COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

BOARD MEETING

Patrick Barrie Room

3005 Boardwalk Dr., Ste. 200, Ann Arbor, MI

Wednesday, December 13, 2023, 6:00 PM

To join by telephone:	**To join by computer:**
1-616-272-5542	**Click here to join the meeting**
Meeting ID: 921554805#	Meeting ID: 215 700 449 069, Passcode: U8jauV

Agenda

		Guide
I.	Call to Order	1 min
II.	Roll Call	2 min
III.	Consideration to Adopt the Agenda as Presented	2 min
IV.	Consideration to Approve the Minutes of the 10-11-2023 Meeting and Waive the Reading Thereof {Att. #1}	2 min
V.	Consideration to Approve the Minutes of the 10-25-2023 Meeting and Waive the Reading Thereof {Att. #2}	2 min
VI.	Audience Participation (3 minutes per participant)	
VII.	Old Business a. Board Information: Finance Report through October 31, 2023 {Att. #3}	15 min
VIII.	New Business a. Contracts {Att. #4} b. FY2024 Quality Assessment and Performance Improvement (QAPIP) Plan {Att. #5}	20 min
IX.	Reports to the CMHPSM Board a. Board Information: SUD Oversight Policy Board – No Update b. Board Information: CEO Report to the Board {Att. #6}	15 min
X.	Closed Session a. Consultation with CMHPSM Attorney on Lawsuit {Att. #7}	
XI.	Adjournment	

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN
REGULAR BOARD MEETING MINUTES
October 11, 2023

Members Present for In-Person Quorum:	Judy Ackley, Patrick Bridge, Rebecca Curley, LaMar Frederick, Bob King, Molly Welch Marahar, Rebecca Pasko, Mary Serio, Holly Terrill
Members Not Present For In-Person Quorum:	Mary Pizzimenti, Alfreda Rooks, Annie Somerville (remote), Ralph Tillotson
Staff Present:	Kathryn Szewczuk, Stephannie Weary, James Colaianne, Matt Berg, Nicole Adelman, Connie Conklin, Stacy Pijanowski, CJ Witherow, Lisa Graham, Nicole Phelps, Michelle Sucharski
Guests Present:	

I. Call to Order
Meeting called to order at 6:02 p.m. by Board Chair B. King.

II. Roll Call
- Quorum confirmed.

III. Consideration to Adopt the Agenda as Presented
Motion by M. Welch Marahar, supported by H. Terrill, to approve the agenda
Motion carried

IV. Consideration to Approve the Minutes of the 9-13-2023 Meeting and Waive the Reading Thereof
Motion by M. Welch Marahar, supported by M. Serio, to approve the minutes of the 9-13-2023 meeting and waive the reading thereof
Motion carried

V. Audience Participation
None

VI. Old Business
a. Board Information: FY2023 Finance Report through July 30, 2023
M. Berg presented.

VII. New Business
a. Board Action: Cost of Living Increase Proposal
Motion by J. Ackley, supported by M. Serio, to adjust the previously approved cost of living increase from 3% to the new rate of 6% for FY24
Motion carried
b. Board Information: FY2021-23 Strategic Plan Metrics Review
- J. Colaianne shared the final metrics for the FY2021-2023 Strategic Plan.
- 10 out of 11 goals were completed.

c. Board Action: FY2024-26 Strategic Plan and FY2024 Plan Metrics

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Motion by M. Welch Marahar, supported by J. Ackley, to accept the FY2024-26 Strategic Plan metrics
Motion carried

d. Board Action: Election Chair/Committee for Officers Election
Motion by M. Welch Marahar, supported by R. Curley, to reappoint the current slate of officers for another term for FY24
Motion carried
- FY2024 Slate of Regional Board officers:
    - ❖ Chair: B. King
    - ❖ Vice-Chair: J. Ackley
    - ❖ Secretary: R. Pasko

VIII. Reports to the CMHPSM Board

a. Board Information: SUD Oversight Policy Board – No update

b. Board Information: CEO Report to the Board
- J. Colaianne's written report includes updates from staff, regional and state levels. Please see the report in the board packet for details.

c. Board Information: FY18-19 Deficit Repayment Update
- J. Colaianne shared a recent communication from the state regarding the deficit. A response is requested within 10 days, which is Friday, 10/13/2023.
- J. Colaianne will send updates to the board as progress happens.

IX. Adjournment

Motion by M. Welch Marahar, supported by P. Bridge, to adjourn the meeting
Motion carried

- The meeting was adjourned at 7:01 p.m.

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Rebecca Pasko, CMHPSM Board Secretary

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COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN
SPECIAL BOARD MEETING MINUTES
October 25, 2023

Members Present for In-Person Quorum:	Judy Ackley, LaMar Frederick, Bob King, Mary Pizzimenti, Mary Serio, Annie Somerville, Holly Terrill
Members Not Present For In-Person Quorum:	Patrick Bridge, Rebecca Curley, Molly Welch Marahar, Rebecca Pasko, Alfreda Rooks, Ralph Tillotson
Staff Present:	Kathryn Szewczuk, Stephannie Weary, James Colaianne, Matt Berg, Nicole Adelman, Connie Conklin, CJ Witherow, Lisa Graham, Nicole Phelps
Guests Present:	

I. Call to Order
Meeting called to order at 6:00 p.m. by Vice-Chair J. Ackley.

II. Roll Call
- Quorum confirmed.

III. Consideration to Adopt the Agenda as Presented
Motion by M. Serio, supported by M. Pizzimenti, to approve the agenda
Motion carried

IV. Audience Participation
- None

V. Old Business
- None

VI. New Business
a. Board Action: FY2018-2019 Deficit Resolution
Motion by J. Ackley, supported by M. Serio, to approve the CMHPSM's participation in the MDHHS proposed one-time exception plan sent to the CMHPSM on September 29, 2023
Motion carried
<u>Roll Call Vote</u>
Yes: Ackley, Frederick, King, Pizzimenti, Serio, Sommerville, Terrill
No:
Absent: Bridge, Curley, Welch Marahar, Pasko, Rooks, Tillotson

VII. Reports to the CMHPSM Board
- None

VIII. Adjournment
Motion by H. Terrill, supported by M. Serio, to adjourn the meeting
Motion carried

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- The meeting adjourned at 6:34 p.m.

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Rebecca Pasko, CMHPSM Board Secretary

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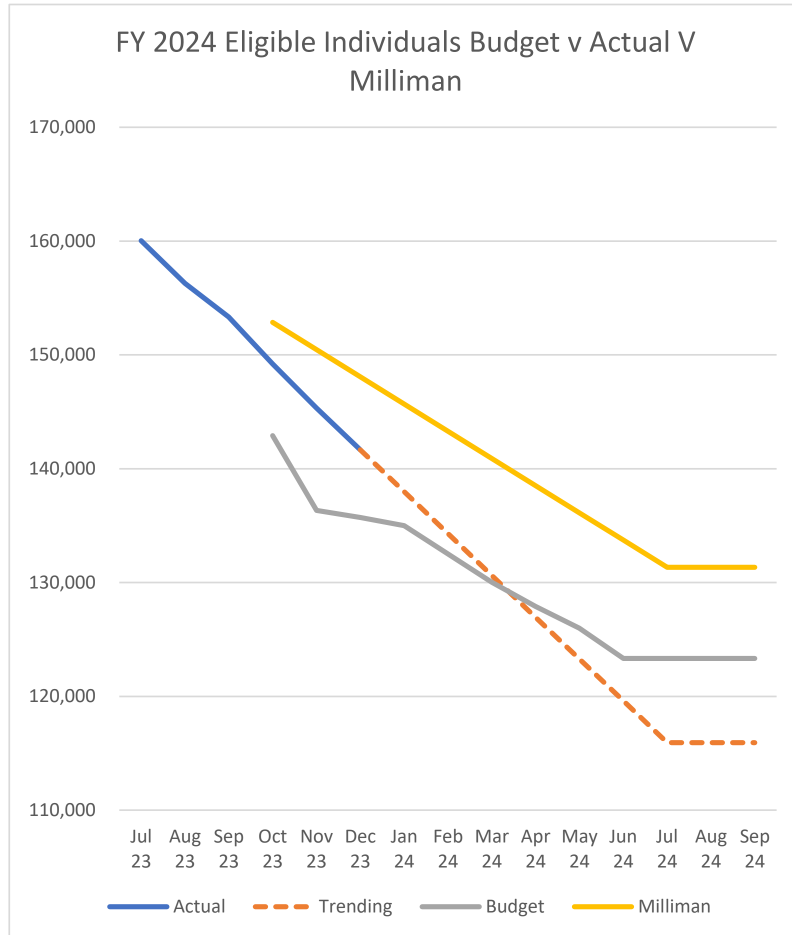
Community Mental Health Partnership of Southeast Michigan
Financial Summary for October 31, 2023



Operating Activities	Budget R1 FY 2022	YTD Budget	YTD Actual	Actual to Budget	Percent Variance	Projected Year-End	Projected to Budget
MH Medicaid Revenue	249,119,741	19,830,800	20,261,708	430,908	2.2%	249,119,741	-
MH Medicaid Expenses	241,381,989	19,458,415	19,457,250	1,165	0.0%	241,381,989	-
MH Medicaid Net	7,737,752	372,385	804,458	432,073	116.0%	7,737,752	-
SUD/Grants Revenue	26,356,613	2,164,851	1,837,981	(326,870)	-15.1%	26,356,613	-
SUD/Grants Expenses	27,374,809	2,229,747	1,639,098	590,649	26.5%	27,374,809	-
SUD/Grants Net	(1,018,196)	(64,896)	198,883	263,779	406.5%	(1,018,196)	-
PIHP							
PIHP Revenue	2,090,000	174,167	363,851	189,684	108.9%	2,090,000	-
PIHP Expenses	3,260,292	191,470	345,216	153,746	-80.3%	3,260,292	-
PIHP Total	(1,170,292)	(17,303)	18,635	35,939	207.7%	(1,170,292)	-
Total Revenue	**277,566,354**	**22,169,817**	**22,463,540**	**293,723**	**1.3%**	**277,566,354**	**-**
Total Expenses	**272,017,090**	**21,879,632**	**21,441,564**	**438,068**	**2.0%**	**272,017,090**	**-**
Total Net	**5,549,264**	**290,186**	**1,021,976**	**731,791**	**252.2%**	**5,549,264**	**-**

Community Mental Health Partnership of Southeast Michigan
Preliminary Statement of Revenue and Expenses Notes
Period Ending October 31, 2023

SUMMARY PAGE

1. The following chart compares the liquid assets of CMHPSM at the start of FY 2024 and at the end of the reporting period, October 31, 2023. Cash went down in October due to missed payments from MDHHS and from paying out September 2023 grants that will not get reimbursed until December or January.

Asset Type	Description	September 2023	October 2023
Cash	Operations	4,225,892	17,403,397
	ISF		
	PA2 Reserve		
	Total Cash	4,225,892	17,403,397
Investments	CD		
	Money Market	12,549,074	12,549,074
	US Treasuries	20,465,890	5,684,101
	Total Investments	33,014,964	18,233,175
Total Liquid Assets		37,240,856	35,636,571

2. The cash balance reflect the first payment of $4,523,448 made on October 30th to the CMHs, but not the second payment of $10,362,345 made on November 1st.

3. Eligible Medicaid payments fell to 145,332 at the end of September.

Medicaid Mental Health

1. Current Medicaid Revenue and Expenses are within 5% of budget.
2. CCBHC payments to the CMHs were less than expected due to a funding misallocation from MDHHS. This misallocation was corrected in November. As of the end of November CCBHC payments were ahead of budget.

Medicaid and Grant SUD

1. SUD revenue is lower than budget. Grant revenues and expenses are typically slow in October. Also, MDHHS missed the October Opioid Health Home payments.
2. SUD expenses were lower than budget in October mostly due to grant activity being slower at the start of the year.

PIHP Administration

1. PIHP Administrative Revenue and Expenses are higher than budget due to late notice from MDHHS that Local Match would be included in FY 2024. Both Washtenaw and Monroe have opted out of making Local Match payments in FY 2024.

FY 2018 & FY 2019 DEFICIT UPDATE

The following charts were copied from the FY 22 Financial Audit presented to the Board in May of 2023.

Note 7 Shows the total amount due to the PIHP from MDHHS as of 9/20/22. This amount includes $10,997,115 due to the PIHP for Fiscal Year 2018 & 2019.

Note 10 shows the total amount due from the PIHP to the CMHs. This amount includes the $10,997,115 due from MDHHS.

Note 6 shows the amount of Funds held by the CMHs for Fiscal Year 2020, 2021 and 2022. These amounts will be cost settled when FY 2018 & 2019 are cost settled with the state.

NOTE 7 - DUE FROM MDHHS

Due from MDHHS as of September 30th consists of the following:

Description	Amount
Due from MDHHS - PBIP/Withhold	2,053,505
Due from MDHHS - FY18 State Shared Risk	7,517,412
Due from MDHHS - FY19 State Shared Risk	3,479,703
Due from MDHHS - HRA 4th Quarter	1,273,262
Grants Receivable	1,570,606
Totals	15,894,488

NOTE 10 - DUE TO AFFILIATE PARTNERS

Due to Affiliate Partners as of September 30th consists of the following:

Description	Amount
Community Mental Health Services of Livingston County	3,164,312
Monroe Community Mental Health Authority	6,847,718
Washtenaw County Community Mental Health	14,092,245
Total	24,104,275

NOTE 6 - DUE FROM AFFILIATE PARTNERS

Due from other affiliate partners as of September 30th consists of the following:

Description	Amount
Lenawee Community Mental Health Authority	6,974,176
Community Mental Health Services of Livingston County	7,572,498
Monroe Community Mental Health Authority	688,490
Washtenaw County Community Mental Health	8,938,263
Totals	24,173,427

Community Mental Health Partnership of Southeast Michigan
Preliminary Statement of Revenues and Expenditures
For the Period Ending October 31, 2023

	Budget FY 2024	YTD Budget	YTD Actual	Actual to Budget	Percent Variance	Projected Year-End	Projected O(U) Budget
MEDICAID							
MEDICAID REVENUE							
Medicaid/Medicaid CCBHC	122,225,746	10,682,530	11,105,641	423,111	4.0%	122,225,746	-
Medicaid Waivers	60,344,963	5,028,747	5,157,854	129,107	2.6%	60,344,963	-
HMP/HMP CCBHC	16,159,382	1,560,996	1,351,269	(209,727)	-13.4%	16,159,382	-
Medicaid Autism	14,603,811	1,276,373	1,516,715	240,342	18.8%	14,603,811	-
Prior Year Carry Forward	15,000,000			-		15,000,000	-
Behavioral Health Home	739,375	61,615	107,242	45,627	74.1%	739,375	-
CCBHC	14,646,464	1,220,539	1,022,987	(197,552)	-16.2%	14,646,464	-
HRA MCAID Revenue	2,700,000			-		2,700,000	-
HRA HMP Revenue	2,700,000			-		2,700,000	-
Medicaid Revenue	**249,119,741**	**19,830,800**	**20,261,708**	**430,908**	**2.2%**	**249,119,741**	**-**
MEDICAID EXPENDITURES							
IPA MCAID	2,208,102			-		2,208,102	-
IPA HMP	272,912			-		272,912	-
HRA MC	2,700,000			-		2,700,000	-
HRA HMP	2,700,000			-		2,700,000	-
Lenawee CMH						-	-
Medicaid (b) & 1115i	17,843,611	1,486,968	1,486,968	(0)	0.0%	17,843,611	-
Medicaid Waivers	6,606,953	550,579	589,216	(38,637)	-7.0%	6,606,953	-
Healthy Michigan Expense	2,537,816	211,485	211,485	0	0.0%	2,537,816	-
Autism Medicaid	1,096,819	91,402	91,402	0	0.0%	1,096,819	-
Behavioral Health Homes	50,000	4,167	4,992	(825)	-19.8%	50,000	-
DHIP		-		-		-	-
Lenawee CMH Total	**28,135,199**	**2,344,600**	**2,384,062**	**(39,462)**	**-1.7%**	**28,135,199**	**-**
Livingston CMH							-
Medicaid (b) & 1115i	25,958,028	2,163,169	2,163,169	0	0.0%	25,958,028	-
Medicaid Waivers	9,563,961	796,997	798,193	(1,196)	-0.2%	9,563,961	-
Healthy Michigan Expense	2,467,711	205,643	205,643	-	0.0%	2,467,711	-
Autism Medicaid	5,309,239	442,437	442,437	0	0.0%	5,309,239	-
Behavioral Health Homes	55,000	4,583	7,175	(2,592)	-56.6%	55,000	
DHIP		-		-		-	-
Livingston CMH Total	**43,353,939**	**3,612,828**	**3,616,617**	**(3,788)**	**-0.1%**	**43,353,939**	**-**
Monroe CMH							-
Medicaid	22,014,214	1,834,518	1,834,518	(0)	0.0%	22,014,214	-
Medicaid Waivers	11,035,801	919,650	1,000,955	(81,305)	-8.8%	11,035,801	-
Healthy Michigan	2,860,301	238,358	238,358	0	0.0%	2,860,301	-
Autism Medicaid	2,066,470	172,206	172,206	0	0.0%	2,066,470	-
CCBHC	12,000,000	1,000,000	883,154		0.0%	12,000,000	
Behavioral Health Homes	96,500	8,042	32,757	(24,716)	-307.3%	96,500	
DHIP		-		-			-
Monroe CMH Total	**50,073,286**	**4,172,774**	**4,161,949**	**10,825**	**0.3%**	**50,073,286**	**-**
							-
Washtenaw CMH							-
Medicaid	49,619,192	4,134,933	4,134,933	(0)	0.0%	49,619,192	-
Medicaid Waivers	31,350,706	2,612,559	2,688,511	(75,952)	-2.9%	31,350,706	-
Healthy Michigan Expense	6,155,256	512,938	512,938	0	0.0%	6,155,256	-
Autism Medicaid	7,423,397	618,616	618,616	(0)	0.0%	7,423,397	-
CCBHC	17,000,000	1,416,667	1,298,756	117,910	8.3%	17,000,000	-
Behavioral Health Homes	390,000	32,500	40,869	(8,369)	-25.8%	390,000	-
DHIP		-		-			-
Washtenaw CMH Total	**111,938,551**	**9,328,213**	**9,294,623**	**33,589**	**0.4%**	**111,938,551**	**-**
Medicaid Expenditures	**241,381,989**	**19,458,415**	**19,457,250**	**1,165**	**0.0%**	**241,381,989**	**-**
Medicaid Total	**7,737,752**	**372,385**	**804,458**	**432,073**	**116.0%**	**7,737,752**	**-**

Community Mental Health Partnership of Southeast Michigan
Preliminary Statement of Revenues and Expenditures
For the Period Ending October 31, 2023

	Budget FY 2024	YTD Budget	YTD Actual	Actual to Budget	Percent Variance	Projected Year-End	Projected O(U) Budget
SUD/GRANTS							
SUD/GRANTS REVENUE							
Healthy Michigan Plan SUD	8,101,577	782,612	820,498	37,886	4.8%	8,101,577	-
Medicaid SUD	3,213,686	280,876	365,492	84,616	30.1%	3,213,686	-
PA2 - Tax Revenue (Est)	1,825,000			0		1,825,000	-
PA2 - Use of Reserve (Est)	1,088,518	90,710	97,561	6,851	7.0%	1,088,518	-
Federal/State Grants	11,277,832	939,819	589,784	(350,035)	-37.2%	11,277,832	-
Opioid Health Homes	850,000	70,833	(35,355)	(106,188)	300.4%	850,000	
SUD/Grants REVENUE	**26,356,613**	**2,164,851**	**1,837,981**	**(326,870)**	**-15.1%**	**26,356,613**	**-**
				0			
SUD/GRANTS EXPENDITURES				0			
SUD Administration							
Salaries & Fringes	1,235,683	51,487	47,902	(3,585)	7.0%	1,235,683	-
Indirect Cost Recovery	(432,333)	(36,028)		36,028		(432,333)	-
SUD Administration	**803,350**	**15,459**	**47,902**	**32,443**	**209.9%**	**803,350**	**-**
Lenawee SUD Services	2,334,501	194,542	149,625	(44,917)	23.1%	2,334,501	-
Livingston SUD Services	2,694,735	224,561	146,397	(78,164)	34.8%	2,694,735	-
Monroe SUD Services	4,110,257	342,521	318,177	(24,344)	7.1%	4,110,257	-
Washtenaw SUD Services	9,225,314	768,776	624,099	(144,677)	18.8%	9,225,314	-
Opioid Health Homes	680,000	56,667	47,451	(9,216)	16.3%	680,000	-
Veteran Navigation	192,000	16,000	7,712	(8,288)	51.8%	192,000	-
COVID Grants	2,872,345	239,362	179,317	(60,045)	25.1%	2,872,345	-
SOR	3,890,236	324,186	116,408	(207,778)	64.1%	3,890,236	-
Gambling Prevention Grant	217,582	18,132	1,772	(16,360)	90.2%	217,582	-
Tobacco/Other	4,000	333	235	(98)	29.5%	4,000	-
Women's Specialty Services	350,489	29,207	2	(29,205)	100.0%	350,489	-
		-					
SUD/Grants Expenditures	**27,374,809**	**2,229,747**	**1,639,098**	**590,649**	**26.5%**	**27,374,809**	**-**
SUD/Grants Total	**(1,018,196)**	**(64,896)**	**198,883**	**263,779**	**406.5%**	**(1,018,196)**	**-**
PIHP							
PIHP REVENUE							
Incentives (Est)	1,890,000	157,500	157,500	-	0.0%	1,890,000	-
Local Match	-		155,465	155,465		-	-
Other Income	200,000	16,667	50,886	34,219	205.3%	200,000	-
PIHP Revenue	**2,090,000**	**174,167**	**363,851**	**189,684**	**108.9%**	**2,090,000**	**-**
PIHP EXPENDITURES							
PIHP Admin		-					
Local Match	-	-	155,465		0.0%	-	-
Salaries & Fringes	1,925,306	80,221	61,062	(19,159)	-23.9%	1,925,306	-
Contracts	865,500	72,125	46,456	(25,669)	-35.6%	865,500	-
Other Expenses	466,486	38,874	81,931	43,057	110.8%	466,486	-
PIHP Admin	**3,257,292**	**191,220**	**344,915**	**(1,770)**	**0.9%**	**3,257,292**	**-**
							-
Board Expense	3,000	250	301	51	20.3%	3,000	-
PIHP Expenditures	**3,260,292**	**191,470**	**345,216**	**153,746**	**-80.3%**	**3,260,292**	**-**
PIHP Total	**(1,170,292)**	**(17,303)**	**18,635**	**35,939**	**-207.7%**	**(1,170,292)**	**-**
							-
Organization Total	**5,549,264**	**290,186**	**1,021,976**	**731,791**	**252.2%**	**5,549,264**	**-**
Totals							
Revenue	277,566,354	22,169,817	22,463,540	293,723	**-1.3%**	277,566,354	-
Expenses	272,017,090	21,879,632	21,441,564	438,068	**-2.0%**	272,017,090	-
Net	5,549,264	290,186	1,021,976	731,791	**252.2%**	5,549,264	-

Attachment #4 – December 2023

Regional Board Action Request – Contracts

Board Meeting Date: December 13, 2023

Action(s) Requested: Approval for the CEO to execute the contracts/amendments listed below.

Organization - Background	Term	Funding Level	Funding Source	Agreement Type
Harm Reduction Michigan – Washtenaw Outreach Now An Anchor Institution program that will provide outreach to the east side of Ypsilanti, MI, with a focus on connecting the African American community with substance use resources including treatment.	10/1/2023 – 9/30/2024	Not to exceed $25,000	ARPA	New Contract
Monroe Public Schools – Project SUCCESS Project SUCCESS is an evidence-based program that prevents and reduces adolescent substance use and abuse. It places a Project SUCCESS Counselor in the middle school and high school to provide individual and group counseling, prevention education in classrooms, to train/consult school staff on prevention issues, coordinate the substance use services and policies of the school and refer and follow-up with students and families needing substance use treatment or mental health services in the community.	10/1/2023 – 9/30/2024	Not to exceed $150,000	COVID BG and ARPA	New Contract
Washtenaw County Health Department – Media Campaign Contract amendment related to an increase in funding for Washtenaw County Health Department to participate in the implementation of a Region Wide Media Campaign that focuses on Substance Use Recovery in Lenawee, Livingston, Monroe, and Washtenaw.	10/1/2023 – 3/14/2024	Increase of COVID BG funding from 22,958 to $74,500	COVID BG	Amend FY24 Contract

Recommend: Approval

Annual Quality Assessment and Performance Improvement Program (QAPIP) Plan for FY2024
Summary of New or Revised Workplan Priorities and Performance Measures

A. Figure 1. FY2024 QAPIP Priorities and Work Plan

MDHHS Performance Indicators	Objectives/Activities	Assigned Person or Committee/Council	Frequency / Due Date
CMHPSM will demonstrate an increase in compliance with access standards.	Monitor access requirements for priority populations, delineated by each priority population type. Establish a mechanism to monitor access requirements for persons enrolled in health homes (OHH, BHH, CCBHC).	Regional CPT Committee CMHPSM Compliance/Quality Manager CMHPSM SUD Services Director	Monthly QAPIP data review Quarterly CAP review Q1 Feb Q2 May Q3 August Q4 November
CMHPSM will show an increase in compliance with access standards for SUD priority populations	Conduct quarterly analysis of CMHSP and SUD provider performance of access standards for priority populations. Data analysis to delineate performance by each priority population. Develop baseline measure and performance expectations specific to each priority population as well as overall access. Require and review corrective action plans where standards were not met. Oversee effectiveness of corrective action plans through monthly review of subsequent data. Incorporate SUD care navigator position to meet access timeliness standards for SUD priority populations. Warm hand off challenge. Hiring PP care navigator – increase access timeframes to timeliness standards	Regional CPT Committee CMHPSM Compliance/Quality Manager CMHPSM SUD Services Director	Monthly QAPIP data review Quarterly CAP review Q1 Feb Q2 May Q3 August Q4 November

BH-TEDS	Objectives/Activities	Assigned Person or Committee/Council	Frequency / Due Date
CMHPSM will demonstrate an improvement or maintain data quality for the BH-TEDS Implement data driven outcomes measurement to address social determinants of health	Analyze and monitor BHTEDS records to improve housing and employment outcomes for persons served. Measurement period is prior fiscal year (FY2023) look back to most recent (FY2024) prior BH-TEDS update or admission record.	CMHPSM CIO Regional EOC Committee Regional CPT Committee	Narrative report to MDHHS by 7/31/2024
	Narrative completed of BH-TEDS process and analysis to improve housing and employment outcomes for persons served for FY24 and FY25 data, including actions steps.	CMHPSM CIO	7/31/2024
Utilization Management Plan	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency / Due Date**
CMHPSM will establish a Utilization Management Plan in accordance with the MDHHS requirements	Complete analysis of parity program compliance with LOC and LOC exceptions.	Regional UM/UR Committee	Quarterly

B. Figure 2. FY24 Performance Measures

*Continuous Quality Strategy Goal(s)	Michigan Mission Based Performance Indicator System	Committee/ Council	FY2023 Performance	FY24 QAPIP Page(s)
1	CMHPSM will meet or exceed the standard for Indicator 2. A The percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (reported by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children.) Performance measured by total % of all populations (total numerator/denominator) CMHPSM FY22 Baseline = 61.3% = 50TH – 75TH Percentile FY24 Performance Measure: reach or exceed the 75th Percentile	Regional CPT Regional EOC	No FY23 Threshold New FY24 standard is Baseline	Pages 23-24
1	CMHPSM will meet or exceed the standard for Indicator 2 e. The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders. Performance measured by total % of all populations (total numerator/denominator) CMHPSM FY22 Baseline = 60.8% = Below 50TH Percentile	Regional CPT Regional EOC	No FY23 Threshold New FY24 standard is Baseline	Pages 23-24

	FY24 Performance Measure: reach or exceed the 50TH Percentile			
1	CMHPSM will meet or exceed the standard for Indicator 3 Percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (reported by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children). Performance measured by total % of all populations (total numerator/denominator) CMHPSM FY22 Baseline = 74.5% = 50TH – 75TH Percentile FY24 Performance Measure: reach or exceed the 75TH Percentile	Regional CPT Regional EOC	No FY23 Threshold New FY24 standard is Baseline	Pages 23-24
Continuous Quality Strategy Goal(s)	**BH TEDS Data**	**Committee**	**FY2023 Performance**	
2, 3	Analyze and monitor BHTEDS records to improve housing and employment outcomes for persons served. Maintain overall BHTEDS completion rates to state 95% standard during FY2024. Improve crisis encounter BHTEDs completion to 95% during FY2024.	Regional EOC Regional CPT	Baseline New FY24 standard	Page 24
Continuous Quality Strategy Goal(s)	**Assessment of Member Experiences**	**Committee**	**FY2023 Performance**	
1, 2, 3	Create plan for improvement in areas that fell below the 85% threshold: My phone calls are returned by the next day 83.4 If I have a concern or a problem I know how to contact Customer Services to file a compliant 76.5	Regional Customer Services Committee	Overall 89.3 Areas that fell below 85% that will be a project plan for CS in FY24	Page 36
Continuous Quality Strategy Goal(s)	**PIHP Performance Based Incentive Payments**	**Committee**	**FY2023 Performance**	
	Implement data driven outcomes measurement to address social determinants of health. Analyze and monitor BHTEDS records to improve housing and employment outcomes for persons served. Measurement period is prior fiscal year. Use most recent update or discharge BH-TEDS record during the measurement period, look back to most recent prior update or admission record.	Regional EOC Committee Regional CPT Committee	N/A Baseline	Page 24

	Percentage of Adults Age 18 and Older with Schizophrenia or Schizoaffective Disorder who were Dispensed and Remained on an Antipsychotic Medication for at Least 80 Percent of their Treatment Period (SAA-AD): CMHPSM will participate in DHHS-planned and DHHS provided data validation activities and meetings and return completed data validation template to state 120 calendar days from January 31, 2024.	Regional EOC Committee Regional CPT Committee	N/A	Page 25
	CMHPSM will reduce the disparity between the index population and at least one minority group regarding the percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who initiate treatment within 14 calendar days of the diagnosis received: **(1. Initiation of AOD Treatment)** Data will be stratified and provided by the State by race/ethnicity Measurement period will be a comparison of calendar year 2022 with Calendar year 2023.	Regional EOC Committee Regional CPT Committee	Baseline	Page 25
	CMHPSM reduce the disparity between the index population and at least one minority group regarding the percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment and who had two or more additional AOD services or Medication Assisted Treatment (MAT) within 34 calendar days of the initiation visit. **(2. Engagement of AOD Treatment)** Data will be stratified and provided by the State by race/ethnicity Measurement period will be a comparison of calendar year 2022 with Calendar year 2023.	Regional EOC Committee Regional CPT Committee	Baseline	Page 25
Continuous Quality Strategy Goal(s)	**Utilization Management/LTSS**	**Committee**	**FY2023 Performance**	
	Assess overutilization of services: Review of inpatient recidivism as potential overutilization of higher level of care, using following factors: • Persons receiving LTSS, and/or on c waiver • Services/status, type, and service utilization before first admission • Type or change in the services/IPOS after the first and/or second admission • Engagement obstacles • If hospitalization known or managed by CMH • Compliance with MMBPIS Indicator 4a	Regional UM/UR Committee	Baseline Data analysis structure completed	Pages 32-36

	Underutilization project: Assess HSW members not receiving monthly services that qualify them for HSW enrollment as potential underutilization, including potential risks of maintaining HSW enrollment with the ending of public health emergency and subsequent enrollment exceptions. Including following factors: • Utilization of monthly habilitative services • Authorized services vs utilized services • Service delays and proper ABD notice where applicable • Person given choice of provider and HSW services	Regional UM/UR Committee	Baseline Data analysis structure completed	Pages 32-34
	Evidence of use of parity program for those with established LOC in CMHPSM reviews of CMHSPs clinical records for all populations (Standard 90%). A parity LOC is completed for each person served, including the accurate population The relevant and appropriate level of care assessment is completed for each person served prior to authorizations being completed. If the exception process is used, the reason for the exception is documented and reviewed at the supervisory level.	Regional UM/UR Committee	Baseline	Pages 32-34
	Consistent regional service benefit is achieved as demonstrated by the percent of outliers (exceptions) to level of care benefit packages (Standard <=5%). Measurement period is FY23	Regional UM/UR Committee	Baseline	Pages 32-34
	Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines. (Target 100%). Implement an inner rater reliability with the MCG Indicia parity system for psychiatric inpatient, crisis residential, and partial hospitalization service decisions. Baseline measurement period is Q1 of FY24	Regional UM/UR Committee	Baseline	Pages 32-34

Community Mental Health Partnership of Southeast Michigan

2024 Quality Assessment and Performance Improvement Program Plan

Fiscal Year 2024

Final Version Approved:

Reviewed by Regional Operations Committee:
CMHPSM Clinical Performance Team: 11/16/2023
Approved by CMHPSM Board:
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I. Overview/Mission Statement

The CMHPSM is one of Michigan's ten Medicaid Prepaid Inpatient Health Plans and is responsible for the counties of Lenawee, Livingston, Monroe, and Washtenaw. We provide oversight of the management and integration of Medicaid mental health services for adults with intellectual/developmental disabilities, serious mental illness and children with serious emotional disturbances. In addition, we oversee substance use disorder services across the four-county region. Mental Health Services are delivered through the Community Mental Health Service Providers in each respective county: Lenawee Community Mental Health Authority, Livingston Community Mental Health Authority, Monroe Community Mental Health Authority and Washtenaw County Community Mental Health Agency. Our goal is to provide meaningful outcomes for our consumers. The Substance Use Disorder services are delivered through core service providers within the region.

The Community Mental Health Partnership of Southeast Michigan (CMHPSM) is a collaborative effort between Lenawee, Livingston, Monroe and Washtenaw counties that was renewed in 2013, the CMHPSM was originally established in 2002. The CMHPSM regional entity was created in response to meeting the state requirement of consolidation to ten PIHP regions.

It is the intention of the CMHPSM to ensure consistent implementation and management of services provided. CMHPSM develops a strategic plan guided by our Vision, Mission, and Values, with quarterly reports submitted to the CMHPSM Board. The current FY21-23 CMHPSM Strategic Plan Metrics/Milestones is available to MDHHS upon request. Strategic plan goals relative to the QAPIP work plan are identified in Figure 2.

The CMHPSM's Vision, Mission, and Values guide our quality assurance and performance improvement activities:

A. Mission Vision and Values

Mission: Through effective partnerships, the CMHPSM ensures and supports the provision of high-quality integrated care that is cost effective and focuses on improving the health and wellness of people living in our region.

Vision: The CMHPSM shall strive to address the challenges confronting people living in our region by influencing public policy and participating in initiatives that reduce stigma and disparities in health care delivery while promoting recovery and wellness.

Values:

- Strength Based and Recovery Focused
- Trustworthiness and Transparency
- Accountable and Responsible
- Shared Governance
- Innovative and Data driven decision making
- Learning Organization

B. Guiding Principles:

Guiding Principle #1: CMHPSM uses quality assurance and performance improvement to make decisions and guide day-to-day operations.

Guiding Principle #2: The QAPIP helps to ensure that our organization, providers, and CMHSPs improve quality of care for persons served.

Guiding Principle #3: The QAPIP incorporates feedback and contribution from employees, departments, providers, and persons served. Participation of persons served related to the QAPIP includes membership in regional committees, outcomes of surveys and focus groups, data related to appeals, grievances, and inquiries to Customer Service, input from local and regional consumer advisory committees.

Guiding Principle #4: The QAPIP focuses on identifying defects in system processes, rather than individuals, and utilizes knowledge and efforts of the individuals involved in these processes.

Guiding Principle #5: CMHPSM uses qualitative and quantitative methods to collect and evaluate data about performance.

Guiding Principle #6: CMHPSM strives to meet and exceed standards established through regulation, the State contract, or through local, statewide, or national databases.

Guiding Principle #7: CMHPSM strives to use statistically valid sampling, data collection, analysis, and interpretation methods in all its performance improvement activities.

Guiding Principle #8: CMHPSM creates a culture that encourages employees to identify deficiencies in processes and areas of improvement.

II. Scope of Plan

The Michigan Department of Health and Human Services (MDHHS) requires that each specialty Prepaid Inpatient Health Plan (PIHP) has a Quality Assessment and Performance Improvement Program (QAPIP) that meets standards required by the PIHP's contracts, including the PIHP contract with MDHHS ; the Balanced Budget Act of 1997 (BBA), Public Law 105-33; and 42 Code of Federal Regulations (CFR) 438.358.

The Community Mental Health Partnership of Southeast Michigan (CMHPSM) completes an annual QAPIP Plan for the current fiscal year, based on performance improvement projects required at the state and federal levels, as well as local initiatives, which address areas of access to care and quality care for persons served in the region.

This QAPIP Plan is an overall assessment of the projects identified in the QAPIP workplan. The Plan's purpose is to describe:

1. an adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPIP;
2. the components and activities of the QAPIP;
3. the role for persons served in the QAPIP; and
4. the mechanisms or procedures used for adopting and communicating process and outcome improvement.

The CMHPSM serves populations in the region who experience mental illness, intellectual developmental disabilities, and substance use The CMHPSM QAPIP encompasses access, quality, and cost of service delivery. This plan outlines the current relationships and structures that exist to promote performance improvement goals. Improvement activities target operational efficiencies, service delivery, and clinical care. This plan is based on contract and regulatory requirements, the previous year's quality assessment and performance improvement projects, and CMHPSM vision, mission, and values.

III. Definitions/Acronyms

Behavioral Health: An individual with a mental illness, intellectual developmental disability and/or substance use disorder or children with a serious emotional disturbance.

BTPRC: Behavior Treatment Plan Review Committee reviews, approves, or disapproves any plans that propose to use restrictive or intrusive intervention, with as defined in the Technical Requirement for Behavior Treatment Plans.

CIRS: Critical Incident Reporting System includes events required to be monitored and reported to MDHHS and the process in which this is completed. The current critical incidents categories include suicide death; non-suicide death; arrest of consumer; emergency medical treatment due to injury or medication error; and type of injury. Subcategories include injuries that resulted from the use of physical management; hospitalization or emergency treatment due to injury or medication error; emergency medical treatment of hospitalization due to injury related to the use of physical management.

CMHSP: Community Mental Health Services Program is a program operating under Chapter 2 of the Michigan Mental Health Code - Act 258 of 1974 as amended.

Comprehensive Quality Strategy (CQS): provides a summary of work done to assess and improve the quality of care and services provided and reimbursed by Michigan's Medicaid programs, in accordance with State and Federal laws and regulations. The CQS provides a framework to accomplish its overarching goals of designing and implementing a coordinated and comprehensive system to proactively drive quality across Michigan Medicaid managed care programs.

Confidential Record of Consumer Treatment (CRCT): the CMHPSM electronic health record (EHR) co-created and shared by the region. This is a primary resource for data entry by local CMHSP and contractual staff, data collection, and has been Meaningful Use Certified.

Contractual Provider: an individual or organization under contract with the CMHPSM Pre-Paid Inpatient Health Plan (PIHP) to provide administrative type services including CMHSPs who hold retained functions contracts.

Critical Incident: defined as the following events: suicide; Non-suicide death; Arrest of Consumer; Emergency Medical Treatment due to injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of physical management; Hospitalization due to Injury or Medication Error: Hospitalization due to injury related to the use of physical management.

Customer: For CMHPSM purposes customer includes all Medicaid eligible individuals (or their families) located in the defined service area who are receiving or may potentially receive covered services and supports. The following terms may be used within this definition: clients, recipients, enrollees, beneficiaries, consumers, primary consumer, secondary consumer, individuals, persons served, Medicaid Eligible. CMHPSM seeks to use the term person(s) served wherever possible based on our philosophy of anti-stigmatizing language and inclusion.

LTSS: Long Term Supports and Services are provided to older adults and people with disabilities who need support because of age; physical, cognitive, developmental, or chronic health conditions; or other functional limitations that restrict their abilities to care for themselves, and who receive care in home/community- based settings, or facilities such as nursing homes.(42 CFR §438.208(c)(1)(2)) MDHHS identifies the Home and Community Based Services Waiver and MI-Choice as recipients of LTSS.

External Quality Review (EQR): the analysis and evaluation by an External Quality Review Organization of aggregated information on quality, timeliness and access to health care services that the CMHPSM furnishes to persons served.

Medicaid Abuse: provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet the professionally recognized standards for health care (see 42 CFR 455.2)

Medicaid Fraud*:* the intentional deception or misinterpretation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or another person (see 42 CFR 455.2). This definition is not meant to limit the meaning of fraud as it is defined under applicable federal or state laws.

Medicaid Services Verification (MSV): is a process which verifies services reimbursed by Medicaid.

MMBPIS: Michigan Mission Based Performance Indicator System includes domains for access to care, adequacy and appropriateness of services provide, efficiency (administrative cost vs. service costs), and outcomes (employment, housing inpatient readmission).

MDHHS: Michigan Department of Health and Services

Outcomes: Changes in consumer health, functional status, satisfaction, or goal achievement that result from health care of supportive services.

PIP: Performance Improvement Projects must be conducted to address clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes.

PIHP: Prepaid Inpatient Health Plan is a managed care organization responsible for administering specialty services for the treatment of mental health, intellectual and developmental disabilities and substance use disorders in accordance with the 42 CFR part 401 et al June 14, 2002, regarding Medicaid managed care, Medicaid regulations, Part 438, MHC 330.1204b.

Provider Network: Refers to a CMHSP and all Behavioral Health Providers that are directly under contract with the CMHPSM PIHP to provide services and/or supports through direct operations or through the CMHSP subcontractors.

Quality Assessment: a systematic evaluation process for ensuring compliance with specifications, requirements or standards and identifying indicators for performance monitoring and compliance with standards.

Quality Assurance: a broad spectrum of evaluation activities aimed at ensuring compliance with minimum quality standards. The primary aim of quality assurance is to demonstrate that a service or product fulfills or meets a set of requirements or criteria. QA is identified as focusing on "outcomes," and CQI identified as focusing on "processes" as well as "outcomes."

Quality Improvement: ongoing activities aimed at improving performance as it relates to efficiency, effectiveness, quality, performance of services, processes, capacities, and outcomes. It is the continuous study and improvement of the processes of providing services to meet the needs of the individual and others.

Quality Managed Care Rules and External Quality Review (EQR): the degree to which the CMHPSM increases the likelihood of desired outcomes of its enrollees through 1) Its structural and operational characteristics; 2) The provision of services that are consistent with current professional, evidenced based knowledge; 3) Interventions for performance improvement.

QAPI: Quality Assurance Performance Improvement

QAPIP: Quality Assessment and Performance Improvement Program includes standards in accordance with the Guidelines for Internal Quality Assurance Programs as distributed by the Health Care Financing Administration Medicaid Bureau guide to states in July of 1993, the Balanced Budget Act of 1997, Public Law 105-33, and 42 Code of Federal Regulations (CFR)438.358 of 2002.

Research: (as defined by 45 CFR, Part 46.102) means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable

knowledge. Activities which meet this definition constitute research for purposes of this policy, whether they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities.

Risk Events: Critical incidents that put individuals (in the same population categories as critical incidents above) at risk of harm. These include Actions taken by individuals who receive services that cause harm to themselves; Actions taken by individuals who receive services that cause harm to others; Two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period.

Root Cause Analysis (RCA): A root cause analysis (The Joint Commission) or investigation (per CMS approval and MDHHS contractual requirement) is “a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance.” (TJC, 2023)

Sentinel Event (SE): A sentinel event is an “unexpected occurrence” involving death (not due to the natural course of a health condition) or serious physical or psychological injury, or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase “or risk thereof” includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome (TJC, 2023). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event

Stakeholder: A person, group, or organization that has an interest in an organization, including consumer, family members, guardians, staff, community members, and advocates.

Subcontractors: Refers to an individual or organization that is directly under contract with CMHSPs or the PIHP to provide services and/or supports.

SUD Providers: Refers to substance use disorder (SUD) providers directly contracted with CMHPSM to provide SUD treatment and prevention services.

Validation: the review of information, data and procedures to determine the extent to which they are accurate, reliable, free from bias and in accord with standards for data collection and analysis.

Veteran Navigator (VN): The role of the Veteran Navigator is to listen, support, offer guidance, and help connect Veterans to services they need.

Vulnerable Person: An individual with a functional, mental, physical inability to care for themselves.

IV. Organizational Structure and Authority:

A. Governance

CMHPSM Board

The CMHPSM Board is responsible for overseeing the QAPIP by performing the following functions:

- Annual review and approval of the current fiscal year QAPIP Plan.
- Annual evaluation and approval of a QAPIP report evaluating the effectiveness of the quality management program and recommending priorities for improvement initiatives for the next year.
- Receive periodic written reports of the activities of the QAPIP, including performance improvement projects (PIPs), actions taken, and the results of those actions.

Following Board approval, CMHPSM submits the written annual QAPIP Plan, including a list of the Board of Directors, and QAPIP Evaluation Report to MDHHS for approval.

Chief Executive Officer

CMHPSM's CEO is hired/appointed by the PIHP Board and is the designated senior official with responsibility for ensuring implementation of the regional QAPIP. The CMHPSM CEO has designated the Compliance and Quality Manager as the PIHP oversight role of the CMHPSM Clinical Performance Team (CPT) Committee and is a member of the MDHHS Quality Improvement Council. In this capacity, the Compliance and Quality Manager under the direction of the Chief Operating Officer, is responsible for the development, review, and evaluation of the Quality Assessment and Performance Improvement Program in collaboration with the CMHPSM Clinical Performance Team (CPT) Committee. The CMHPSM CEO allocates adequate resources for the quality management program and is responsible for linking the strategic planning and operational functions of the organization with the quality management functions. The CEO assures coordination occurs among members of the Regional Operations Committee to maintain quality and consumer safety. Additionally, the CEO is committed to the goals of the quality improvement plan and to creating an environment that is conducive to the success of quality improvement efforts, ensuring affiliation involvement, removing barriers to positive outcomes, and monitoring results of the quality improvement program across the PIHP. The CEO reports to the PIHP Board of Directors recommending policies and/or procedures for action and approval. The CEO is responsible for managing contractual relationships with the CMHSPs partners and Substance Use Disorder Providers and for issuing formal communications to the CMHSP/SUD Providers regarding performance that does not meet contractual requirements or thresholds. Similarly, the CEO is responsible for assuring ongoing monitoring and compliance with its MDHHS contract including provision of quality improvement plans as required.

CMHPSM Leadership Staff

The CMHPSM Leadership Staff oversee the regional committees that implement the QAPIP and address specific issues in need of remediation. *(Attachment A)*

Regional Operations Committee

The Regional Operations Committee (ROC) ROC is comprised of the CMHPSM Chief Executive Officer, the four CMHSP Executive Directors, and the CMHPSM Substance Use Services Director and operates under a shared governance structure.
The CMHPSM Chief Operating Officer (COO), on behalf of the Regional Clinical Performance Committee, ensures ROC reviews and approves the plan before regional Board review. The CMHPSM CEO and CMHSP Executive Directors also serve as coaches on each regional committee to support implementation and oversight of the QAPIP projects.

Regional Clinical Performance Team (CPT) Committee

The Clinical Performance Team (CPT) Committee and PIHP staff are responsible for monitoring the implementation and effectiveness of the QAPIP and performance improvement projects. CPT may implement workgroups along with other staff, committees, and providers who implement PI projects.

Membership includes PIHP staff, clinical and performance improvement staff from each of the CMHSPs within the region, and representatives of persons served. The CPT reviews the annual QAPIP Plan and may make revision suggestions. PIHP staff involved include the CMHPSM Chief Operations Officer, Compliance/Quality Manager, Chief Information Officer, Health Data Analyst, and Regional Data Coordinator.

CPT Committee responsibilities include:

- systematically gather information from various stakeholders
- define performance standards
- evaluate performance and/or gaps
- complete root cause analyses
- compete priority ranking of barriers
- develop interventions
- implement interventions
- evaluate effectiveness of the interventions
- examine the capacity to support and sustain improved performance

The CPT Committee develops the structures in which performance improvement projects are implemented, including recommending any work or projects that would be allocated to other regional committees or ad hoc work groups and how those projects are reported to the CPT Committee. Performance improvement projects are based on the population health needs of the community. To assess population health needs, CMHPSM analyzes data from performance measures, clinical records, state and local indicators of health, and collaborates with providers and members to carry out initiatives such as surveys, and other data indicative of individuals experience with services such as service requests, service utilization, grievances, appeals, and stakeholder feedback.

The CPT Committee meets monthly to review progress on PI projects and to ensure clear and consistent communication to staff, persons served, and stakeholders. Each CMHSP is responsible for the local functions in implementing the QAPIP, with CMHSP committee representatives responsible to communicate the progress of PI projects to their staff, local

Boards, persons served, contractual providers, and community stakeholders; to ensure communication of local compliance requirements in QAPIP implementation; and to collect and provide local feedback to the CPT committee. Communication efforts include making information about QAPIP projects available to persons served, providers, and community stakeholder through such means as local websites, newsletters, internal communications boards, staff meetings, consumer advisory boards, and provider or community meetings.

The Regional CPT Committee works closely with the Regional Electronic Operations (EOC) Committee to provide leadership and support for data collection, analysis and report writing, compliance needs, system enhancements/development and training to support QAPIP projects.

B. Committee Structure

CMHPSM structure is based on shared governance, which includes that wherever possible, CMHPSM will delegate functions to CMHSPs to meet local needs and decisions will be made collaboratively between CMHPSM and CMHSPs for administrative efficiency and the improvement of quality services for persons served. In addition to the Regional Operations Committee, the development and practice of regional committees have been an inherent component of this structure for the oversight and monitoring of delegated and shared functions. Functions that cannot be delegated per state and federal regulation, or that do not meet the goal of administrative efficiency and quality improvement, are maintained at the PIHP leadership staff level.

Regional committees are comprised of CMHSP provider staff, persons served or their families, PIHP staff, and key partners with specific expertise in the area of the committee work. Regional Committees either report to the Regional Clinical Practice Team or directly to the Regional Operations Committee (ROC).

Within the CMHPSM operational structure, the QAPIP is implemented using various committees, work groups, and advisory groups including but not limited to the following:

- Regional Clinical Practice Team
    - Children's Administrators Workgroup, IDD/CI Administrators Workgroup, Co-Occurring (MI and SUD) Services Administrators Workgroup, Regional Parity Workgroup
- Regional Consumer Advisory Committee
    - Local CMHSP Advisory Committees
- Regional Utilization Review/Utilization Management Committee
- Regional Electronic IM Operations (EOC) Committee
- Regional Customer Services Committee
- Regional Network Management Committee
- Regional Compliance Committee
- Regional Finance Committee

CMHPSM staff and the CPT Committee are responsible for general oversight of the QAPIP. The CMHPSM Chief Operations Officer and the Compliance and Quality Manager are the PIHP staff responsible for the oversight of QAPIP Implementation. *(See* Attachment A—CMHPSM Organizational Chart*)*.

CMHPSM has created several regional policies, as required by contract and regulation, which make up components of the QAPIP. The policies are implemented by the various regional committees, CMHPSM departments, contracted CMHSPs, and providers.

The Provider Network Structure of this plan includes the regional committees and relevant regional policies to describe their correlation with the components of the QAPIP and relevant PI projects noted in the QAPIP.

C. Provider Network Structure

Within the CMHPSM operational structure, the majority of network structure is implemented using various committees, work groups, and advisory groups.
Committees are responsible for providing recommendations and reviewing regional policy's regarding related managed care operational decisions. Each committee develops and approves a Charge and work plan that identifies: Purpose, Decision Making Scope, Defined Goals, Monitoring, Reporting, Communication Plan, Membership, Roles and Responsibilities Meeting Frequency, and Upcoming Goals supporting the CMHPSM Strategic Plan and QAPIP. The Regional Operations Committee approves all committee charges. Each committee makes recommendations considered by the ROC on the basis of obtaining a consensus or simple majority vote of the four CMHSPs. The CMHPSM CEO retains authority for final decisions or for recommending action to the CMHPSM Board.
Among other duties, these committees identify, receive, and respond on a regular basis to opportunities and recommendations for system improvements arising from the CMHPSM Quality Assessment and Performance Improvement Program and reports annually on the progress of accomplishments and goals.

CMHSPs/SUD Provider staff have the opportunity to participate in and to support the QAPIP through organization wide performance improvement initiatives. In general, the CMHSP/SUD Provider staff's role in the PIHP's performance improvement program includes:

- Participating in valid and reliable data collection related to performance measures/indicators at the organizational or provider level.
- Identifying organization-wide opportunities for improvement.
- Having representation on organization-wide standing councils, committees, work groups.
- Reporting clinical care errors, informing consumers of risks, and making suggestions to improve the safety of consumers.
- Responsible for communication between the Regional CPT Committee and the SUD provider network.

All policies referenced in this plan can be located at: https://www.cmhpsm.org/regional-policies

Regional Clinical Practice Team (CPT) Committee
A quality and clinical representative from each CMHSP is appointed by the CMHSP CEO to participate in the. Primary and/or secondary consumer representatives are appointed by each CMHSP Director and Customer Services manager. Substance Use Disorder (SUD) Treatment Providers are represented by CMHPSM SUD Staff. Committee members represent the needs of all individuals and populations served, and local communities to inform, advise, and work with the CMHPSM to bring local perspectives, local needs, and greater vision to regional that effective and efficient service delivery systems are in place that represent best practice and result in positive outcomes for the people served in the region
The regional CPT Committee also provides functions of the implementation and oversight of the QAPIP, as described in Section IV, B. and C of this plan.

Population specific workgroups comprised of PIHP lead staff and CMHSP clinical experts meet regularly to address populations specific trends, needs and upcoming initiatives, to inform and report to the Regional CPT Committee. They include Children's Administrators Workgroup, IDD/CI Administrators Workgroup, Co-Occurring (MI and SUD) Services Administrators Workgroup, and the Regional Parity Workgroup. Workgroup projects include those assigned by the CPT Committee. Members are appointed by their respective CMHSP/PIHP CEO.

Regional Policies: The committee oversees the following regional policies. All policies referenced in this plan can be located at: https://www.cmhpsm.org/regional-policies

Advanced Directive and DNR Orders Assessment and Reassessment Behavior Treatment Committee Clinical Practices Guidelines Clinical Record Content Continuity of Care Coordination of Integrated Healthcare Crisis Safety Planning Policy Consumer Employment Diagnosis & Clinical Formulation Ethics & Conduct	Incident Reporting Medication Administration, Storage, & Other Treatment Performance Improvement Person Centered Planning Psychotropic Medication Orders & Consents Report & Review of Death Self Determination Timeliness of Service Provision & Documentation Training Transition Planning for Individuals Being Released from State Facilities Trauma-Informed Practice

SUD Oversight Policy Board
Pursuant to section 287 95) of Public Act 500 of 2012, CMHPSM established a Substance Use Disorder Oversight Policy Board (OPB) with and membership appointed by each of the four counties served. The SUD-OPB is responsible to approve an annual budget inclusive of local funds for treatment and prevention of substance use disorders; and serves to advise the CMHPSM Board on other areas of SUD strategic priority, local community needs, and performance improvement opportunities.

The CMHPSM SUD Director and SUD Team are responsible for policy development and revisions approved by the SUD OPB.

Regional Policies: The committee oversees the following regional policies. All policies referenced in this plan can be located at: https://www.cmhpsm.org/regional-policies

Communicable Disease Fetal Alcohol Spectrum Disorders Screening Individual Treatment & Planning Integrated Community Housing Medication Assisted Treatment – Buprenorphine and Vivitrol Medication Assisted Treatment – Methadone Regional Naloxone Overdose Rescue Kit Distribution & Utilization	SUD Media Campaigns SUD Outpatient Treatment & Recovery Continuum SUD Recipient Rights SUD Residential Room & Board SUD Residential Treatment Services Welcoming Policy Women's Specialty Treatment Services

Regional Customer Services (CS) Committee

Customer Services managers from each CMHSP are appointed by the CMHSP CEOs to participate in the committee. Primary and/or secondary consumer representatives are appointed by each CMHSP Director and Customer Services manager. Committee members represent the needs of all individuals and populations served, and local communities. The committee is responsible for the oversight of Customer Services standards, including the regional Guide to Services and other informational materials for persons served to ensure compliance with state and federal requirements. Committee work includes oversight of grievance processes across the region, and maintenance of grievance data. All grievance data is maintained in a shared module within the regional EHR, and informational materials are created collectively and used throughout the region. The Committee develops and implements an annual survey and report of persons experiences with services and supports and develops performance improvement projects from survey trends. The CS Committee ensures quarterly reporting of the QAPIP measures is provided to the Regional Consumer Advisory, which serves as the primary source of consumer input to the CMHPSM. This committee is supported by the PIHP Compliance and Quality Manager and the CMHPSM Chief Operating officer serving as the PIHP Customer Service contact. The Customer Services Committee reports to the Regional CPT Committee including annual reports and recommendations with surveys of persons served experiences and satisfaction with services and supports.

Regional Policies: The committee oversees the following regional policies. All policies referenced in this plan can be located at: https://www.cmhpsm.org/regional-policies

Culturally & Linguistically Relevant Services Customer Services Notice of Privacy Practices

Regional Electronic IM Operations (EOC) Committee

The EOC Committee assures maintenance and development of core electronic medical record (EMR) software functions, the optimization and standardization of EMR processes whenever

possible, and supporting data integrity. The committee oversees the maintenance of core EMR functions including the incorporation of federal and state requirements, emerging best practices, and feedback from the regional EOC Satisfaction Survey submitted annually to CMHSP partners. The EOC Committee develops and implements this satisfaction survey. The committee is comprised of the CMHPSM Chief Information Officer (CIO) as chair and the CMHSP information technology staff appointed by the respective CMHSP CEO/Executive Director. CMHSP members ensure local implementation and local data integrity of EOC Committee oversight functions.

Regional Policies: The committee oversees the following regional policies. All policies referenced in this plan can be located at: https://www.cmhpsm.org/regional-policies

Privacy & Security of Workstations Sanctions for Breaches of Security or Confidentiality Security of Consumer Related Information

Regional Utilization Management/Utilization (UM/UR) Review Committee

The UM/UR Committee assures effective implementation of the CMHPSM's UM/UR functions and compliance with UM/UR requirements for CMHPSM policy, the Michigan Department of Health and Human Services Prepaid Inpatient Health Plan Contract and related Federal & State laws and regulations related to service and eligibility decisions, conflict free decisions, parity program oversight, and the appeals process. Members are appointed by the CMHSP CEOs comprised of UM/UR staff, internal appeals coordinators, and fair hearings officers of CMHSPs and the CMHPSM, with the CMHPSM COO as chair.

Regional Policies: The committee oversees the following regional policies. All policies referenced in this plan can be located at: https://www.cmhpsm.org/regional-policies

Access System Assessment and Reassessment Assessment and Authorization of CLS Services Claims Payment & Appeal Conflict Free Case Management Consumer Appeals Person Centered Planning Utilization Management & Review

Regional Compliance Committee (RCC)

The RCC ensures compliance with requirements identified within CMHPSM policy development, procedures and compliance plan; the Michigan Department of Health and Human Services Prepaid Inpatient Health Plan Contract; and all related Federal and State laws and regulations, inclusive of the Office of Inspector General guidelines and 42 CFR 438.608.

Regional Policies: The committee oversees the following regional policies. All policies referenced in this plan can be located at: https://www.cmhpsm.org/regional-policies

Confidentiality and Access to Consumer Records Corporate Compliance Policy Critical Incident, Sentinel Event, & Risk Event Peer Review Service Verification

Regional Network Management Committee (NMC)
The Regional NMC Committee provides counsel and input to with respect to regional policy development and strategic direction. Counsel and input will typically include: 1) network development and procurement, 2) provider contract management (including oversight and monitoring), 3) provider qualifications, credentialing, privileging and primary source verification of professional staff, 4) periodic assessment of network capacity, 5) developing inter- and intra-regional reciprocity systems, and 6) regional minimum training requirements for administrative, direct operated, and contracted provider staff. In fulfilling its charge, the Regional NMC understands that provider network management is a Prepaid Inpatient Health Plan function delegated to Community Mental Health Service Programs (CMHSP). Provider network management activities pertain to the CMHSP direct operated and contract functions.

Regional Policies: The committee oversees the following regional policies. All policies referenced in this plan can be located at: https://www.cmhpsm.org/regional-policies

Credentialing and Clinical Responsibilities for LIPs Debarment, Suspension, & Exclusion Employee Competency & Credentialing Organizational Credentialing & Monitoring

Regional Consumer Advisory Council (RCAC)
The RCAC is charged with serving as the primary source of consumer input to the CMHPSM to the development and implementation of Medicaid specialty services and supports requirements in the region.

D. Communication of Process and Outcomes

The CMHPSM staff and Regional Clinical Performance Team, in coordination with the CMHSPs and SUD Providers through regional committees and councils, is responsible for monitoring and reviewing performance measurement activities including identification and monitoring of opportunities for process and outcome improvements.
After committee/council meetings, the status of key performance indicators, consumer satisfaction survey results, and performance improvement (PI) projects are reported to consumers and stakeholders are communicated through means such as websites, newsletters, provider meetings, consumer advisory councils, and town halls and focus groups.

Final performance and quality reports are available to the stakeholders and the general public as requested, and through the CMHPSM website. The Board of Directors receives periodic and an annual report on the status of organizational performance.

V. Performance Management

A. Determination of Performance Measures:

CMHPSM endeavors to use objective and systematic methods of measurement in the areas of access, efficiency, and outcome. to achieve minimum performance levels on performance indicators and analyze the causes of any statistical outliers.
CMHPSM utilizes performance measurement to monitor system performance, promote improved performance, identify opportunities for improvement and best practices, and to ensure compliance with PIHP contract requirements and State and Federal processes and requirements.

Where state or federal regulations do not require specific performance measures, measures are chosen by CMHPSM leadership in collaboration with CMHPSM committees, councils, and work groups based on the following guidelines:
1) Priorities for improvements are based on performance in the previous year regarding existing standards, audits; community assessments, and the prevalence of a condition among, or need for a specific service by, the organization's individuals; consumer demographic characteristics and health risks; and the interest of individuals in the aspect of service to be addressed. CMHPSM also incorporates the needs of the community, stakeholder feedback, efficient use of resources, and providing person -centered and effective services.

2) Specific clinical and non-clinical performance measures, or indicators. Indicators are indirect measures used to assess and improve quality and can indicate certain areas that require more attention. These are based on compliance with regulations, contract requirements, chosen projects, and external audits. CMHPSM also chooses indicators based on:

- Relevance to the outcome or process that we want to assess and improve.
- Measurability, given finite resources.
- Accuracy: whether the performance measure is based on accepted guidelines.
- Feasibility: Can the performance rate for an indicator realistically be improved?

Additionally, various types of indicators may be used to assess performance. Indicator types include:

- Process measures: What a provider does to maintain or improve quality of services, health, or outcomes of persons served. Assesses steps/activities in carrying out a service. For example,
  - o The percentage of persons served with a mental illness who receive a LOCUS assessment at least annually.
- Outcome measures: reflect the impact of behavioral health care services or intervention on the health status persons served. For example,
  - o The rate of Hospital Acquired Conditions.
- Balancing measures: Making sure problems do not result from improvement steps implemented in another part of the system. For example,
  - o As systems are modified to increase access to care and reduce disparities with access, does satisfaction also increase? Stay the same? Or decrease? are other services inadvertently created?
- Structural measures: Fixed characteristics of an organization. For example,

- Whether an organization uses electronic health records; or
- an organization's calculation of co-pays.

B. Prioritizing Measures

Where state or federal regulations do not require specific performance measures, measures are chosen by CMHPSM leadership in collaboration with CMHPSM committees, councils, and work groups based on the following guidelines:

1. Adherence to law, regulatory, accreditation requirement and/or clinical standards of care. And performance in the previous year regarding audits of compliance standards, audits

2. The needs of the community, stakeholder feedback, efficient use of resources, and providing person -centered and effective services. This can include community assessments, and the prevalence of a condition among, or need for a specific service by, the organization's individuals; consumer demographic characteristics and health risks; and the interest of individuals in the aspect of service to be addressed.

3. The effect on a significant portion of persons served with potentially significant effect on quality of care, services, or satisfaction.

4. Specific clinical and non-clinical performance measures, or indicators. Indicators are indirect measures used to assess and improve quality and can indicate certain areas that require more attention. These are based on compliance with regulations, contract requirements, chosen projects, and external audits. CMHPSM also chooses indicators based on:

- Relevance to the outcome or process that we want to assess and improve.
- Measurability, given finite resources.
- Accuracy: whether the performance measure is based on accepted guidelines.
- Feasibility: Can the performance rate for an indicator realistically be improved?

Clinical indicators derive from evidence-based clinical guidelines for measuring an outcome of care. Examples of sources for clinical measures are the Healthcare Effectiveness Data and Information Set (HEDIS), and MDHHS's CC360 data derived from Medicaid claims/encounters data in the state CHAMPS system. Clinical areas include high volume services, high-risk services, disparities, and coordination of care.

Non-clinical indicators are used to assess operational aspects of an organization. Non-clinical areas include appeals, grievances, trends of Recipient Rights complaints, satisfaction surveys, National Core Indicators, and access to services. Indicators can be used to identify steps in a process that CMHPSM should adopt, adapt, or abandon.

C. Data Collection and Analysis

The purpose of data collection is to monitor performance, identify growth areas, and monitor the effectiveness of interventions. A description of the measure is written and may include, but is not limited to the following:

• Baseline
• Standard/Target/Goal
• Data collection timeframe, and remeasurement periods,
• Frequency of data analysis
• Population/sample
• Use of standardized data collection tools,
• Data source, and
• Consistent data collection techniques.
• Strategies to minimize inter-rater reliability concerns and maximize data validity.
• Measure Steward

If a sampling method is used, the population from which a sample is pulled, and appropriate sampling techniques to achieve a statistically reliable confidence level are included in the project/study description. The default confidence level for CMHPSM performance measurement activity is a 95% confidence level with a 5% margin of error.

Data is aggregated at a frequency appropriate to the process or activity being studied. Statistical testing and analysis are used as appropriate to analyze and display the aggregated data. PIHP data is analyzed over time to identify patterns and trends and are compared to established performance targets and/or externally derived benchmarks when available. Performance targets are set through established contract requirements and/or externally derived benchmarks. If there is no set performance target, baseline data should be considered prior to setting a target.

Baseline data is data that is collected for a period of time, typically up to one year, prior to establishing a performance target. Historical data, when available may be used for baseline. When collecting baseline data, it is important to establish a well- documented, standardized, and accurate method of collecting the data and set ongoing frequencies to review the data (monthly, quarterly, etc.).

Once the baseline has been collected for a measure, it can be determined if a performance target should be established or not. If the baseline data is at or above the state and national benchmarks when available, and deemed to be within acceptable standards, it is up to the monitoring committee or team to determine if a performance measure should be established or if the measure should continue to be monitored for variances in the baseline data. If the baseline data is below the state and national benchmarks when available, a performance target should be established that is at, or greater than, the state and national average. Targets may be defined by a set percentage for achievement to meet the outcome being measured or a percentage increase/decrease change to be achieved.

The data is reviewed at the established intervals by the appropriate council, committee, or workgroup, in collaboration with CPT. The data is analyzed for undesirable patterns, trends, or variations in performance. In some instances, it may be necessary to complete further data collection and analysis to isolate the causes of poor performance or excessive variability, proceeding with performance improvement action steps until the performance target is met.

D. Framework for Performance Improvement Projects

The CMHPSM uses Plan-Do-Study-Act (PDSA) cycles to guide its performance improvement projects. This involves the following:

1. Develop a plan to test the change (*Plan*),
2. carry out the test (*Do*),
3. observe, analyze, interpret, and learn from the test (*Study*), and
4. determine what modifications, if any, to make for the next cycle (*Act*).

** Italics signify examples of a diagram/tool that may be used to guide and document work.*
Systematic steps for performance improvement projects and CAPs are implemented according to the following framework/guide (also available as a process flowchart in Attachment B):

1. Deficiencies identified (i.e., through Audits, complaints, over/under- utilization, clinical quality, administrative quality)

- If CMHPSM choice: Select issue for PI project based on population needs, impact, cost of care etc.
- If a performance measure fell below certain standards required by regulation or contract—must implement a CAP for that standard.

2. Select a new or pre-existing quality indicator to measure performance of identified deficiency. (**Plan**)

- Conduct root cause analyses
  - *Fishbone Diagram, 5 Whys, Key Driver Diagram*
- Narrow down Causes:
  - *Pareto chart and table*
- Define Indicator & data Collection Plan
  - *Defining Indicator*:
    - Includes numerator and denominator, exclusion criteria, standard and goal (if pre-existing standard, otherwise add in step 4).
  - *Indicator collection & monitoring Plan*:
    - Data source, sample size, frequency of measurement, duration, display, person responsible

3. Collect data on quality indicator to establish Baseline. (**Plan**)

- Baseline is a snapshot of performance that is typical over a period of time.
- Use a historical baseline (preexisting indicator); or
- a new baseline averaged over one year.

4. Set targets for improvement (Aim/goal/standard) (**Plan**)

- Pre-existing targets set by regulation or contract (see step 2)?
- SMART: **S**pecific, **M**easurable, **A**cceptable, **R**ealistic to Achieve, **T**ime-bound with a deadline

5. Develop a specific Work plan/intervention that will lead to improved performance/outcomes (**Plan**)

- *Project Planning Form*
    - Detail tasks to be performed, Persons responsible for tasks, timeline

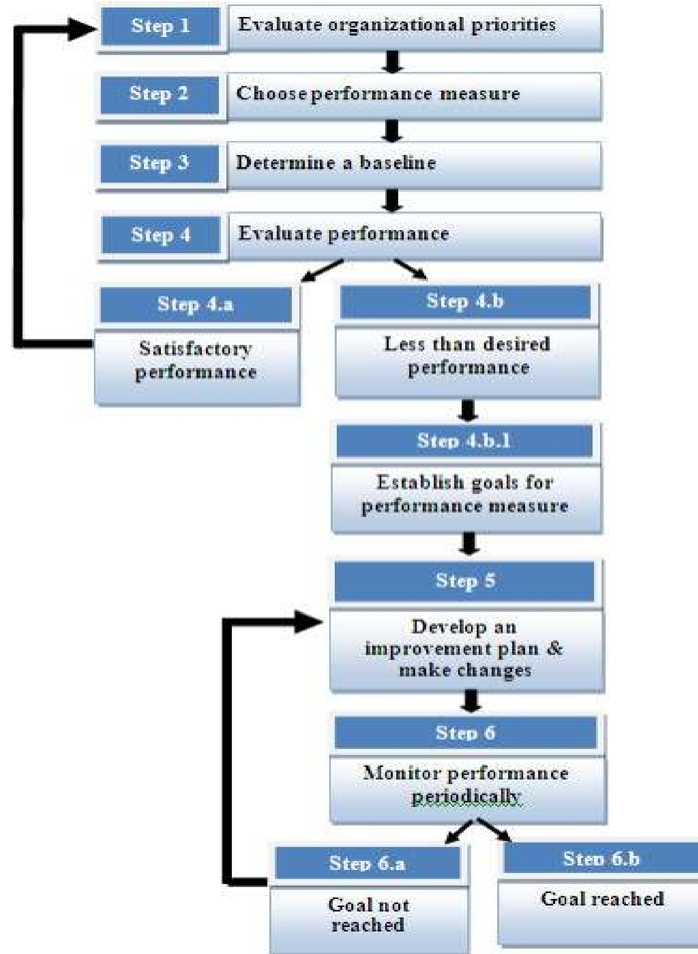
6. Implement change; gather new data at regular intervals to assess the success of intervention (**Do**)
- Carry out the test
- Collect data and monitor performance periodically (*Monitoring Interventions*)

7. Analyze results and compare to baseline. (**Study**)
- Analyze results and compare to baseline
    - Appropriate statistical analyses
    - Run chart
- Interpret results and lessons learned

8. Based on analyses—make a decision (**Act**)
- A) Adopt: continue process as is with same indicators/data monitoring OR test on larger scale
- B) Adapt/ Modify Process (i.e., implement additional interventions to remove barriers and run another test)
    - Possibly add new monitors/quality indicators
    - Identified Barriers?
        - Complete *Root cause analyses diagram* (e.g., fishbone, 5whys, key driver)
        - Complete *Rank barrier* (quantitative or qualitative)
        - Define new indicator for sub-intervention and *data collection plan*
        - Complete *Project planning form*
        - Implement change
        - Analyze results to see if barrier is eliminated, compare against baseline (results with the barrier in place)
- C) Abandon: don't do another test on the change idea/intervention.

9. Work plan for sustainability of solution (*Sustainability Planning*)

The above framework fits into the steps in the following overview Process Map for Performance Management created by the Health Resources and Services Administration (HRSA).



VI. CMHPSM Measures of Performance

A. Performance Measures

Review and analysis of the following performance improvement data helps to identify deficiencies or opportunities for clinical and operational improvements. CMHPSM uses these opportunities to inform its decisions on Performance Improvement Projects. Review and analysis of this data falls under step 1 in the PIP guide/framework under Section V of this plan. The requirements of this data are defined in the MDHHS-PIHP contract.

The Michigan Department of Health and Human Services (MDHHS) delegates the collection and reporting of performance indicators to the PIHP as defined in the Michigan Mission Based Performance Indicator System (MMBPIS). The performance indicators have been selected to measure dimensions of quality that include access/timeliness for services, efficiency, and outcomes.

The Michigan Department of Health and Human Services (MDHHS), in compliance with Federal mandates, establishes measures in access, efficiency, and outcomes. Pursuant to its contract with MDHHS, CMHPSM is responsible for ensuring that it's CMHSPs and Substance Use Disorder Providers are measuring performance using standardized performance indicators and participate

in the Michigan Mission Based Performance Improvement System (MMBPIS). Data is reviewed within the region on a quarterly basis at the Regional CPT Committee. If minimum performance targets or requirements are not met, CMHSPs/SUD providers develop a quality improvement plan documenting causal factors, interventions, implementation timelines, and any other actions taken to correct undesirable variation. The plan is reviewed by the Regional CPT Committee to ensure sufficient action planning. Regional trends are identified and discussed at the Regional CPT and relevant committee/council if applicable for regional planning efforts and coordination. The effectiveness of the action plan will be monitored based on the re-measurement period identified.

MMBPIS indicators are also analyzed for trends in service delivery and health outcomes over time, including whether there have been improvements or barriers impacting the quality of health care and services for members as a result of the activities.

Michigan Mission Based Performance Indicators
1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within 3 hours
2a: The percentage of new persons during the quarter receiving a completed bio-psycho-social assessment within 14 calendar days of a non-emergency request for service.
2b: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders.
3: Percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment.
4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days (child and adult).
4b: The percentage of discharges from an SUD detox unit during the quarter that were seen for follow-up care within 7 days.
10: The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.

B. PIHP-only Pay for Performance (P4P) Measures

MDHHS establishes specific performance indicators for PIHPs to improve specific behavioral health outcomes for people served across both systems for each fiscal year. The PIHPs performance with these measures determines if a pay for performance incentive will be provided to the PIHP and the amount of that incentive. CMHPSM will participate in the following PIHP performance measures for FY2024 per the MDHHS-PIHP contract:

Measure P.1 . Implement data driven outcomes measurement to address social determinants of health.

CMHPSM will analyze and monitor BHTEDS records to improve housing and employment outcomes for persons served. The measurement period is the prior fiscal year as a look back to most recent prior BHTEDS update or admission record. CMHPSM will conduct an analysis and submit a narrative report of findings and project plans aimed at improving outcomes per state requirements, including beneficiary changes in employment and housing and actions taken to improve housing and employment outcomes.

Measure P.2. Adherence to antipsychotic medications for individuals with schizophrenia (SAA-AD): Percentage of Adults Age 18 and Older with Schizophrenia or Schizoaffective Disorder who were Dispensed and Remained on an Antipsychotic Medication for at Least 80 Percent of their Treatment Period
CMHPSM will participate in state-planned and state provided data validation activities and meetings and will submit data validation documentation as required by MDHHS. mtgs. PIHPs will be provided SAA-AD data and validation template by January 31, and within 120 calendar days, return the data validation templated, completed, to DHHS

Measure P.3. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
The percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:
1. Initiation of AOD Treatment: The percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis.
2. Engagement of AOD Treatment: The percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or Medication Assisted Treatment (MAT) within 34 calendar days of the initiation visit.

CMHPSM will seek to reduce racial/ethnic disparities, reducing the disparity between the index population and at least one minority group. The measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2022 with calendar year 2023. Data will be stratified by the State by race/ethnicity and provided to PIHPs.

Measure P.4.: Increased participation in patient-centered medical homes [(PA 107 of 2013 Sec. 105d (18)]
CMHPSM will submit a narrative report to the state summarizing prior FY efforts, activities, and achievements of the CMHPSM region Contractor to increase participation in patient-centered medical homes. Information to be addressed in the narrative will include:
1. Comprehensive Care
2. Patient-Centered
3. Coordinated Care
4. Accessible Services
5. Quality & Safety

C. Shared Metrics Projects Between the CMHPSM, CMHSPs and the Michigan Medicaid Health Plans

MDHHS establishes performance indicators that are shared between the PIHPs and the Medicaid Health Plans (MHPs) to ensure collaboration and integration between Medicaid Health Plans (MHPs) and improve specific behavioral health outcomes for people served across both systems. Data includes all services, including those not funded by the PIHP and covered by Medicaid Health Plans. The state data is based on Medicaid claims data which often involves a 6-12 month delay in the data. For FY2024 these metrics include:

Care Coordination for High Risk/High Utilization:
Implementation of Joint Care Management Processes Collaboration between entities for the ongoing coordination and integration of services. CMHPSM, the Mental Health Plans (MHP), and the CMHSPs meet monthly to review consumers with high risk or high utilization of services to discuss interventions and supports to stabilize and better serve them in ways that reduce their risks. CMHPSM will ensure state required documentation of this care coordination is maintained and provided per state requirements.

For FY2024 the CMHPSM and our partner MHPs will include a process for identifying minors with appropriate severity/risk and providing care coordination of the population.

Follow-Up after Hospitalization for Mental Illness (30 days) (FUH):
1. The percentage of discharges for adults (18 years or older) who were hospitalized for treatment of selected mental illness and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days The minimum performance standard for adults is 58%.

2. The percentage of discharges for children (ages 6-17 years) who were hospitalized for treatment of selected mental illness and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days The minimum performance standard for children is 70%.

3. Racial/ethnic group disparities will be reduced for beneficiaries six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days. CMHPSM will reduce the racial/ethnic disparity between the index population and at least one minority group. Racial/ethnic group disparities will be reduced: CMHPSM will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following a psychiatric hospitalization (adults and children). Disparities are calculated using the scoring methodology developed by MDHHS to detect statistically significant differences. The measurement period will be calendar year 2023.

Follow up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence: For persons serves 13 years and older with an Emergency Department (ED) visit for alcohol and other drug dependence that had a follow-up visit within 30 days, CMHPSM will seek to reduce racial/ethnic disparities, reducing the disparity between the index population and at least one minority group. The measurement period for addressing racial/ethnic disparities will be a performance comparison of calendar year 2022 with calendar year 2023. Data will be stratified by the State by race/ethnicity and provided to PIHPs and MHPs.

See the CMHPSM QAPIP Figure 2. FY24 Performance Measures for specific FY2024 goals.

D. Performance Improvement Projects (PIPs)

MDHHS requires CMHPSM to implement at least two PIPs each year. MDHHS chooses one based on Michigan's Quality Improvement Council recommendations. MDHHS contracts with an

external quality review (EQR) organization to monitor and review this PIP. CMHPSM chooses the second PIP based on population needs and analyses of the previous year's performance indicators.

In FY22 MDHHS transitioned to two new PI project requirements for a FY22-25 PI cycle. Project 1 describes the project required by the state that includes oversight and auditing by the external quality review entity HSAG. For Project 2 the state description is less prescribed and not federally audited, with PIHP's able to choose a project that addresses local needs. In reviewing Performance Improvement Project (PIP) topics for the new FY22-25 cycle, MDHHS and HSAG recommended the FY22-25 PIP topic focus on the reduction of racial and ethnic disparities in healthcare and health outcomes, and for the PIHPs to conduct a PIP that includes identification of a measure or performance area where there is a disparity and focus on efforts to eliminate those disparities. Where racial and ethnic disparities occur, the PIP focus would need to include these disparities. Where racial and ethnic disparities do not occur, PIHPs are expected to focus on reducing other health disparities among other identifiable populations with poor health outcomes or access issues, or improvement in consumer engagement with a focus on retaining beneficiaries in treatment and service.

In the literature review conducted for this topic, studies show individuals with greater health or social service needs are at higher risk for not attending an initial appointment for treatment and are more likely to have mental health risk factors, greater use of emergent or medical services, and legal problems. This suggests the need for greater outreach, and an assumption that persons served who do not show up for an initial assessment are in as much or greater need of services and supports as those who do present for care.

1. Reducing Racial Disparities Specific to No-Shows for the Initial Biopsychosocial Assessment (BPS) in Individuals Accessing CMH services

Project Description: This project aims to reduce the disparity in no-shows related to MMBPIS indicator 2a. CMHPSM found disparities with this indicator between White/Caucasian and Black/African American populations. Therefore, CMHPSM will implement interventions to reduce these disparities between the two populations in the percentage of no-shows to a biopsychosocial assessment within 14 days of a non-emergency request for services. This Performance Improvement Project will be measured by HSAG.

2. Overall increase in performance in new persons receiving a completed bio-psycho-social initial assessment within 14 calendar days of a non-emergency request for service.

Project Description: This project aims to increase the percentage of new persons during the quarter receiving a completed bio-psycho-social assessment within 14 calendar days of a non-emergency request for service for all populations. CMHPSM also focuses on MMBPIS Indicator 2 and will implement interventions to improve this overall rate while supporting PIP #1 (reducing the disparity in no-shows for this indicator).

E. Critical Incidents (CIs), Sentinel events (SEs), Unexpected deaths (UDs), and Risk Event (RE) Management

Structure

The Regional CPT Committee reviews and analyzes data related to critical events, sentinel events, and risk events reported by CMHSPs and SUD providers, including that which qualifies as "reportable events" according to the MDHHS Critical Event Reporting System. Event data is analyzed current trends and trends over time, , appropriate use of root cause analyses, monitor action plans and corrective action plans (CAP) related to events data, determine educational needs, and verify compliance with policy and procedures. Sentinel events and identified trends may require a root cause analysis and a CAP to prevent future occurrences. Critical and sentinel event reporting is required per the MDHHS-CMHPSM contract.
CMHPSM ensures that each CMHSP/SUD provider has a system in place to monitor these events, utilizing staff with appropriate credentials for the scope of care, and reporting or follow up within the required timeframes.

Regional Policies:
Regional Critical Incident, Sentinel Event, and Risk Event Policy
Regional Performance Improvement Policy
https://www.cmhpsm.org/regional-policies

Reporting

Critical incidents. sentinel events, risk events, and unexpected deaths that occur in the region are reported to the state by CMHPSM within MDHHS required timeframes via the regional EHR incident and critical event reporting systems, with a direct feed to the state CRM. Reporting includes those receiving mental health or substance use services who are in residential settings in CRCT. CMHPSM also reports SUD Sentinel Event data to MDHHS in accordance with Schedule E Reporting Requirements of the MDHHS-PIHP contract. Data on critical incidents is reported to MDHHS monthly.

High-risk events that have a critical impact are reported to the state directly and more immediately. This includes specific types of death and specific types of provider network changes.

Critical incidents that are also risk events Include language to support that residential treatment providers (both SUD and MH) prepare and file CIs reports.
CMHPSM delegates the responsibility of the review and follow-up of sentinel events, critical incidents, and other risk events that put people at risk of harm to the CMHSPs and SUD providers.

Risk events are monitored by the providers and include actions taken by individuals receiving services as defined by MDHHS
• Actions taken by individuals who receive services that cause harm to themselves.
• Actions taken by individuals who receive services that cause harm to others.
• Two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period.

CMHSPs report suicide deaths, non-suicide deaths, arrests, emergency medical treatment and/or hospitalization for injuries and medication errors for required populations as defined by MDHHS. Additionally, subcategories reported for deaths include accidental/unexpected and homicide. Subcategories for emergency medical treatment and hospitalizations include those injuries from the use of physical management.
SUD Providers, including but not limited to residential providers, review and report deaths, injuries requiring emergency medical treatment and/or hospitalization, physical illness requiring hospitalization, serious behavioral issues, medication errors, and arrests and/or convictions as defined by MDHHS.
Reporting includes analysis is used to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents.

Addressing Quality of Care
CMHPSM and CMHSPs report critical events through the state CRM system and the incident reporting process. All CMHPSM providers are responsible to review critical incidents within three days of the occurrence to determine if the incident is a sentinel event. Once appropriately qualified and credentialed staff identify an incident as sentinel, a root cause analysis/investigation is to commence within 2 business days of the identification of the sentinel event. Following completion of a root cause analysis, or investigation, the CMHSP/SUD Provider will develop and implement either a plan of action to address immediate safety issues, an intervention to prevent further occurrence or recurrence of the adverse event, or documentation of the rationale for not pursuing an intervention. The plan shall address the staff and/or program/committee responsible for implementation and oversight, timelines, and strategies for measuring the effectiveness of the action.

CMHPSM ensures compliance of delegated functions related to sentinel events, including meeting timeframes, utilization of root cause analyses, staff credentials, and corrective actions through CMHPSM monitoring processes. Following review, CMHPSM recommends improvements, identifies educational needs for staff and providers, and monitors compliance related to critical incidents.

CMHPSM providers are responsible to report any death that occurs as a result of staff action or inaction, subject to recipient rights, licensing, or police investigation within 48 hours of the death or receipt of the notification of the death and/or investigation.

Following immediate event notification to the MDHHS the PIHP will submit to the MDHHS, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within one year of the individual's discharge from a State-operated service.

In the event of a death of a person served within one year of discharge from a state-operated service, CMHPSM immediately notifies MDHHS and submits a written report of its analysis of the death within 60 days after the month in which it occurred.

Monitoring/Review
CMHPSM and the CMHSPs use both qualitative and quantitative methods to review Critical Incidents, Sentinel Events, and Risk events for both mental health and substance use disorder (SUD) services, including persons in CMHSP SUD contractual residential settings and those identified as LTSS.

The CMHPSM completes quarterly monitoring and reviews of these events for assessments of compliance and performance improvement opportunities. A review includes analyses of provider and member trends, causal factors (performance improvement opportunities), and compliance with CMHPSM policy and procedures. CMHPSM also reviews biannual reports of critical incidents related to persons served by SUD providers services. The CMHPSM provides to MDHHS, upon request, documentation of the quarterly review process for critical incidents, sentinel events, and risk events. Event analysis includes:

- Quantitative and qualitative analyses.
- Review of the details of and commonalities between events.
- Member-specific, provider-specific, and systemic trends.
- Incorporation of events related to SUD providers and members receiving SUD services.
- A review of data per event type per 1,000 members in order to conduct a comparative analysis between CMHSPs and providers.
- Conducting an in-depth review of CMHSPs and providers who consistently report minimal or no critical incidents, sentinel events, and risk events.
- Ensuring reporting requirements are standardized between CMHSPs and providers to allow the PIHP to easily aggregate the data.

During FY24 CMHPSM will implement the data enhancements created by a CMHPSM regional workgroup in FY23 to improve the quality of the data, create guidance materials for staff completing data entry, and review opportunities for technical supports with data reporting that has been a manual process.

F. Behavioral Treatment Review

Structure
Each CMHSP has a Behavior Treatment Committee (BTC) responsible for implementing state and federal BTC requirements. Chairpersons of each committee ensure BTC data elements are reported to the CMHPSM.

<u>Regional Policy:</u>
Behavior Treatment Committee Policy

Reporting
Each local CMHSP conducts quarterly reviews of data on behavior treatment where intrusive or restrictive techniques have been used and when physical management or involvement of law enforcement were used in a behavioral emergency. Only the techniques permitted by the Technical Requirement for Behavior Treatment Plans and those that have been approved during person-centered planning by the member or his/her guardian may be used with members. Data includes:

BTC Indicator/Performance Measure
1. Positive behavioral supports pursued prior to restrictive techniques
2. Positive interventions and supports are used prior to any modifications to the person-centered service plan
3. Less intrusive methods of meeting the need that have been tried but did not work.
4. Medications being given for behavioral reasons (no MH dx to justify) have BTC review
5. Ensure documentation of individualized assessed need, description of the condition directly proportionate to the specific assessed need, and service plan
6. Intrusive or restrictive techniques were approved/consented by consumer/guardian
7. Behavior Treatment Plan is reviewed at least quarterly
8. Regular collection and review of data to measure the ongoing effectiveness of the modification.
9. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
10. Assurance that interventions and supports will cause no harm to the member.
11. Process for reviewing service plans related to a modification due to a member's physical need or due to restrictions of another individual residing in the home.
12. If emergency interventions were used three or more times in a 30-day period, BTC has reviewed the IPOS for potential modifications to reduce recurrence.

The CMHSP's monitor whether the intrusive or restrictive techniques were approved, and consent given by the person served or guardian in the Person-Centered Plan and permitted by the MDHHS Technical Requirement for Behavior Treatment Plans.

BTC data collection includes that in cases where an increase of 3 or more such techniques were used within a 30-day period, the BTC committee reviews the individual's case within 30 days for any potential modifications to the individual's plan of service that could reduce the use of such techniques.

BTC Chairpersons of each CMHSP ensure collection and maintenance of data and report BTC data quarterly to the CMHPSM Compliance/Quality Manager. The CMHPSM Compliance/Quality Manager works collaboratively with BTC Chairpersons to ensure the analysis of this data and provide reports and recommendations for potential PI projects to the Regional CPT Committee.

Monitoring/Review

The Regional CPT Committee reviews CMHPSM data analysis and reporting of BTC performance measures.

The CMHPSM site reviews and auditing of delegated functions includes CMHSP compliance with BTC performance measures at least annually, and more frequently if performance improvements projects are implemented, as determined by the project development process.

G. Clinical Practice Guidelines

Structure

The Regional CPT Committee ensures the review and updates of clinical practice guidelines (CPGs).Adherence to provide use of clinical practice guidelines is monitored by CMHSPM annual review of CMHSP and SUD providers and delegated to CMHSPs for any relevant sub-contractual provider service provision.

Regional Policy:
Clinical Practice Guidelines Policy

Reporting
CMHPSM, through the Regional CPT Committee, assures reporting and communication of CPGs to persons served and the provider network through communication plans and informational materials overseen by relevant regional committees.

Monitoring/Review
CMHPSM ensures implementation of processes for the adoption, development, implementation, and continuous monitoring and evaluation of practice guidelines when there are nationally accepted, or mutually agreed-upon (by the MDHHS and the PIHPs) clinical standards, evidence-based practices, practice-based evidence, best practices, and promising practices that are relevant to the individuals served.

The Regional CPT Committee reviews the Clinical Practice Guidelines at least every 6 months and on an as needed basis if new guidelines are approved or required. CPT recommends a clinical practice for use within the network only when such practices are evidence-based or represent the consensus of health care professionals. Additionally, recommended practices will be based on the needs of the persons served by our region.

The Regional CPT Committee makes recommendations to adopt new CPGs to the Regional Operations Committee (ROC). ROC determines whether the recommended practice(s) will be adopted, require regional implementation, or will be locally implemented. Once ROC adopts a practice, the affiliates develop and disseminate an implementation plan to affected providers and to members upon request.

H. Utilization Management

Structure
CMHPSM and CMHSPs are responsible for utilization management and review procedures to evaluate medical necessity, criteria used, information sources, and service decisions of persons served in accordance with federal and state requirements, including but not limited to the MI Mental Health Code and the MI Medicaid Provider Manual.

All CMHSPs and applicable regional providers are required to follow federal and state mental health parity requirements, which include use of the following assessments to determine level of care needs for persons served:
American Society of Addiction Medicine (ASAM) – for adults and adolescents with a substance use disorder.
Child, Adolescent Functional Assessment Scale (CAFAS) – for the assessment of children 7 to 18 years of age with suspected serious emotional disturbance.

Devereux Early Childhood Assessment (DECA) - for the assessment of infant mental health services for infants and young children, 1 month to 47 months, with suspected serious emotional disturbance.
Preschool and Early Childhood Functional Assessment Scale (PECFAS) – for the assessment of young children, 4 to 7 years of age, with suspected serious emotional disturbance.
Level of Care Utilization System (LOCUS) - for adults age 18/21 and up with a mental health diagnosis.
Milliman Care Guidelines (MCG) for Behavioral Health – for adults and children in need of acute behavioral healthcare services such as an inpatient stay.

All CMHSPs are required to follow the parity program that was developed by CMHPSM per state requirements, according to the regional parity parameters and complying with documentation required in the regional EHR. The parity parameters were programmed into the regional EHR during FY24.

Oversight and monitoring of the process used to review and approve the provision of medical services is conducted by the CMHPSM including the Regional Utilization Review (UR)/Utilization Management (UM) Committee. The Regional UM/UR Committee purpose is to ensure the most efficient and effective use of clinical care resources, to support the utilization management process, and to review service delivery patterns that include underutilization, over utilization, analysis of trends in service delivery and health outcomes over time, and high risk, high volume, and high-cost services. The Regional UM/UR Committee also conducts analysis of compliance with the regional parity program.

The committee continuously monitors and improves the utilization review process, identifies, and corrects over- and under- utilization and ensures appropriate and cost-efficient utilization of services. The committee reviews and analyzes aggregated case record data to ensure medical necessity and appropriateness of care, including persons served with special health care needs and those with long-term supports and services.

Reporting
UM/UR related data is entered in a shared regional electronic health record (EHR) called CRCT. This includes service decisions, service authorizations and denials, grievances, appeals, claims submission, and claims management and data reporting.

The UM/UR Committee reports data analysis and recommendations relevant to PI projects and workplan items to Regional CPT Committee, and to the Regional RCAC committee for feedback and suggestions for interventions or improvements.

Monitoring/Review
The CMHPSM Utilization Management and Utilization Review Committee (UM/UR Committee) develops and monitors coverage criteria for services provided to populations served. This includes oversight of the implementation of regional requirements related to service decisions, adverse benefit determinations, internal and state level consumer appeals processes, state parity requirements, and the regional parity program that was developed during FY20-FY22 and implemented at the onset of FY23 by the Regional Parity Workgroup.

The UM/UR Committee's FY24 review of the region's compliance with he parity program will include the use of the LOCUS assessment therefore monitoring of fidelity to the LOCUS will be incorporated into the parity program analysis and the previous LOCUS project will be discontinued for FY24.
The CMHPSM includes CMHPSM UM/service decisions in its annual monitoring of CMHSPs and reports these findings to relevant regional committees and the CMHPSM Board as part of the QAPIP Evaluation.

Utilization Review Decisions
Utilization review of services can be prospective, concurrent, or retrospective. CMHPSM requires that utilization review decisions delegated to the CMHSPs are made by qualified professionals and based on medical necessity. The service authorization and utilization review systems in the shared EHR ensure the reasons for decisions are documented and available to persons served in a timely manner, along with a description of due process/appeals rights when services are denied or there is a disagreement or dissatisfaction with service provision.

For FY24 the committee will review an over utilization and underutilization project.
The over utilization project reviews inpatient recidivism as potential overutilization of a higher level of care
The underutilization project consists of assessing HSW members not receiving monthly services that qualify them for HSW enrollment as potential underutilization, including potential risks of maintaining HSW enrollment with the ending of public health emergency and subsequent enrollment exceptions.

The UM/UR Committee will be available in FY24 to review any risk issues with high cost or high utilization, service decisions or service utilization, or high risk issues of service provision as needed in FY24 such as Community Living Supports (CLS), if data review for the year indicates a need.

With the regional implementation of a parity program in FY23, the UM/UR Committee will conduct analysis on compliance with the program for all populations relevant to state parity requirements, as well as patterns and percentages of parity exceptions that made require modifications to the system.

The committee will include review of consumer and provider satisfaction in this analysis by way of grievances and appeals submitted by person served, and provider appeals of claims denials to assist in evaluating the effectiveness of UM decisions.

Where indicated, the UM/UR Committee will recommend and develop training needs for staff making or reviewing service decisions.

I. Vulnerable Individuals

CMHPSM assures the health and welfare of the region's person served by establishing standards of care for individuals served. CMHPSM defines vulnerable people as individuals who have

functional limitations and/or chronic illnesses. Each CMHSP /SUD Provider shall have processes for addressing and monitoring the health, safety and welfare of all individuals served.

CMHPSM ensures that long term supports and services are consistently provided in a manner that considers the health, safety, and welfare of consumers, family, providers, and other stakeholders. When health and safety, and/or welfare concerns are identified, those concerns will be acknowledged, and actions taken as appropriate.

CMHPSM assesses the quality and appropriateness of care furnished by monitoring of population health through data analytics software to identify adverse utilization patterns and to reduce health disparities, and by conducting individual clinical chart reviews during program specific reviews to ensure assessed needs are addressed and in the individual's plan of service using practices that adhere to person centered and self-determination principles, and during transitions between care settings.

CMHPSM monitors compliance with federal and state regulations annually through a process that may include any combination of desk review, site review verification activities and/or other appropriate oversight and compliance enforcement strategies, as necessary. CMHSP organizations and SUD Providers that are unable to demonstrate acceptable performance may be subject to additional PIHP oversight and intervention.

CMHPSM oversight includes a Regional Waiver Coordinator that monitors regional compliance with persons served within the Home and Community Based Services Waiver and/or enrolled in (c) waivers to ensure health, safety, and welfare concerns are prevented or addressed in assessing and providing for their needs.

J. Long-Term Services and Supports (LTSS)

CMHPSM is committed to ensuring efforts to support community integration for members using LTSS and creating improvements in the quality of healthcare and services for members as a result of QAPIP activities and incorporates those served within the Home and Community Based Services (HCBS) waiver and those receiving 1915(i) services that are fundamental to persons served in achieving their desired goals and outcomes.

CMHPSM ensures that long term supports and services are consistently provided in a manner that considers the health, safety, and welfare of consumers, family, providers, and other stakeholders. When health and safety, and/or welfare concerns are identified, those concerns will be acknowledged, and actions taken as appropriate. CMHPSM assesses the quality and appropriateness of care furnished by monitoring of population health through data analytics to identify adverse utilization patterns and to reduce health disparities, and by conducting individual clinical chart reviews during program specific reviews to ensure assessed needs are addressed and in the individual's plan of service and during transitions between care settings. CMHPSM monitors compliance with federal and state regulations annually through site review verification activities and/or other appropriate oversight and compliance enforcement strategies, as necessary. CMHSP organizations and SUD Providers that are unable to demonstrate acceptable performance may be subject to additional PIHP oversight and intervention.

CMHPSM incorporates the identification of persons using LTSS in data analysis, including QAPIP projects where applicable and possible, such as critical incidents, sentinel events, risk events, behavior treatment, member satisfaction results, practice guidelines, credentialing and recredentialing, verification of Medicaid services, over- and underutilization, provider network capacity and monitoring, trends in service delivery and health outcomes over time, and monitoring of progress on performance goals and objectives. LTSS is defined as those persons functional limitations and/or chronic illnesses that support their goals of being a participant in their community in ways meaningful to them, and the supports and services that assist in this aim.

K. Member Experience with Services

Consumers receiving services funded by CMHPSM and organizations providing services to persons served are surveyed by CMHPSM at least annually using a standardized survey or assessment tool. The tools vary in accordance with service population needs, address quality, availability, and accessibility of care. Focus groups are conducted as needed to obtain input on specific issues. Consumers may also be queried by the CMHSPs/SUD providers regarding the degree of satisfaction via periodic reviews of the status of their person-centered plans, as well as during discharge planning for the cessation or transition of services. Data used to assess stakeholder and member experiences include but are not limited to the following; in-person surveys, focus groups, town halls, web-based surveys, phone surveys, grievance data, appeals data.

The aggregated results of the surveys and/or assessments are collected, analyzed and reported by Regional Customer Service Committee to the Regional CPT Committee, Regional Consumer Advisory Council, and other relevant committees/councils, who identify strengths, areas for improvement and make recommendations for action and follow up as appropriate. Regional benchmarks and/or national benchmarks are used for comparison when available. The data is used to identify best practices, demonstrate improvements, or identify growth areas. The Regional CPT Committee, RCAC, and CMHPSM Board determines appropriate action for improvements. The findings are incorporated into program improvement action plans as appropriate. The CMHSPs/SUD providers take action on individual cases, as appropriate, to identify and investigate sources of dissatisfaction and determine appropriate follow-up.

Survey or assessment results are included in the annual PIHP QAPIP Report and presented to the CMHPSM governing body and Regional Consumer Advisory Council including recommendations and pursuit of governing body feedback on recommendations. Survey and assessment results are presented to CMHSPs and SUD Providers and are accessible on the CMHPSM website. Findings are also shared with stakeholders on a local level through such means as advisory councils, staff/provider meetings and printed materials.

Regional Customer Services: Consumer Satisfaction Survey

CMHPSM conducts periodic quantitative (surveys) and qualitative (focus groups) assessments of consumer experiences (including those receiving long-term supports). These assessments are

representative of the persons served, and services and supports offered. A random sample of persons served, families and/or guardians from all populations served will be asked to participate in customer satisfaction surveys. Other types of surveys/focus groups may be general or population specific depending on the topic or interventions developed from PI projects.

The Regional Customer Service committee collects and analyzes the data to address issues of quality, availability, and accessibility of care. Analysis includes:

- All activities to assess member experience with services such as all member satisfaction surveys, focus groups, member interviews, feedback from the consumer advisory council, member grievances, appeals etc.
- National surveys and how the PIHP compares to national benchmarks.
- Identifying an area (or areas) of focus across all activities to target action steps and interventions to improve satisfaction.
- An evaluation of the previous year's action steps and interventions to determine if they led to improved satisfaction.
- Challenges or barriers in achieving member satisfaction goals.
- Year-to-year comparison of activity results; area(s) of focus could be directed toward a year-to-year decrease in member satisfaction in a particular area.
- Should member satisfaction goals be achieved and sustained over a period of time, make revisions to the mechanisms for assessing member experience, such as identifying new member satisfaction surveys or developing new satisfaction questions; revise sampling methodology; and initiate new activities to assess satisfaction.
- Activities and findings specific to members receiving LTSS or home-and community-based services (HCBS).
- National Core Indicators (NCI) survey results. While not specific to PIHPs, the committee will assess the results to identify and investigate regional/local areas of dissatisfaction and implement interventions for improvement.

For FY24 the CMHPSM will explore the use of surveys, and other opportunities for the voice of persons served, in the analysis and implementation of PIP Project 1 and PI Project 2 relevant to access to the initial intake described in Section VI of this plan.

As a result of the analyses, performance improvement projects and corrective actions are implemented, CMHPSM and CMHSP Boards, Consumer Advisory Committees, persons served, and provider informed of assessment results and any subsequent recommendations and interventions. The Board and Consumer Advisory Consumer are also requested to provide feedback and recommendations relevant to the assessment or future surveys.

Recovery Self-Assessment (RSA)

While the RSA is no longer a state requirement, each year the Regional Co-Occurring Workgroup reviews if there is an equivalent survey the region could implement that would address the value-added elements of the RSA, and to date has not yet found such an equivalent. The workgroup will continue to explore an equivalent alternative annually, while deciding whether to continue the RSA each year.

For this fiscal year CMHPSM will continue to distribute the Recovery Self-Assessment-Revised survey (RSA-R) (O'Conell, Tondora, Croog, Evans, &Davidson, 2005) to the contracted providers in its four-county region that use the Recovery Oriented System of Care (ROSC) model. "A ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with a risk of alcohol and drug problems" (SAMHSA, 2010). The survey is distributed to survey Lenawee, Livingston, Monroe, and Washtenaw counties. The CMHPSM seeks to accurately assess and measure the effectiveness of Substance Use Disorder (SUD) and Community Mental Health (CMH) providers in the implementation of recovery focused services from the perspective of clients, provider staff, and administrative staff. Current fiscal year data is analyzed to include year-to-year comparisons and long-term trends from at least the last five years. Survey questions use a 5-point Likert Scale (1 = Strongly Disagree; 2 = Disagree; 3 = I am neutral; 4 = Agree; 5 = Strongly Agree; N/A = Not Applicable; D/K = Don't Know) and include a comment box.

Oversight, monitoring and reporting of RSA survey data and results is conducted by the Regional Co-Occurring Workgroup, which reports to the Regional CPT Committee. Each CMHSP develops a work plan based on survey findings, to focus on local planning of improvements.

Survey or assessment results are included in the annual PIHP QAPIP Report and presented to the CMHPSM governing body and Regional Consumer Advisory Council including recommendations and pursuit of governing body feedback on recommendations. Survey and assessment results are presented to CMHSPs and SUD Providers.

VII. Provider Standards

A. Provider Qualifications

Structure

CMHPSM has established written policy and procedures, in accordance with MDHHS's Credentialing and Re-Credentialing Processes, for ensuring appropriate credentialing and re-credentialing of the provider network. Whether directly implemented, delegated or contracted, CMHPSM shall ensure that credentialing activities occur upon employment/contract initiation, and minimally every two (2) years thereafter. CMHPSM written policies and procedures also ensure that non-licensed providers of care or support are qualified to perform their jobs, in accordance with the Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services & HCPCS/CPT Codes chart.

Credentialing/recredentialing, privileging, primary source verification, and qualification of organizational providers is delegated to CMHSPs/SUD Provider staff and their contractors CMHPSM monitors the CMHSP and SUD Provider compliance with federal, state, and local regulations and requirements at least annually through desk review, site review verification activities and specific performance improvement projects.

CMHPSM policies and procedures are established to address the selection, orientation, and training of directly employed or contracted staff. PIHP employees receive annual reviews of

performance and competency. Individual competency issues are addressed through staff development plans. CMHPSM is responsible for ensuring that each provider, employed and contracted, meets all applicable licensing, scope of practice, contractual, and Medicaid Provider Manual requirements, including relevant work experience and education, and cultural competence. The CMHSPs/SUD Providers are responsible for the selection, orientation, training and evaluation of the performance and competency of their own staff and subcontractors

All CMHSPs and the CMHPSM use the same electronic system for provider management operations and data entry, credentialing and recredentialing processes, boilerplate contracts, and monitoring tools developed collaboratively with PIHP oversight to ensure compliance with state and federal requirements.

Regional Network Management Committee
The committee is responsible for overseeing policies and procedures that address the selection, orientation, training, and qualifications of directly employed or contracted staff for CMHSPs and organizational providers.
Regional Network Management is involved the development of an annual Network Adequacy Plan, and oversees capacity and performance

Regional LIP Committee
The CMHPSM conducts credentialing and re-credentialing reviews of LIPs for the region through review by the CMHPSM Regional LIP Committee.

Regional Policies
Organizational Credentialing/Recredentialing and Monitoring Policy
Credentialing for Licensed Independent Providers Policy
Employee Competency and Credentialing Policy

Reporting
Regional Network Management reports to ROC including factors of procurement, performance, and capacity of the provider network, and provides performance improvement reporting to relevant committees such as Regional CPT Committee.

Monitoring/Review
CMHPSM uses a written contract to define its relationship with each CMHSP and providers. The contract template and monitoring template for sub contractual providers is used by all four CMHSPs in their sub contractual relationships with providers. The contract requires compliance with federal and state laws and the CMHPSM contract with MDHHS. CMHPSM and the CMHSPs regularly monitor its provider network through audits and screenings—in accordance with written policies and procedures, contractual requirements, and regulations. For example, CMHPSM verifies that service delivery is performed by qualified employees. When providers fail to meet the standards established by CMHPSM, federal and state laws, and/or the MDHHS contract, they are required to complete a Corrective Action Plan (CAP). CMHPSM approves and monitors progress on CAPs. Further, provider monitoring, and CAPs are subject to review by MDHHS. Finally, if fraudulent services for billing, waste, and abuse are discovered, CMHPSM will take appropriate

actions including conducting investigations, recouping overpayments where indicated, and/or reporting to the Office of Inspector General.

Contracts and monitoring tools are updated to include regulatory or practice changes, areas of risk, or trends found with provider performance.

CMHPSM will conduct annual reviews of how CMHSPs ensure internal and external providers determine that healthcare professionals, who are licensed by the State and who are employees of or under contract to CMHPSM are qualified to perform their services, and how CMHSPs ensure non-licensed internal and external providers of care or support are qualified to perform their jobs. This is conducted by reviews of CMHSPs documentation of internal/directly employed staff qualifications as well as evidence sub contractual organizational provider monitoring to ensure compliance with provider qualifications.

Network Adequacy Plan: In accordance the MDHHS PIHP contract and federal regulations 42 CFR §438.207 §438.68 and §438.206(c)(1), must provide documentation on which the State bases its certification that Contractor complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network as referenced in 42 CFR Page 37 of 139 Parts 438.604(a)(5); 438.606; 438.207(b) and 438.206. d. CMHPSM PIHP conducts a network adequacy plan in conjunction with the regional Network Management Committee that assesses at minimum:

- Assurance of sufficient amount and scope of a qualified provider network that meets the service array and needs of the populations served that is sufficient in numbers, mix, and geographic locations throughout region for the provision of all covered services.
- Assurance the provider network meets Home and Community Based Service Waiver requirements around choice and access for persons served that provides integrated experiences in their community in areas of provider choice, choice in place and type of residence, choice in place and type of vocational or community opportunities, and freedom to direct their resources.
- Considers anticipated enrollment and expected utilization of services.
- Timely appointments, including MMBPIS and appointment standards for its SUD priority populations.
- Language, including an assessment of languages spoken by its membership and its provider network, and an analysis of the use of interpreter services.
- Cultural competency, including an assessment of the cultural and ethnic make-up of its membership and the capability of its provider network to meet the needs of its members.
- Physical accessibility, including an analysis of provider types who can or cannot provide physical accessibility to members with disabilities.

B. Credentialing and Recredentialing

CMHPSM has established written policy and procedures, in accordance with MDHHS's Credentialing and Re-Credentialing Processes, for ensuring appropriate credentialing and re-credentialing of the provider network. Whether directly implemented, delegated or contracted, CMHPSM shall ensure that credentialing activities occur upon employment/contract initiation, and minimally every two (2) years thereafter.

CMHPSM written policies and procedures also ensure that non-licensed providers of care or support are qualified to perform their jobs, in accordance with the Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services & HCPCS/CPT Codes chart.

Credentialing, privileging, primary source verification and qualification of staff who are employees of CMHPSM, or under contract to the PIHP, are the responsibility of CMHPSM. Credentialing, privileging, primary source verification, assessment of provider quality indicators, and assuring qualification of CMHSP/SUD Provider staff and their contractors is delegated to the CMHSP Participants/SUD Providers.

Competence for all CMHSPM and CMHSP employees is assessed at the time of hire and annually thereafter. Employees must meet qualifications for education, work experience, cultural competence, and certification or licensure as required by law. CMHSPs and CMHPSM also provide training and continuing education for staff development. Before assigning clinical responsibilities, the CMHSP/SUD Provider verifies identity, applicable licensure, training, and other evidence of the ability to perform the assigned responsibilities.

CMHPSM monitors the CMHSPs and SUD Provider compliance with federal, state, and local regulations and requirements annually through an established process including desk review, site review verification activities and/or other appropriate oversight and compliance enforcement strategies. CMHPSM policies and procedures are established to address the selection, orientation, and training of directly employed or contracted staff. PIHP employees receive annual reviews of performance and competency. Individual competency issues are addressed through staff development plans. CMHPSM is responsible for ensuring that each provider, employed and contracted, meets all applicable licensing, scope of practice, contractual, and Medicaid Provider Manual requirements, including relevant work experience and education, and cultural competence. The CMHSPs/SUD Providers are likewise responsible for the selection, orientation, training and evaluation of the performance and competency of their own staff and subcontractors.

Oversight of credentialing activities is conducted by the Regional Network Management and LIP Committees, including analysis and reporting of trends in provider performance and capacity/ service delivery over time, including collaboration with Regional CS Committee and regional CPT Committee on whether there have been improvements and barriers impacting in the quality of health care and services for members.

All CMHSPs and the CMHPSM use the same electronic system assessment, and monitoring tools for provider management operations and data entry, credentialing and recredentialing processes, and boilerplate contracts, collaboratively within Regional Network Management and LIP Committees with PIHP oversight to ensure compliance with state and federal requirements.

CMHPSM conducts regular audits of CMHSPs and providers to ensure compliance with staff qualifications and credentialing/recredentialing requirements.
For FY24 credentialing/recredentialing performance improvement projects will be conducted and reported to the Regional Network Management Committee. The PIHP will continue to review samples of credentialing and recredentialing cases to ensure compliance with policy and

state/federal requirements for organizational licensed/non-licensed staff, LIPs and CMHSP licensed and non-licensed staff.

C. Verification of Services

CMHPSM has established a written policy and procedure for conducting site reviews to provide monitoring and oversight of the Medicaid and Healthy Michigan funded claims/encounters submitted within the provider network. CMHPSM verifies the delivery of services billed to Medicaid and Healthy Michigan in accordance with federal regulations and the state technical requirement.

Medicaid Services Event Verification for Medicaid and Healthy Michigan Plan includes testing of data elements from the individual claims/encounters to ensure the proper code is used for billing; the code is approved under the contract; the eligibility of the beneficiary on the date of service; that the service provided is part of the beneficiaries individualized plan of service (and provided in the authorized amount, scope and duration); the service date and time; services were provided by a qualified individual and falls within the scope of the code billed/paid; the amount billed/paid does not exceed the contract amount; and appropriate modifiers were used following the HCPCS guidelines.

Data collected through the Medicaid Event Verification process is aggregated, analyzed, and reported for review at Regional CPT Committee and Regional Compliance Committee meetings, and opportunities for improvements at the local or regional level are identified. The findings from this process, and any follow up needed, are reported annually to MDHHS through the Medicaid Event Verification Service Methodology Report.

Regional Policies
Service Verification Policy
Services Suited to Condition Policy

D. Cultural Competence

CMHPSM and its provider network are committed to linguistic and cultural competence that ensures access and meaningful participation for all people in the service area. Such commitment includes acceptance and respect for the cultural values, beliefs and practices of the community, as well as the ability to apply an understanding of the relationships of language and culture to the delivery of supports and services.

Competence includes a general awareness of the cultural diversity of the service area including race, culture, religious beliefs, regional influences in addition to the more typical social factors such as gender, gender identification, sexual orientation, marital status, education, employment and economic factors, etc.

Regional Policies

Culturally and Linguistically Relevant Services Policy
Customer Services Policy

CMHPSM and its providers participate in efforts to achieve cultural competence in the following ways (but not limited to):

- Providing language and communication assistance to support persons full and meaningful access and participation in services.
- Ensuring that cultural and language needs are discussed with persons served initially and as needed but at least annually.
- Authorize or make recommendations for specialty services for speech, language, hearing, and cultural service needs.
- Evaluate effectiveness of a referral and person's satisfaction with the services.
- Incorporating cultural competence in performance improvement processes
- Incorporating feedback and recommendations from governing boards and consumer advisory committees on areas of improvement.
- Requiring the CMHPSM, CMHSPs and contract service providers to have practices and procedures in place for persons served to identify and request the need for interpretive services, and services that meet cultural and linguistic needs as outlined in the person's plan of service.
- Requiring all providers to be trained in cultural competence.

E. Provider Monitoring

CMHPSM uses a standard written contract to define its relationship with CMHSPs/SUD Providers that stipulates required compliance with all federal and state requirements, including those defined in the Balance Budget Act (BBA), the Medicaid Provider Manual, and the master contract between the PIHP and MDHHS. Each CMHSP/SUD Provider is contractually required to ensure that all eligible recipients have access to all services required by the master contract between the PIHP and MDHHS, by either direct service provision or the management of a qualified and competent provider panel. Each CMHSP /SUD Provider is also contractually required to maintain written subcontracts with all organizations or practitioners on its provider panel.

SUD Providers must first obtain written authorization from CMHPSM in order to subcontract any portion of their agreement with CMHPSM. These subcontracts shall require compliance with all standards contained in the BBA, the Medicaid Provider Manual, and the Master Contract between the PIHP and the MDHHS. Each CMHSP/SUD Provider is required to document annual monitoring of each provider subcontractor as required by the BBA and MDHHS. The monitoring structure shall include provisions for requiring corrective action or imposing sanctions, up to and including contract termination if the contractor's performance is inadequate. CMHPSM continually works to assure that the CMHSPs support reciprocity by developing regionally standardized contracts, provider performance protocols, maintain common policies, and evaluate common outcomes to avoid duplication of efforts and reduce the burden on shared contractors. CMHPSM monitors compliance with federal and state regulations annually through a process that includes any combination of desk review, site review verification activities, and/or other appropriate oversight and compliance enforcement strategies. CMHSPs/SUD Providers that are unable to demonstrate acceptable performance may be required to provide corrective action, may

be subject to additional PIHP oversight and interventions, and may be subject to sanctions imposed by CMHPSM, up to and including contract termination.

All CMHSPs and the CMHPSM use the same electronic system assessment, and monitoring tools for provider management operations and data entry, credentialing and recredentialing processes, and boilerplate contracts. These processes and tools are developed collaboratively within Regional Network Management and LIP Committees with PIHP oversight to ensure compliance with state and federal requirements. Monitoring tools used are available for review upon MDHHS request.

The CMHPSM monitoring CMHSP Access systems for both CMH and SUD access services for FY24 will incorporate any barriers related to the findings of the previous years monitoring and the FY22-25 PIP. Analysis of findings, corrective action plans (CAPs) and performance improvement projects to be developed based on findings and trends of monitoring data will continue into FY24.

F. External Quality Reviews (EQR)

CMHPSM is subject to annual external reviews through MDHHS and/or an external quality reviewer contracted by MDHHS to ensure quality and compliance with all regulatory requirements. CMHPSM collaborates with MDHHS and the external quality reviewer to provide relevant evidence to support compliance.

In accordance with the MDHHS-PIHP, all findings that require improvement based on the results of the external reviews are incorporated into the QAPIP Priorities for the following year and reported to governing bodies. An action plan will be completed that includes the following elements: improvement goals, objectives, activities, timelines, and measures of effectiveness in response to the findings. The improvement plan will be available to MDHHS upon request.

CMHPSM addresses any potential performance improvement projects with relevant regional committees/workgroups and incorporates PI projects in the QAPIP where indicated.

VIII. Resources

Centers for Medicare and Medicaid, QAPI Process Tool Framework.
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapitools.

HEALTH SERVICES ADVISORY GROUP , Quality Assurance and Performance Improvement

https://www.hsag.com/QAPI

MDHHS PIHP CONTRACT, SCHEDULE A- STATEMENT OF WORK CONTRACT ACTIVITIES , Quality Improvement and Program Development (current FY24).

MDHHS PIHP CONTRACT, POLICIES & PRACTICE GUIDELINES ,, *Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans* (current version).
https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines

MDHHS MANAGED LONG-TERM SERVICES AND SUPPORTS (MLTSS)
https://www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/medicaid-providers/upcoming-initiatives/managed-long-term-services-and-supports-mltss

SAMHSA Behavioral Health Equity https://www.samhsa.gov/behavioral-health-equity

SAMHSA Addressing Disparities by Diversifying Behavioral Health Research
https://www.samhsa.gov/blog/addressing-disparities-diversifying-behavioral-health-research

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN RESOURCES, HRSA. Clinical Quality Improvement Resources
https://bphc.hrsa.gov/technical-assistance/clinical-quality-improvement

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN RESOURCES, HRSA. Performance Measurement & Quality Improvement
https://www.hrsa.gov/library/performance-measurement-quality-improvement

INSTITUTE FOR HEALTHCARE IMPROVEMENT. *Quality Improvement Essentials Toolkit*.
http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx

IX. CMHPSM Quality Assessment and Performance Improvement Program QAPIP Priorities and Workplan Priorities FY2024

The QAPIP priorities shall guide quality efforts for FY24. Figure 1 provides the QAPIP Priorities and Quality Work Plan for FY24. The FY24 QAPIP Workplan includes completion of required elements of the QAPIP, growth areas based on external site reviews, and the review of effectiveness.

QAPIP activities are aligned with the MDHHS 2023-2026 Continuous Quality Strategy Goals (https://www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/reports) and CMHPSM Strategic Plan Metrics and Milestones that support CMHPSM Mission, Vision and Values contributing to for the individuals we serve. Figure 2 provides the FY24 QAPIP Performance Measures.

Priorities that are new or revised from the previous fiscal year are highlighted in green.

A. Figure 1. FY2024 QAPIP Priorities and Work Plan

Governance	Objectives/Activities	Assigned Person or Committee/Council	Frequency / Due Date
CMHPSM Board of Directors will approve the QAPIP Plan and Report	Submit the annual QAPIP Plan to the Board. Submit the annual QAPIP Evaluation to the Board	CMHPSM COO	12/14/23 02/08/24
Board of Directors review QAPIP Progress Reports	Submit QAPIP progress reports to the Board.	CMHPSM COO	Quarterly
CMHPSM QAPIP will be submitted to Michigan Department of Health and Human Services	Submit the Board approved QAPIP Plan, Report(Evaluation), and Governing Body Form to MDHHS. (via MDHHS FTP Site)	CMHPSM Compliance/Quality Manager	2/28/24
Communication of Process and Outcome Improvements	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency / Due Date**
The QAPIP Plan and Report will be provided annually to network providers and to members upon request.	Post to the CMHPSM website. Ensure CMHSP contractors receive the QAPIP. Provide QAPIP Plan and Evaluation reporting at CMHPSM provider meetings. Communications to providers on the availability of QAPIP reports on the CMHPSM website. Communications to regional committees. Ensure Regional Customer Services Committee includes members ability to request QAPIP documents in informational materials	CMHPSM Compliance/Quality Manager CMHPSM Network Management Committee Regional Customer Services Committee	03/03/2024

Consumers & Stakeholders receive reports on key performance indicators, consumer satisfaction survey results and performance improvement projects	To present reports on QAPIP activities and performance measures to RCAC on Consumer Services reports on persons experience, satisfaction survey results, grievances, appeals, PIPs, MMBPIS, event data, quality policies/procedures and Customer Service Reports to RCAC. Incorporate RCAC feedback in interventions and recommendations related to survey data and QAPIP activities. Postings to the CMHPSM website. Ability to request information is in informational materials for consumers and stakeholders.	CMHPSM Compliance/Quality Manager Regional Customer Services Committee	Quarterly Annually Annually
Performance Measurement and Quality reports are made available to stakeholders and general public.	Post to the CMHPSM website. Ensure CMHSP contractors receive the QAPIP and inform communities of its availability on the website.	CMHPSM COO Regional NMC Committee	Annually
MDHHS Performance Indicators	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency / Due Date**
CMHPSM will meet or exceed the MMBPIS standards for Indicators 1, 4, 10 as required by MDHHS.	Complete quality checks on data prior to submission to ensure validity and reliability of data	CMHSPs CPT leads	Quarterly
	Verify Medicaid eligibility prior to MMBPIS submission. Submit MMBPIS data to MDHHS quarterly by due date.	CMHPSM Regional Data Coordinator CMHPSM CIO	Quarterly
	Conduct quarterly analysis of CMHSP and CMHPSM provider MMBPIS performance. Require and review corrective action plans where standards were not met. Oversee effectiveness of corrective action plans through monthly review of subsequent data.	Regional CPT Committee CMHPSM Compliance/Quality Manager	Monthly QAPIP data review Quarterly CAP review Q1 Feb Q2 May Q3 August Q4 November
CMHPSM will demonstrate an increase in compliance with access standards.	Monitor access requirements for priority populations, delineated by each priority population type. Establish a mechanism to monitor access requirements for persons enrolled in health homes (OHH, BHH, CCBHC).	Regional CPT Committee CMHPSM Compliance/Quality Manager CMHPSM SUD Services Director	Monthly QAPIP data review Quarterly CAP review Q1 Feb Q2 May Q3 August

			Q4 November
CMHPSM will show an increase in compliance with access standards for SUD priority populations	Conduct quarterly analysis of CMHSP and SUD provider performance of access standards for priority populations. Data analysis to delineate performance by each priority population. Develop baseline measure and performance expectations specific to each priority population as well as overall access. Require and review corrective action plans where standards were not met. Oversee effectiveness of corrective action plans through monthly review of subsequent data. Incorporate SUD care navigator position to meet access timeliness standards for SUD priority populations. Warm hand off challenge. Hiring PP care navigator – increase access timeframes to timeliness standards	Regional CPT Committee CMHPSM Compliance/Quality Manager CMHPSM SUD Services Director	Monthly QAPIP data review Quarterly CAP review Q1 Feb Q2 May Q3 August Q4 November
BH-TEDS	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency / Due Date**
CMHPSM will demonstrate an improvement or maintain data quality for the BH-TEDS Implement data driven outcomes measurement to address social determinants of health	Analyze and monitor BHTEDS records to improve housing and employment outcomes for persons served. Measurement period is prior fiscal year (FY2023) look back to most recent (FY2024) prior BH-TEDS update or admission record.	CMHPSM CIO Regional EOC Committee Regional CPT Committee	Narrative report to MDHHS by 7/31/2024
	Narrative completed of BH-TEDS process and analysis to improve housing and employment outcomes for persons served for FY24 and FY25 data, including actions steps.	CMHPSM CIO	7/31/2024
Performance Improvement Projects	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency / Due Date**

CMHPSM will engage in two performance improvement projects for the FY22-25 PIP cycle: 1. Reducing Racial Disparities Specific to No-Shows for the Initial Biopsychosocial Assessment (BPS) in Individuals Accessing CMH services. 2. Overall increase in performance in new persons receiving a completed bio-psycho-social initial assessment within 14 calendar days of a non-emergency request for service.	Implement CMHPS specific interventions identified in causal barrier analysis in FY24. Conduct monthly trends and quarterly analysis of performance with PIP indicators. Determine casual barriers and factors where disparity was not reduced. Require and review corrective action plans and interventions where standards were not met. Oversee effectiveness of corrective action plans through monthly review of subsequent data.	Regional CPT Committee Regional EOC Committee CMHPSM Compliance/Quality Manager CMHPSM CIO CMHPSM Health Data Analyst	Monthly Quarterly
	Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations). Review with relevant committees/councils.	Regional CPT Committee CMHPSM Compliance/Quality Manager	Monthly data review Quarterly reporting to Regional CPT RCAC, and CMHPSM Board
	Complete and submit PIP 1 to HSAG as required for validation.	CMHPSM Compliance/Quality Manager	June/July 2024
	Complete and submit PIP 1 to MDHHS as required.	CMHPSM Compliance/Quality Manager	2/28/2024
Quantitative and Qualitative Assessment of Member Experiences	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency / Due Date**
CMHPSM will obtain a qualitative and quantitative assessment of member experiences for all representative populations, including members receiving LTSS, and take specific action as needed, identifying sources of dissatisfaction, outlining systematic action steps and interventions, evaluating for	Develop surveys for all populations. Incorporate identification of persons receiving LTSS in survey data	Regional Customer Services Committee CMHPSM SUD Services Director	03/31/2024
	Incorporate the analysis of Michigan specific National Core Indicator Data to identify trends and areas for improvement.	Regional Customer Services Committee CMHPSM Compliance/Quality Manager	09/30/2024

effectiveness to improve satisfaction, communicating results.	Complete annual assessment of the member experience report to include the trends, causal sources of dissatisfaction, and interventions in collaboration with relevant committees/councils. Report the results of the member satisfaction survey to RCAC and CMHPSM Board for input and feedback on planned interventions.	Regional Customer Services Committee CMHPSM SUD Services Director	09/30/2024
	Conduct analysis of a potential new SUD community survey tool to replace the RSA. Continue RSA for FY244 if new survey undetermined.	CMHPSM SUD Services Director	04/30/2024
CMHPSM will meet or exceed the standard for Grievance resolution in accordance with federal and state standards.	CMHPSM will conduct quarterly monitoring of compliance with data collection/documentation that meets state and federal grievance standards, providing retraining and interventions, as needed.	CMHPSM COO CMHPSM Compliance/Quality Manager Regional Customer Services Committee	12/31/2024 Monthly Quarterly Q1 February Q2 May Q3 August Q4 November
Event Monitoring and Reporting	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency / Due Date**
CMHPSM will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths) are collected, monitored, reported, and followed up on as specified in the PIHP Contract.	Submit Critical Events monthly timely and accurately. Conduct analysis of Behavior Treatment Committee data quarterly.	CMHSPs CMHPSM Compliance /Quality Manager CMHPSM COO	Monthly Quarterly Q1 February Q2 May Q3 August Q4 November
	Submit CMH Sentinel Events (MDHHS CRM) immediate notification) to CMHPSM based on notification requirements of the event. (24 hour, 48 hours, 5 days)	CMHSPs SUD Providers	As Needed
	Submit SUD Sentinel events bi-annually as required	CMHPSM SUD Providers (Residential, Recovery Housing)	April 2023 October 2023
	Conduct oversight through SE data review and provider monitoring to ensure appropriate follow up is occurring for all events dependent on the type and severity of the event,	CMHPSM Compliance/Quality Manager	Quarterly Q1 February Q2 May

	including a root cause analysis, mortality review, immediate notification to MDHHS as applicable, and meeting required timeframes. Conduct primary source verification of critical incidents and sentinel events.	CMHPSM COO Regional CPT Committee	Q3 August Q4 November
CMHPSM will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths) are monitored and followed up on as specified in the PIHP Contract.	Conduct analysis on critical events to monitor compliance with reporting, trends, and opportunities for performance improvements.	CMHPSM Compliance/Quality Manager CMHPSM COO Regional CPT Committee	Quarterly Q1 February Q2 May Q3 August Q4 November
Medicaid Services Verification	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency / Due Date**
CMHPSM will meet or exceed a 95% rate of compliance of Medicaid delivered services in accordance with MDHHS requirements.	Complete Medicaid Event verification reviews in accordance with CMHPSM policy and procedure.	CMHPSM COO CMHPSM CFO	12/31/2024
	Complete the MEV Annual Methodology Report identifying trends, patterns, strengths and opportunities for improvement.	CMHPSM COO	12/31/2024
	Submit the Annual MEV Methodology Report to MDHHS as required	CMHPSM COO	12/31/2024
Utilization Management Plan	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency / Due Date**
CMHPSM will establish a Utilization Management Plan in accordance with the MDHHS requirements	Complete performance summary quarterly reviewing trends, patterns of under / over utilization, medical necessity criteria, and the process used to review and approve provision of medical services. Identify CMHSPs/SUDPs requiring improvement and present/provide to relevant committees/ councils.	Regional UM/UR Committee	Quarterly Q1 February Q2 May Q3 August Q4 November
	Ensure utilization of parity screening tools and admission criteria. LOCUS, CAFAS, PECFAS DECA, MCG, ASAM.	Regional UM/UR Committee Regional CPT Committee	Quarterly (parity)
	Complete analysis of parity program compliance with LOC and LOC exceptions.	Regional UM/UR Committee	Quarterly
	Oversight of compliance with policy through primary source		Quarterly

CMHPSM will demonstrate full compliance with timeframes of service authorization decisions in accordance with the MDHHS requirements.	verification during CMHPSM reviews of ABD state data reports and reviews of delegated functions of CMHSPs. Analysis of ABD data reports in meeting service decision timeframes.	Regional UM/UR Committee	Q1 February Q2 May Q3 August Q4 November
CMHPSM will meet or exceed the standard for compliance with the adverse benefit determination notices completed in accordance with the 42 CFR 438.404 Includes assurance that ABDs accurately provide service denial reasons in language understandable to person served, type of denial, accuracy of service and denial decision explanation, and compliance with timeframes	Revise ABD training for staff based on outcomes of state data reporting. Staff to complete training. Oversight of compliance with policy through primary source verification during CMHPSM reviews of ABD state data reports and reviews of delegated functions of CMHSPs.	Regional UM/UR Committee Regional UM/UR Committee	03/30/2024 Quarterly Q1 February Q2 May Q3 August Q4 November
CMHPSM will meet or exceed the standard for Appeal resolution in accordance with federal and state standards.	CMHPSM will conduct quarterly monitoring of compliance with data collection/documentation that meets state and federal appeals standards, providing retraining and interventions, as needed.	CMHPSM COO CMHPSM Compliance/Quality Manager Regional UM/UR Committee	Quarterly
Practice Guidelines	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency / Due Date**
CMHPSM will adopt, develop, implement nationally accepted or mutually agreed upon (CMHPSM/MDHHS) clinical practice guidelines/standards, evidenced based practices, best practice, and promising practices relevant to the individual served.	Review of CPGs for any updates or revisions to CPGs being utilized in the region. Update CPG list, including providers that implement/offer CPGs. Communicate available CPGs to provider networks	Regional CPT Committee CMHPSM COO Regional NMC Committee	Bi-annually or as needed if new CPGs are adopted Bi-annually March 2024 December 2024

CMHPSM will demonstrate full compliance with MDHHS required practice guidelines.	Oversight during CMHPSM reviews of managed care delegated functions to ensure providers adhere to practice guidelines as required.	CMHPSM COO CMHPSM Compliance/Quality Manager	Annually
Oversight of Vulnerable Individuals and Long Term Supports and Services	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency / Due Date**
CMHPSM will evaluate health, safety and welfare of persons served considered vulnerable and receiving LTSS order to determine opportunities for improving oversight of their care and their outcomes.	Ensure the identification of LTSS remains in all regional quality/health and safety data reporting including events data, behavior treatment data, survey data of persons experience, performance measures. Ensure LTSS populations served are incorporated in measures of provider monitoring, service authorization, and reviews of outcomes data.	CMHPSM COO CMHPSM Health Data Analyst Regional CPT Committee	Quarterly data review Q1 February Q2 May Q3 August Q4 November
Assure accurate identification of persons served within HCBS, 1915i services, and LTSS.	Conduct data analysis of completion and accuracy of HCBS and 1915i assessment and documentation in the clinical record. 90% compliance with clinical documentation of those persons qualified for HCBS/1915i identified in the EHR. 100% of 1915i recipients enrolled in MDHHA WSA Maintain identification of LTSS in data analysis.	CMHPSM COO CMHPSM Health Data Analyst Regional CPT Committee	Report analysis Quarterly Q1 February Q2 May Q3 August Q4 November
CMHPSM will assess the quality and appropriateness of care furnished to members(vulnerable people) receiving LTSS including an assessment of care between care settings, a comparison of services and supports received	Include analysis of regional committee performance reports (including barriers, improvement efforts, recommendations, and status of recommendations) for efforts to support community integration. critical incidents, sentinel events, risk events, behavior treatment plans, member satisfaction results, practice guidelines, credentialing and recredentialing, verification of Medicaid services, over and underutilization, provider network monitoring,	CMHPSM COO CMHPSM Compliance/Quality Manager Regional CPT Committee Regional CS Committee Regional NMC Committee	Quarterly Q1 February Q2 May Q3 August Q4 November
Behavior Treatment	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency / Due Date**
	Submit data on Behavior Treatment Plans where intrusive and or restrictive techniques have been approved by the	CMHPSM BTC Chairs	FY24 Quarterly February

CMHPSM will demonstrate an increase in compliance with Behavior Treatment data collection and analysis.	behavior treatment committee and where emergency interventions have been used	CMHPSM Compliance/Quality Manager	May August, November
	Complete Behavior Treatment performance reports that analyze the use of emergency interventions, plans approved with restrictive and/or intrusive interventions, and adherence to the BTPR Standards (including barriers, improvement efforts, recommendations, and status of recommendations).	CMHPSM Compliance/Quality Manager Regional CPT Committee	FY24 Annual QAPIP Plan 2/28/24 FY24 QAPIP Evaluation 2/28/25 FY24 Quarterly February May August, November
	CMHPSM will explore system abilities to report BTC data electronically more efficiently while maintaining security/privacy and reporting standards.	CMHPSM Compliance/Quality Manager Regional CPT Committee	FY24 Annual Report 2/28/23 FY24 quarterly February May August, November
	CMHPSM will conduct quarterly analysis and reporting of BTC data to Regional CPT Committee for any corrective action measures to be taken, and incorporated into the CMHPSM QAPIP documents and reports	CMHSM COO CMHPSM Compliance/Quality Manager	FY24 Quarterly March May August, November
Provider Monitoring	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**
CMHPSM will be in compliance with PIHP Contract Requirements.	Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP. Coordinate quality improvement plan development, incorporating goals and objectives for specific growth areas based on the site reviews, and submission of evidence for the follow up reviews.	Regional NMC Committee CMHPSM COO CMHPSM SUD Services Director	Annual

CMHPSM will demonstrate an increase in compliance with the External Quality Review(EQR)-Compliance Review	Implement corrective action plans for areas that were not in full compliance, and quality improvement plans for recommendations. See CAP for specific action steps. Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	CMHPSM COO CMHPSM Compliance/Quality Manager Regional Compliance Committee	Monthly Quarterly
CMHPSM will demonstrate full compliance with the EQR-Performance Measure Validation Review	Implement quality improvement plans for recommendations provided by the external quality review team. Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	CMHPSM CIO CMHPSM COO CMHPSM Compliance/Quality Manager Regional CPT Committee Regional EOC Committee	9/30/2024
CMHPSM will receive a score of "Met" for the EQR Performance Improvement Project Validation	Implement and comply with all PIP Validation submission requirements	CMHPSM CIO CMHPSM COO CMHPSM Compliance/Quality Manager Regional CPT Committee Regional EOC Committee	9/30/2024
CMHPSM will demonstrate an increase in compliance with the MDHHS c waiver/1915 Reviews.	Monitor systematic remediation for effectiveness through delegated managed care reviews and performance monitoring through data.	CMHPSM COO CMHPSM Compliance/Quality Manager	09/30/24
CMHPSM will demonstrate full compliance with the MDHHS Substance Use Disorder Protocols	Provide evidence to support SUD requirements	CMHPSM COO CMHPSM SUD Services Director	09/30/24
CMHPSM will demonstrate assurances of adequate capacity and services for the region, in accordance with the MDHHS Network Adequacy standards.	Submit Network Adequacy Report to MDHHS Complete Network Adequacy Assessment including all required elements.	CMHPSM COO Regional NMC Committee	02/28/24 09/30/24
Provider Qualifications	**Objectives/Activities**	**Assigned Person or**	**Frequency/**

		Committee/Council	Due Date
CMHPSM will ensure physicians, other healthcare providers, and non-licensed individuals are qualified to perform their jobs.	CMHPSM will conduct quarterly monitoring of compliance with Organizational credentialing and re-credentialing requirements, providing retraining and procedures revisions as needed Data reports of progress will be included in the QAPIP report to the Regional CPT Committee and the CMHPSM governance bodies.	CMHPSM COO Regional NMC Committee	Quarterly
CMHPSM will have credentialing policies/ procedures, in accordance with MDHHS Credentialing and Re-Credentialing Process, for ensuring that all providers rendering services to individuals are appropriately credentialed within the state and are qualified to perform their services.	CMHPSM will conduct quarterly monitoring of compliance with LIP credentialing and re-credentialing requirements providing retraining and procedures revisions as needed. Data reports of progress will be included in the QAPIP report to the Regional CPT Committee and the CMHPSM governance bodies.	CMHPSM COO Regional NMC Committee	Quarterly
CMHPSM ensures all delegates performing credentialing functions comply with all initial (including provisional/temporary) credentialing requirements according to initial credentialing and re-credentialing monitoring tools for organizations and LIPs	Primary Source Verification and credentialing and recredentialing policy and procedure review will occur during CMHPSM reviews of CMHSP delegated functions and Medicaid Service Verification activities. CMHPSM will increase monitoring for providers scoring less than 90% on the file review and will be subject to additional review of credentialing and re-credentialing records.	CMHPSM COO Regional NMC Committee	Annually
	Review semi-annual credentialing and re-credentialing report to ensure credentialing within the appropriate timeframes.	CMHPSM COO Regional NMC Committee	Semi Annually May 2024 November 2024
Clinical service providers are credentialed by the CMHSP prior to providing services and ongoing.	CMHPSM will conduct quarterly monthly monitoring of compliance with credentialing and re-credentialing requirements for directly hired CMHSP staff as delegated to the CMHSPs, providing retraining and procedures revisions as needed	CMHPSM COO Regional NMC Committee	Quarterly reporting

Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements.	CMHPSM Oversight and monitoring during CMHSP and SUD Provider reviews of delegated functions.	CMHPSM COOCMHPSM SUD Services Director Regional NMC Committee	Annually
Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements.	CMHPSM Oversight and monitoring during CMHSP and SUD Provider reviews of delegated functions.	CMHPSM COO CMHPSM SUD Services Director Regional NMC Committee	Annually

B. Figure 2. FY24 Performance Measures

Performance measures that are new or revised from the previous fiscal year are highlighted in green.
*MDHHS 2023-2026 Continuous Quality Strategy (CQS) Goals:
Goal #1: Ensure high quality and high levels of access to care.
Goal #2: Strengthen person and family-centered approaches.
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external).
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes.
Goal #5: Improve quality outcomes through value-based initiatives and payment reform.

*Continuous Quality Strategy Goal(s)	Michigan Mission Based Performance Indicator System	Committee/ Council	FY2023 Performance	FY24 QAPIP Page(s)
1	CMHPSM will meet or exceed the standard for Indicator 1: Percentage of Children who receive a Prescreen within 3 hours of request (Standard is 95% or above)	Regional CPT Regional EOC	Met for FY23	Pages 23-24
1	CMHPSM will meet or exceed the standard for Indicator 1: Percentage of Adults who receive a Prescreen within 3 hours of request (Standard is 95% or above)	Regional CPT Regional EOC	Met for FY23	Pages 23-24
1	CMHPSM will meet or exceed the standard for Indicator 2. A The percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (reported by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children.) Performance measured by total % of all populations (total numerator/denominator) CMHPSM FY22 Baseline = 61.3% = 50TH – 75TH Percentile FY24 Performance Measure: reach or exceed the 75th Percentile	Regional CPT Regional EOC	No FY23 Threshold New FY24 standard is Baseline	Pages 23-24

1	CMHPSM will meet or exceed the standard for Indicator 2 e. The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders. Performance measured by total % of all populations (total numerator/denominator) CMHPSM FY22 Baseline = 60.8% = Below 50TH Percentile FY24 Performance Measure: reach or exceed the 50TH Percentile	Regional CPT Regional EOC	No FY23 Threshold New FY24 standard is Baseline	Pages 23-24
1	CMHPSM will meet or exceed the standard for Indicator 3 Percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (reported by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children). Performance measured by total % of all populations (total numerator/denominator) CMHPSM FY22 Baseline = 74.5% = 50TH – 75TH Percentile FY24 Performance Measure: reach or exceed the 75TH Percentile	Regional CPT Regional EOC	No FY23 Threshold New FY24 standard is Baseline	Pages 23-24
1, 3	CMHPSM will meet or exceed the standard for Indicator 4a1: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (Standard is 95% or above) (Child)	Regional CPT Regional EOC	Met for FY23 Q4 pending	Pages 23-24
1, 3	CMHPSM will meet or exceed the standard for Indicator 4a2: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (Standard is 95% or above) (Adult)	Regional CPT Regional EOC	Met for FY23 Q4 pending	Pages 23-24
1, 3	CMHPSM will meet or exceed the standard for Indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (Standard is 95% or above)	Regional CPT Regional EOC	Met for FY23 Q4 pending	Pages 23-24
1, 3	CMHPSM will meet or exceed the standard for Indicator 10: Re-admission to Psychiatric Unit within 30 Days (Standard is 15% or less) (Child)	Regional CPT Regional EOC	Met for FY23 Q4 pending	Pages 23-24
1, 3	CMHPSM will meet or exceed the standard for Indicator 10: Re-admission to Psychiatric Unit within 30 Days (Standard is 15% or less) (Adult)	Regional CPT Regional EOC	Met for FY23 Q4 pending	Pages 23-24
1, 3	CMHPSM will demonstrate and increase in compliance with access standards for the SUD priority populations. (Compared to FY23 Data)	Regional CPT Regional EOC	FY23 was a Baseline year	Page 14 Page 47
Continuous Quality Strategy Goal(s)	**BH TEDS Data**	**Committee**	**FY2023 Performance**	
2, 3	Analyze and monitor BHTEDS records to improve housing and employment outcomes for persons served. Maintain overall BHTEDS completion rates to state 95% standard during FY2024. Improve crisis encounter BHTEDs completion to 95% during FY2024.	Regional EOC Regional CPT	Baseline New FY24 standard	Page 24

Continuous Quality Strategy Goal(s)	Performance Improvement Projects	Committee	FY2023 Performance	
1, 2, 3, 4	PIP 1: The racial disparities of no-shows for the initial Biopsychosocial Assessment (BPS) in individuals accessing CMH services will be reduced or eliminated. (FY242 Baseline)	Regional EOC Regional CPT	FY23 reduction in racial disparity in one county; no reduction in overall disparity in region	Pages 26-27
1, 2, 3, 4	PIP 2: Overall increase in performance in new persons receiving a completed bio-psycho-social initial assessment within 14 calendar days of a non-emergency request for service.	Regional EOC Regional CPT	Not met for FY23	Pages 26-27
Continuous Quality Strategy Goal(s)	**Assessment of Member Experiences**	**Committee**	**FY2023 Performance**	
1, 2, 3	Percentage of children and/or families indicating satisfaction with mental health services. (Standard 85%/) Percentage of adults indicating satisfaction with mental health services. (Standard 85%) Percentage of individuals indicating satisfaction with long-term supports and services. (Standard 85%) Create plan for improvement in areas that fell below the 85% threshold: My phone calls are returned by the next day 83.4 If I have a concern or a problem I know how to contact Customer Services to file a compliant 76.5	Regional Customer Services Committee	Overall 89.3 Areas that fell below 85% that will be a project plan for CS in FY24	Page 36
1, 2, 3	Percentage of consumers indicating satisfaction with SUD services. (Standard 85% OR 4 Likert score)	CMHPSM SUD Director Regional Co-Occurring Workgroup	Above 4 Likert score in all RSA areas.	Pages 36-37
Continuous Quality Strategy Goal(s)	**Member Appeals and Grievance Performance Summary**	**Committee**	**FY2023 Performance**	

1, 2, 3	The percentage (rate per 100) of Medicaid appeals which are resolved in compliance with state and federal timeliness and documentation standards including the written disposition letter (30 calendar days) of a standard request for appeal. (Standard 95%) The percentage of appeals cases that meet documentation requirements in the EHR.	Regional UM/UR Committee Regional CPT Committee	Met at 100%	Pages 36-38
1, 2, 3	The percentage (rate per 100) of Medicaid grievances are resolved with a compliant written disposition sent to the consumer within 90 calendar days of the request for a grievance. (Standard 95%) The percentage of grievance cases that meet documentation requirements in the EHR.	Regional CS Committee Regional CPT Committee	Met at 100%	Pages 36-38
Continuous Quality Strategy Goal(s)	**Adverse Event Monitoring and Reporting**	**Committee**	**FY2023 Performance**	
	The rate of critical incidents per 1000 persons served will demonstrate a decrease from previous year. (CMHSP) (excluding deaths)	Regional CPT Committee Regional EOC Committee	Slight decrease	Pages 28-30
	The rate, per 1000 persons served, of Non-Suicide Death will demonstrate a decrease from previous year. (CMHSP)(Natural Cause, Accidental, Homicidal) Ensure compliance with timely and accurate reporting of critical and sentinel events (100%) 100% CEs reporting 100% timely reporting	Regional CPT Committee Regional EOC Committee	100% Complete	Pages 28-30
	Quarterly report and analysis of type, trends over time (including mortality), events per 1,000, regional trends over time for the fiscal year, analysis of trends by service, engagement in treatment, precipitating events. Analysis of CE trends for potential PI projects	Regional CPT Committee Regional EOC Committee	100% Complete	Pages 28-30
	The rate, per 1000 persons served, of Sentinel Events will demonstrate a decrease from the previous year.	Regional CPT Committee Regional EOC Committee	Complete (decrease occurred)	Pages 28-30
	Individuals involved in the review of sentinel events must have the appropriate credentials to review the scope of care. 100% reported to PIHP and state 100% timeframes met	Regional CPT Committee Regional EOC Committee	100% Complete	Pages 28-30

Continuous Quality Strategy Goal(s)	Joint Metrics	Committee	FY2023 Performance	
	3day review of critical events (CEs) that are sentinel events (SEs) 100% RCA completion			
	Collaboration meeting completed between entities for the ongoing coordination and integration of services. (100%)	Regional EOC Committee Regional CPT Committee	100%	Pages 25-26
	The percentage of discharges for adults (18 years or older) who were hospitalized for treatment of selected mental illness and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days. FUH Report, Follow-Up After Hospitalization Mental Illness **Adult** (Standard-58%) Measurement period will be calendar year 2023.	Regional EOC Committee Regional CPT Committee	65% -above Statewide standard (most recent state data 3/31/23)	Pages 25-26
	The percentage of discharges for children (ages 6-17 years) who were hospitalized for treatment of selected mental illness and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days. FUH Report, Follow-Up After Hospitalization Mental Illness **Child** (Standard-70%) Measurement period will be calendar year 2023.	Regional EOC Committee Regional CPT Committee	80% -above Statewide standard (most recent state data 3/31/23)	Pages 25-26
	Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days Racial/ethnic group disparities will be reduced for beneficiaries six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days. CMHPSM will reduce the racial/ethnic disparity between the index population and at least one minority group. (Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences) Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2022 with calendar year 2023.	Regional EOC Committee Regional CPT Committee	Adult – no change in disparity Child – disparity increased (most recent state data 3/31/23)	Pages 25-26

	Follow up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence: CMHPSM will reduce the disparity between the index population and at least one minority group. For beneficiaries 13 years and older with an Emergency Department (ED) visit for alcohol and other drug dependence that had a follow-up visit within 30 days. (Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences) Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2022 with calendar year 2023	Regional EOC Committee Regional CPT Committee	46% - above statewide standard No change in disparity (most recent state data 3/31/23)	Pages 25-26
Continuous Quality Strategy Goal(s)	**PIHP Performance Based Incentive Payments**	**Committee**	**FY2023 Performance**	
	Implement data driven outcomes measurement to address social determinants of health. Analyze and monitor BHTEDS records to improve housing and employment outcomes for persons served. Measurement period is prior fiscal year. Use most recent update or discharge BH-TEDS record during the measurement period, look back to most recent prior update or admission record.	Regional EOC Committee Regional CPT Committee	N/A Baseline	Page 24
	Percentage of Adults Age 18 and Older with Schizophrenia or Schizoaffective Disorder who were Dispensed and Remained on an Antipsychotic Medication for at Least 80 Percent of their Treatment Period (SAA-AD): CMHPSM will participate in DHHS-planned and DHHS provided data validation activities and meetings and return completed data validation template to state 120 calendar days from January 31, 2024.	Regional EOC Committee Regional CPT Committee	N/A	Page 25
	CMHPSM will reduce the disparity between the index population and at least one minority group regarding the percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who initiate treatment within 14 calendar days of the diagnosis received: **(1. Initiation of AOD Treatment)** Data will be stratified and provided by the State by race/ethnicity Measurement period will be a comparison of calendar year 2022 with Calendar year 2023.	Regional EOC Committee Regional CPT Committee	Baseline	Page 25
	CMHPSM reduce the disparity between the index population and at least one minority group regarding the percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment and who had two or more additional AOD services or Medication Assisted Treatment	Regional EOC Committee Regional CPT Committee	Baseline	Page 25

	(MAT) within 34 calendar days of the initiation visit. **(2. Engagement of AOD Treatment)** Data will be stratified and provided by the State by race/ethnicity Measurement period will be a comparison of calendar year 2022 with Calendar year 2023.			
	CMHPSM will increase participation in patient-centered medical homes/health homes. (narrative report)	Regional CPT Committee	Met	Page 25
Continuous Quality Strategy Goal(s)	**Priority Measures**	**Committee**	**FY2023 Performance**	
	Clinical SUD			
	CMHPSM SUD providers will meet ASAM continuum completion rates (Target 75%) CMHPSM SUD providers will improve meeting priority population timelines (Target 75%) Screening requirement met 85.1% Admission requirement met 45.8% CMHPSM SUD provider will show a decrease in open SUD wrapper admissions without service and an increase in closed cases. (30%) Monthly data reviews and quarterly data analysis reporting**.** (Target 95%)	Regional CPT Committee	Baseline ASAM done: 82% Timeframe Met: 64% Baseline 21.5% Met	Pages 25-26
Continuous Quality Strategy Goal(s)	**Utilization Management/LTSS**	**Committee**	**FY2023 Performance**	
	Correct timeframes used for advance action notice (Target 100%) Accurate use of reduction, suspension, or termination decisions. (Target 100%) ABDs provide service denial reasons in language understandable to person served. Analyze type of denial, accuracy of service and denial decision explanation, and compliance with timeframes.	Regional UM/UR Committee	95.6% compliance	Pages 32-34
	Assess overutilization of services: Review of inpatient recidivism as potential overutilization of higher level of care, using following factors: • Persons receiving LTSS, and/or on c waiver • Services/status, type, and service utilization before first admission • Type or change in the services/IPOS after the first and/or second admission • Engagement obstacles • If hospitalization known or managed by CMH	Regional UM/UR Committee	Baseline Data analysis structure completed	Pages 32-36

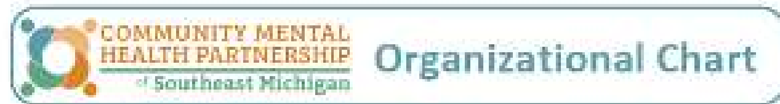
	• Compliance with MMBPIS Indicator 4a			
	Underutilization project: Assess HSW members not receiving monthly services that qualify them for HSW enrollment as potential underutilization, including potential risks of maintaining HSW enrollment with the ending of public health emergency and subsequent enrollment exceptions. Including following factors: • Utilization of monthly habilitative services • Authorized services vs utilized services • Service delays and proper ABD notice where applicable • Person given choice of provider and HSW services	Regional UM/UR Committee	Baseline Data analysis structure completed	Pages 32-34
	Evidence of use of parity program for those with established LOC in CMHPSM reviews of CMHSPs clinical records for all populations (Standard 90%). A parity LOC is completed for each person served, including the accurate population The relevant and appropriate level of care assessment is completed for each person served prior to authorizations being completed. If the exception process is used, the reason for the exception is documented and reviewed at the supervisory level.	Regional UM/UR Committee	Baseline	Pages 32-34
	Consistent regional service benefit is achieved as demonstrated by the percent of outliers (exceptions) to level of care benefit packages (Standard <=5%). Measurement period is FY23	Regional UM/UR Committee	Baseline	Pages 32-34
	Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines. (Target 100%). Implement an inner rater reliability with the MCG Indicia parity system for psychiatric inpatient, crisis residential, and partial hospitalization service decisions. Baseline measurement period is Q1 of FY24	Regional UM/UR Committee	Baseline	Pages 32-34
Continuous Quality Strategy Goal(s)	**Behavior Treatment**	**Committee**	**FY2023 Performance**	
	Consistent quarterly reporting of BTC data (100%) Consistent data analysis of BTC data (100%)	Regional CPT Committee	100%	Pages 30-31
	The percentage of individuals who have an approved Behavior Treatment Plan which includes restrictive and intrusive techniques.	Regional CPT Committee	Baseline	Pages 30-31

Continuous Quality Strategy Goal(s)	Clinical Practice Guidelines	Committee	FY2023 Performance	
	CPGs reviewed at least bi-annually.	Regional CPT Committee	100%	Page 32
	CPGs published to both provider network and members.	Regional CS Committee Regional NMC Committee	50%	Page 32
Continuous Quality Strategy Goal(s)	**Provider Monitoring**	**Committee**	**FY2023 Performance**	
	Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements.	Regional NMC Committee	Met	Pages 38-42
	Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements.	Regional NMC Committee	Pending close of FY23 auditing	Pages 38-42
	Credentialing and re-credentialing of organizational providers meet all state/federal requirements and timelines.	Regional NMC Committee	83% 174/203	Pages 38-42
	Credentialing and re-credentialing of LIP providers meet all state/federal requirements and timelines.	Regional LIP Committee	FY23 100% LIPs (6/6 Q1-2; 11/11 Q3-4)	Pages 38-42
	Complete assessment of FY24 CMHPSM audits of CMHSP Access functions (CMH and SUD) and development performance improvement projects where indicated based on findings and resultant CAPs.	CMHPSM COO Regional CPT Committee Regional Compliance Committee	Pending close of FY23 auditing	Pages 38-42
	CMHPSM will demonstrate an increase in applicable providers within the network that are "in compliance" with the HCBS rule (MDHHS HCBS CAP Guidance form).	Regional NMC Committee	Completed	Pages 38-42
Continuous Quality	**Health Home (OHH, BHH, CCBHC) Performance Measures**	**Committee**	**FY2023 Performance**	

Strategy Goal(s)				
	Meet or exceed OHH performance benchmarks.	CMHPM SUD Team	Met	
	Meet or exceed BHH performance benchmarks.	Regional BHH Workgroup	Met	
	Meet or exceed federally defined QBP measures and benchmarks for CCBHCs.	Regional CCBHC Workgroup	Met	

X. Attachments

A. Attachment A: CMHPSM Organizational Structure



Updated: 11/6/2023

Chief Executive Officer
James Colaianne

Operations Department
Chief Operating Officer*
CJ Witherow

Finance Department
#117
Chief Financial Officer
Matt Berg

Substance Use Services Dep.
#102
Substance Use Services Director
Nicole Adelman

Information Management Dep.
Chief Information Officer**
Michelle Sucharski

Regional Coordinator
Stephannie Weary

Compliance & Quality Manager
Raquel Sparkman

#127
Operations Specialist
Callie Tinsel

Behavioral Health Home
Geralyn Harris

Waiver Services Coordinator
Jason Newberry

Regional Project Assistant
Jennifer Landstrom

Financial Accountant & Analyst
Lyndsay Kieselbach

Finance Analyst
Michelle Lyons

Veteran Navigator
Erika Behm

Grant Coordinator
Alyssa Tumolo

Rebecca DuBois

Opioid Health Home
Elizabeth Stankov

Substance Use Prevention Coordinator
Jane Goerge

Substance Use Service Program Coordinator
Danielle Brunk

Robert Bull

#109
Clinical Treatment Coordinator
Joelen Kersten

Substance Use Disorder Care Navigator
Jessy Macumber

Substance Use Disorder Care Navigator
Jonathan Huhn

Utilization & Treatment Specialist
Kara Hendricks

Information Management Coordinator
James Lackey

#110
Regional Health Data Analyst
Jessica Sehgurgis

Data Reporting Coordinator
Teresa Sharp

Regional Admin. Assistant
Stacy Pijanowski

Regional Project Assistant
Vacant

CMHPSM CEO
Department Leader
Supervisory Staff
Administrative Position
Fully Grant Funded Position
Partially Grant Funded Position

*The COO serves as the CMHPSM privacy officer. **The CIO serves as the CMHPSM security officer.

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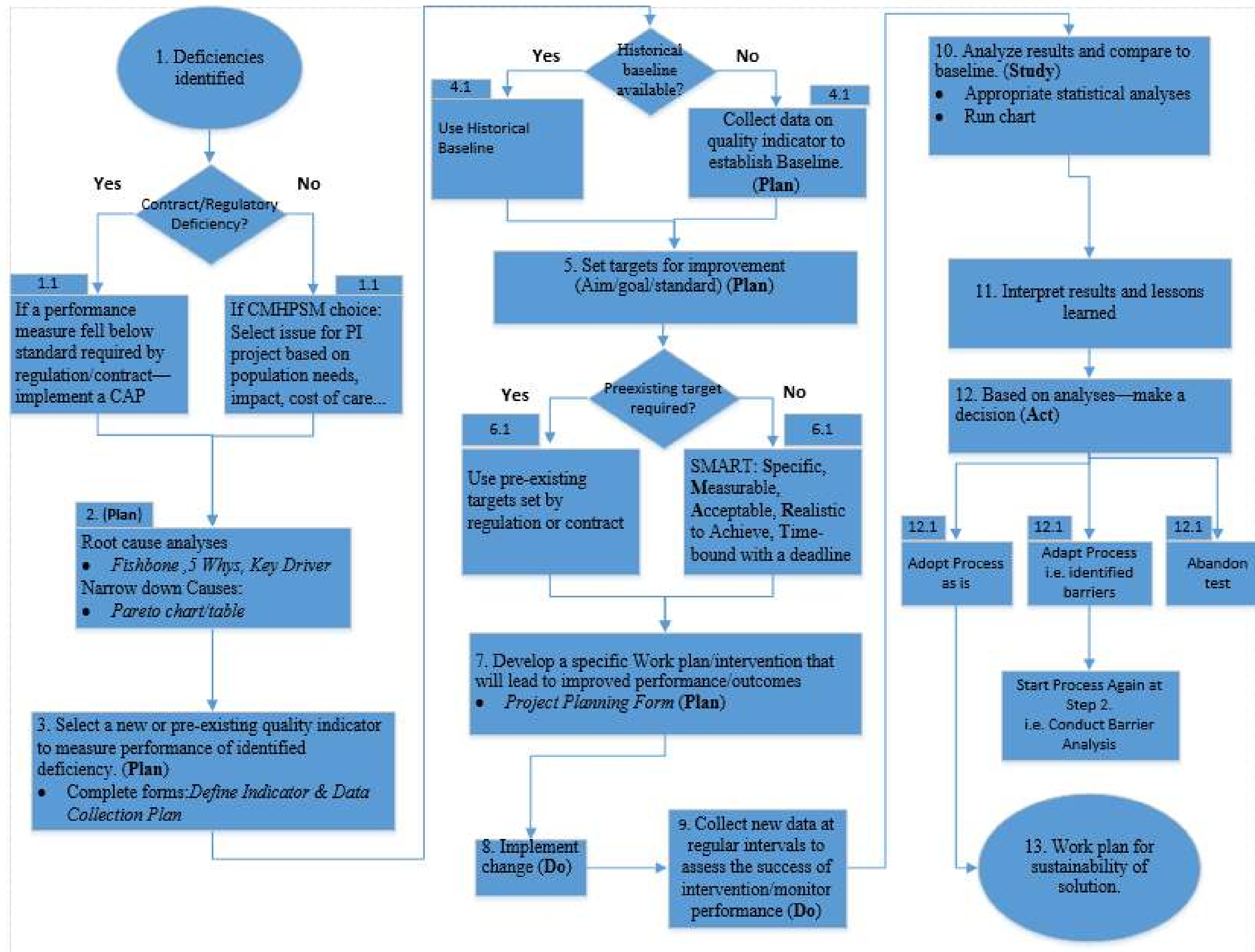
B. *Attachment B: Performance Improvement Framework*



Attachment 5c – December 2023

Regional Board Action Request – Annual Quality Assessment and Performance Improvement Program (QAPIP) Plan for FY2024

Board Meeting Date:	December 13, 2023
Action Requested:	Approve the annual plan for quality assessment and improvement plan activities during FY2024.
Background:	The CMHPSM, as a Pre-paid Inpatient Health Plan, is required to annually assess the need for improvement throughout the regional administrative and service functions and to prepare a plan to make quality improvements that will ensure that recipients of services are provided high quality, timely, cost-effective supports and services. The FY2024 QAPIP includes workplans for QAPIP Priorities and Performance Measures. Priorities and performance measures that are new or revised from the previous fiscal year are highlighted in green.
Connection to:	PIHP/MDDHS Contract, AFP, Regional Strategic Plan and Shared Governance Model, and MDHHS 2023-2026 Continuous Quality Strategy Goals. Quality Assessment/Performance Improvement Program and Standards
Recommend:	Approval

CEO Report

Community Mental Health Partnership of Southeast Michigan

Submitted to the CMHPSM Board of Directors

December 6, 2023 for the December 13, 2023 Meeting

CMHPSM Update

- The CMHPSM held an all-staff meeting on Monday November 13, 2023, we cancelled the October 9 meeting due to the float holiday.
- We held open enrollment for CMHPSM benefits on November 27, 2023. Staff were presented with all health insurance and supplemental insurance options available for calendar year 2024.
- The CMHPSM leadership team continues to meet on a weekly basis on Tuesday mornings.
- An update on FY2018-19 deficit resolution will be provided at the meeting.

COVID-19 Update

- The following webpage was created on our CMHPSM regional website related to the end of the public health emergency: https://www.cmhpsm.org/phe-end

CMHPSM Staffing Update

- The CMHPSM currently has no open positions that we are actively recruiting at this time.
- More information and links to job descriptions and application information can be found here: https://www.cmhpsm.org/interested-in-employment

Regional Update

- Our regional committees continue to meet using remote meeting technology and expect we will continue to do so until that option is no longer feasible.
- The Regional Operations Committee continues to schedule to meet on a weekly basis.
- We are currently monitoring capitation payment information for the region and recently have participated in an effort by the PIHPs to compile such information on a statewide basis. We are closely monitoring DAB eligibles, individuals we serve and overall revenue payments.

Statewide Update

- PIHP statewide CEO meetings are being held remotely on a monthly basis. Since our last Regional Board meeting, the PIHP CEOs met on November 7, 2023 and December 5, 2023.
- The PIHP CEO / MDHHS operations meetings with MDHHS behavioral health leadership staff were held on November 2, 2023 and December 7, 2023. I provide a summary of those meetings to our regional directors at our Regional Operations Committee meetings each month.
- The pull-back process of capitation payments noted in the October 2023 report, have been paused again as MDHHS is investigating options related to the process.
- The Medicaid Health Plan re-bid process was initiated and responses are due in early 2024. I pulled down the documents related to the MDHHS RFP and have made them accessible within the following folder: https://cmhpsmorg-my.sharepoint.com/:f:/g/personal/colaiannej_cmhpsm_org/EqdthpVmw7xFkpdY7BmnH70BuCF-oO1GjI6h8yNlKj4Vvw?e=8IlicG
- The PIHPs are awaiting additional information from MDHHS related to the upcoming Medicaid Health Plan contracts. There have been limited discussions of changes coming to the populations served within the public behavioral health system and Medicaid Health Plans. Changes to the PIHP contracts would be necessary and we hope to have information related to any care coordination or population coverage changes in early 2024. The new contracts will take effect on October 1, 2024 for the Medicaid Health Plans.

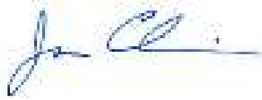
Legislative Updates

- The Michigan Legislature ended the legislative session early on November 9, 2023, setting November 14, 2023 as the official last day of work for the legislature. While a special session could be called, it is expected that the legislature won't return until December 10, 2023. The 2024 primary elections will be held on February 27, 2023. The legislative rules related to this schedule move were one of the reasons the legislative session was ended earlier than originally scheduled.

Future Updates

- We are planning to cover the following items at our February 2024 meeting:
    - FY2023 Quality Assessment and Performance Improvement Plan (QAPIP) Status Update
    - FY2024 Budget Review

Respectfully Submitted,



James Colaianne, MPA

Attachment #7 – December 2023

Regional Board Action Request – Closed Session

Board Meeting Date: December 13, 2023

Action(s) Requested: Enter closed session pursuant to MCL 15.268(1)(e) to discuss settlement and trial strategy in the pending litigation of Waskul et al v. Washtenaw County Community Mental Health et al, Case Number 2:16-cv-10936-PDB-EAS, Eastern District of Michigan, because discussion in the open session will be detrimental to our position.

Vote Requirement: Roll Call Vote with 2/3 Majority