Name of Project:
Racial or Ethnic Disparities between the black/African American Medicaid recipients and the white Medicaid recipients having received PIHP managed services.

Summary of Project:

The Performance Improvement Project (PIP) was chosen by the PIHP based on the needs of the population served, previous measurement and analysis of process, satisfaction, and/or outcome trends that may have an impact on the quality of service provided.

Mid-State Health Network (MSHN) conducted a review of data to identify existing racial or ethnic disparities. After reviewing the numbers, it was determined that the Non-clinical Performance Improvement Project will address access to services for the largest historically marginalized group, Black/African American, within the MSHN region. The identification of barriers for access to services for this group will result in action, ensuring all Black/African American individuals served have the same opportunities to be healthy both mentally and physically. The MSHN Quality Improvement Council, through consensus, recommended this topic to Operations Council for approval. Operations Council supported the PIP topic for 2022-2025.

Is this project optional or required? If required by whom?
The study topic is one of two required PIPs for MSHN. The topic itself is not required.

Aim Statement
Do the targeted interventions reduce or eliminate the racial or ethnic disparities in the penetration rate between the black/African American penetration rate and the index (white) penetration rate of those who are eligible for Medicaid services?

Population definition: Medicaid eligible individuals in the 834-enrollment file within the Midstate Health Network region. The African American/ Black and the white race and ethnicity will be obtained through the race/ethnicity field included in the 834 file.

Enrollment requirements (if applicable): Individuals who are eligible for Medicaid services. All Medicaid enrollees included in the Medicaid enrollment file provided to MSHN by MDHHS monthly will be included in this project. The length of enrollment is a minimum of one month during the measurement period. This is not continuous enrollment. Services received have occurred during the time period in which the individual was enrolled in Medicaid.

Member age criteria (if applicable): Includes all members, adult and child.

Inclusion, exclusion, and diagnosis criteria:

Inclusion: Service encounters submitted by the Community Mental Health Specialty Programs (CMHSP), including those CMHSP participants who are a Certified Community Behavioral Health Clinic (CCBHC). Substance use services provided through a CCBHC, with an encounter submitted by the CMHSP will be included.

Exclusion: The data for those who are receiving substance use services from a substance use only provider are not currently available for aggregation and analysis. Therefore, will be excluded from the numerator for this project. SUD services are defined as those services delivered by the PIHP through a subcontractor licensed to operate as a substance use treatment and or rehabilitation program in accordance with the provisions of Act 368 of the Public Act of 1978 and the Administrative rules (R 325.14101-R 325.14928) of Michigan Department of Licensing and Regulatory Affairs**.**

Diagnosis/procedure/pharmacy/billing codes used to identify the eligible population (if applicable): There are currently no excluded codes for this project submitted by the CMHSP participants.

Goal: The goal of the indicator is to reduce or eliminate racial or ethnic disparities between the African American/Black minority penetration rate and the index (white) penetration rate.

Indicator 1:

Numerator: The number of unique Medicaid eligible individuals who are black/African American and have received a PIHP managed service.

Indicator 2:

Numerator: The number of unique Medicaid eligible individuals who are white and have received a PIHP managed service.

Denominator:

The number of unique Medicaid eligible individuals within the Mid State Health Network region.

Data Collection Process:

The PIP will utilize administrative data for the analysis. The data source will be a programmed pull form claims/encounters and the 834 eligibility files. The report used is a standard report within REMI. Estimated percentage of reported administrative data completeness at the time the data are generated is 95% complete.

Description of the process used to calculate the reported administrative data completeness percentage. Include a narrative of how claims lag may have impacted the data reported:

Claims and encounters are submitted to MDHHS from all types of providers. MDHHS will not accept claims/encounters into the warehouse without meeting the minimum standards for submission. Providers are required to submit Medicaid encounters to MDHHS within 30 days after the service was provided. Transactions will not be accepted if they do not meet

completeness requirements. Typically, over 95% of the transactions are submitted within the 30 days after service datetime frames. Completeness is estimated by looking at expected levels of service and BH TEDS data based on historical counts of services provided, received and processed through REMI. Completeness is defined as those Medicaid encounters that have been submitted to MDHHS successfully and matched with monthly reconciliation reports.

Step 1: MSHN, through REMI (Managed Care Information System) receives automated downloads of the Medicaid eligibility files (834) from the FTS.
Step 2: CMHSP collect, enter, and validate encounter data in their data systems and submit (no less than monthly) to MSHN through REMI.
Step 3: MSHN combines, validates, and submits files to MDHHS (weekly)
Step 4: MSHN retrieves MDHHS response files from the FTS and loads into REMI (Managed Care Information System) to update the status of each encounter/claim.
Step 5: The eligible population (denominator) will be the unique number of enrollees in the MDHHS Medicaid eligibility file (834).
Step 6: The eligible population (numerator) will be the unique number of enrollees in the service table where the Medicaid ID matches the Medicaid eligible enrollees in the denominator.

To ensure the completeness and accuracy of the data in determining the study indicator rate, the PIHP will take into account the time lag allowed for the submission of claims for the CMHSP consumers. The data utilized to determine the study indicator rate will be retrieved foranalysis 60 days after the end of the measurement period.

Indicator Results:
Baseline Narrative: CY21 (1/01/2021 to 12/31/2021)

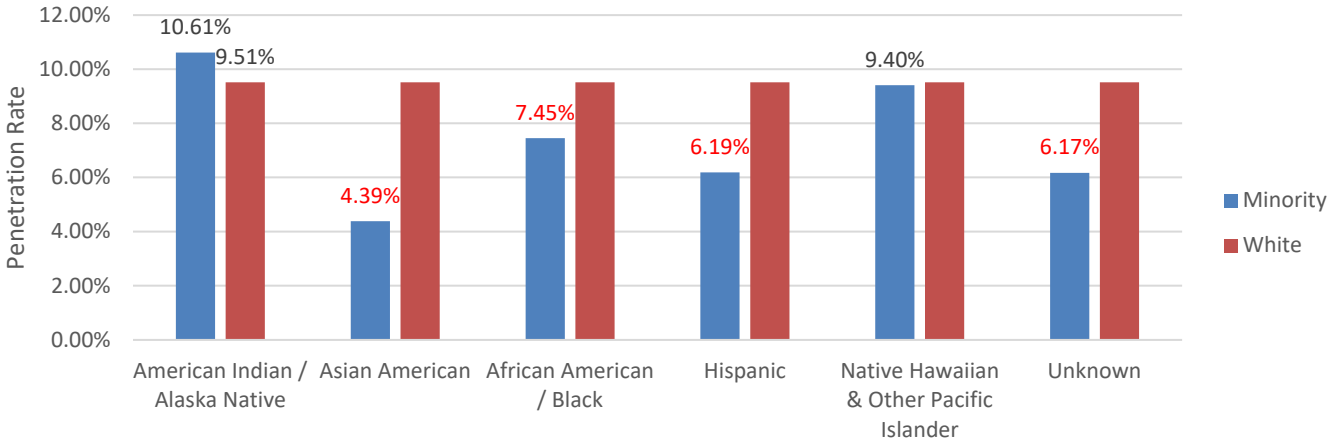
Race/Ethnicity	Denominator	Rate	Margin of Error	95% CI Lower	95% CI Upper	Chi-Square Statistic (p-value)
American Indian/Alaskan Native	7,078	10.61%	0.72%	9.89%	11.33%	9.8282 (p=0.0017)
Asian American	3,147	4.39%	0.72%	3.67%	5.10%	95.5179 (p<0.0001)
African American / Black	70,267	7.45%	0.19%	7.26%	7.65%	299.4162 (p<0.0001)
Hispanic	29,710	6.19%	0.27%	5.91%	6.46%	360.8898 (p<0.0001)
Native Hawaiian & Other Pacific Islander	553	9.40%	2.43%	6.97%	11.84%	0.0068 (p=0.9343)
Unknown	40,486	6.17%	0.23%	5.93%	6.40%	488.3443 (p<0.0001)
White (Index)	373,783	9.51%	0.09%	9.41%	9.60%	Reference

Baseline data was obtained for CY2021. The data was drawn from a reporting process currently being developed in REMI, the MSHN Managed Care Information System. The individuals were broken down by race/ethnicity into the following categories: African American / Black, American Indian / Alaskan Native, Asian American, Hispanic, Native Hawaiian & Other Pacific Islander, Unknown, and White. A numerator and denominator (see Step 5) were obtained for each racial/ethnic group, and the rate was calculated by dividing the numerator by the

denominator. Using a 95% confidence interval and a calculated margin of error, the upper and lower control limits were calculated. The upper and lower control limits were used to identify if a minority group penetration rate was significantly higher or lower than the white penetration rate. If the upper control limit of the minority group was lower than the lower control limit of the white group, the result was that the minority rate was significantly lower than the white rate. If the lower control limit of the minority group was higher than the upper control limit of the index group, the result was that the minority rate was significantly higher than the white rate. The focus of the improvement efforts will be on the minority group that demonstrates a rate that is significantly lower than the white group and where interventions will impact the largest number of individuals.

A chi-square test was performed to determine which minority groups had statistically significant lower penetration rates than the index (white) group and to calculate p values for each relationship. There were four groups that had significantly lower penetration rates ($p < 0.0001$) than the white group rate of 9.51% (95% CI: 9.41, 9.60) (Table 1). The African American / Black penetration rate was 7.45% (95% CI: 7.26, 7.65); the Hispanic rate was 6.19% (95% CI: 5.91, 6.46); the Asian American rate was 4.39% (95% CI: 3.67, 5.10); and the "Unknown" rate was 6.17% (95% CI: 5.93, 6.40). The other minority group rates were either significantly higher than the white rate (American Indian / Alaskan Native) or not statistically significant (Native Hawaiian & Other Pacific Islander). Figure 1 visually demonstrates the penetration rate comparison between the minority and white groups. Significantly lower penetration rates are highlighted in red.

Figure 1: Penetration Rate by Race/Ethnicity Compared to White Penetration Rate



There may be factors affecting the validity of the baseline and remeasurement findings. Primarily, there could be some people who were unsure about their race/ethnicity and as a result, marked the wrong category. Additionally, there could be people who didn't understand the question and chose the wrong category as a result. It is likely, however, that these were not factors for most individuals and will not greatly impact the results. The data calculated for this baseline measurement period will be compared to data collected in the remeasurement period

in CY2023 in order to determine if the intervention strategies were a success. No other factors that might threaten the comparability of the measurement periods were identified.

Baseline CY21 (1/01/2021 to 12/31/2021)
Gap Year CY22 (1/01/2022 to 12/31/2022) Identify causal factors and interventions
Gap Year CY22 (1/01/2022 to 6/30/2022) Monitoring
Gap Year CY22 (1/1/2022 to 12/31/2022) Monitoring
Remeasurement Period One- (1/01/2023 to 12/31/2023)
Remeasurement Period Two- (1/01/2024 to 12/31/2024)