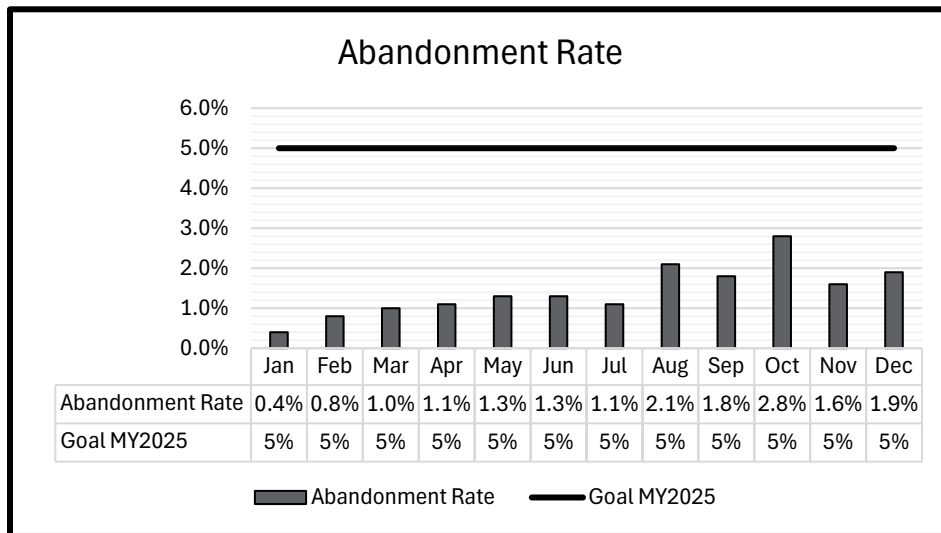
Graph 19: MY2025 ASA



The plan's ASA goal is <30 seconds. Graph 19 presents the plan's ASA performance during MY2025. Quantitatively, ASA fluctuated across MY2025, with periods where average speed of answer increased above the <30 second target (indicating longer waits) and other periods closer to or within goal. Months with elevated ASA are consistent with the periods of lower TSF performance and likely reflect higher demand and/or capacity constraints. Overall, the pattern suggests opportunity to strengthen call-forecasting and staffing alignment, optimize call routing/queue management, and deploy deflection and proactive communications during peak demand periods to consistently maintain ASA below 30 seconds.

Graph 20: MY2025 Abandonment Rate





Graph 20 presents the plan’s abandonment rate during MY2025. The plan’s goal for abandonment rate is <5%. As shown in Graph 20, abandonment rate fluctuated during MY2025, with periods where performance was at or below the <5% target and periods where the rate increased above goal (indicating a higher proportion of callers disconnecting before being served). Months with higher abandonment are directionally consistent with the months of higher ASA and lower TSF (Graphs 19 and 18), suggesting that longer wait times and capacity constraints contributed to call abandonment. Overall, the pattern indicates opportunity to improve abandonment performance by strengthening call forecasting and staffing alignment, optimizing queue and call-routing practices, and deploying targeted communications or call-deflection strategies during high-volume periods to maintain abandonment below 5%.

H. Other processes and outcome measures

Oral Health

Our HAP CareSource Oral Health Program is designed to improve access to, utilization of, and outcomes related to dental services for Michigan MI Health Link 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 16 audits on all its delegates and vendors. The plan identified four performance deficiencies with zero vendors/delegates requiring a CAP.



Table 12: Delegates and Vendors

Vendor Name	Product Line(s)	# Regulatory Deficiencies	Type of Audit
Area Agency of Aging 1-B (AgeWays)	MI Health Link	0	Closing Audit
Braille Works	MI Health Link	0	Annual Attestation of Compliance/RAM
Delta Dental	MI Health Link	6	Annual Audit
Detroit Area Agency on Aging 1-A (AAA 1A)	MI Health Link	0	Closing Audit
Detroit Wayne Integrated Health Network	MI Health Link	0	Annual Audit
ESI	MI Health Link	6	Annual Audit
EyeMed	MI Health Link	0	Annual Audit
GT Independence	MI Health Link	0	Annual Audit
Joint Venture Hospital Laboratories (JVHL)	MI Health Link	0	Annual Audit
MTM	MI Health Link	0	Annual Audit
NationsBenefit/ NationsHearing	MI Health Link	0	Annual Audit
NationsBenefit/NationsOTC	MI Health Link	0	Annual Audit
O'Neil	MI Health Link	0	Annual Audit
Strategic Operations Solutions	MI Health Link	0	Annual Audit
The Senior Alliance (Area Agency on Aging – 1C)	MI Health Link	0	Closing Audit
United Direct Solutions	MI Health Link	0	Annual Audit



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

Overall, MI Health Link 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:

- Michigan MI Health Link is projected to have met at least nine out of twelve measures for Measurement Year 2025, demonstrating strong progress toward CMS/MDHHS priority requirements (final quality withhold determination pending).
- Member experience (CAHPS®): MY2025 CAHPS performance met the established goal for 7 of 11 reported measures/composites, with notable strengths in Getting Needed Care and Getting Care Quickly.
- Population growth: MI Health Link served 4,236 members in CY2025, representing a 10% year-over-year increase compared to CY2024.
- Clinical improvement and care coordination: The plan demonstrated measurable improvement in key initiatives, including narrowing the CBP disparity gap (Black/African American vs. White/Caucasian) by MY2024 remeasurement, improved EED year-over-year in MY2025, and increased HRA completion (23.2% to 49% in MY2025), supported by targeted outreach and care coordination interventions.

BARRIERS:

- Member outreach challenges including high unable-to-reach (UTR) rates and inaccurate/unstable contact information reduced the effectiveness of care coordination, gap-closure outreach, and follow-up activities.
- Access barriers (e.g., difficulty securing timely appointments, transportation barriers, and related no-show risk) continued to impact member utilization and successful completion of preventive and chronic care services.



- Staffing opportunities in key operational areas (e.g., care coordination/outreach) and contributed to slower progress on certain initiatives requiring high-touch member engagement.
- Delayed clinical measure data availability impacting real-time improvement opportunities and slowed intervention targeting and evaluation.

OPPORTUNITIES FOR IMPROVEMENT:

- Strengthen member outreach effectiveness by improving contact data quality, continue multi-channel outreach (phone, text, mail), and monitoring unable-to-reach (UTR) trends to increase engagement in care coordination and gap-closure activities.
- Reduce access barriers by partnering with network and community resources to improve timely appointment availability and by optimizing transportation support (education, scheduling assistance) to decrease no-show risk and improve service completion.
- Optimize care coordination high-impact workflows (e.g., transitions of care, HRA completion, chronic condition outreach) by ensuring consistent tools/training so high-touch initiatives can be executed reliably.
- Improve timeliness and completeness of performance data by expanding supplemental clinical data capture and enhancing reporting cadence to support faster intervention targeting; continue strengthening committee documentation to clearly track decisions, member feedback, and follow-up actions.

RESOURCES/STAFFING:

- During MY2025, MI Health Link maintained a multidisciplinary QI infrastructure with defined market and enterprise roles supporting clinical quality, population health, member experience, data/analytics, utilization management, care management, and accreditation readiness. Core market resources included the Market Medical Director (chairing key market committees), dedicated Physical Health and Behavioral Health Medical Directors, and market quality leadership and staff responsible for implementation and monitoring of the QI Work Plan and Program Evaluation. Enterprise resources (e.g., Quality and Performance Outcomes, HEDIS Operations & Analytics, Consumer Experience, Utilization Management, and Care Management leadership) provided additional subject matter expertise, standardized tools, reporting, and oversight.



- QI governance and oversight were supported through an established committee structure that met prescribed frequencies in MY2025 (e.g., QIC, PAC, MAC, QEC, P&TC, and CPGC), enabling regular review of performance, interventions, and required reporting.
- Resources supported execution of multiple concurrent priorities (e.g., quality withhold measures, HEDIS®/CAHPS®, PIPs, member safety, network adequacy, and delegation oversight) through cross-functional collaboration among Quality Improvement, Population Health, Care Management, Network, UM, and Consumer Experience teams.
- Staffing capacity within high-touch operational functions (notably care coordination/outreach) required ongoing focus on caseload optimization, workflow standardization, and support resources.
- Timeliness of clinical measure data and availability of supplemental/provider data reinforced the need for continued investment in data infrastructure and operational reporting cadence to impact the ability for rapid cycle testing.

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.) Improve BP control for Black/African American members while maintaining White/Caucasian performance and reduce disparity. 2.) Increase diabetic eye exams by 5% from baseline and assess disparity. 3.) Increase HRA completion from 23.2% to 85% by 09/30/2025.
Improve enrollee and provider experience with healthcare services	
Member experience improvement (CAHPS®)	Achieve a 4-STAR rating for specified CAHPS® composites/measures (e.g., GNC, GCQ, CS, CC, etc.).
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).



Customer Care operational access metrics	Monitor and manage member services accessibility (e.g., TSF goal 80%, ASA <30 sec, abandonment <5%) and respond to trends.
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 MI Health Link 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.
Strengthen care coordination and transitions of care to reduce avoidable utilization and improve outcomes	Increase successful post-discharge care transition activities (e.g., medication reconciliation and timely follow-up) to improve transitions-of-care performance and reduce readmission risk.
Maintain a robust population health strategy.	



Maintain and strengthen a data-driven Population Health Management (PHM) strategy aligned to the MI Health Link 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 MI Health Link 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 – Michigan Market
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



