Community Mental Health Partnership of Southeast Michigan

FY2022 Quality Assurance and Performance Improvement Program Evaluation

Evaluation Year FY2022

Final Version Approved: 02/8/2023

Reviewed by Clinical Performance Committee: 01/19/2023
Approved by CMHPSM Board: 02/08/2023
Submitted to MDHHS for Review: 02/27/2023

Table of Contents

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 FY2021-2023 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, member 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 QAPIP Evaluation

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 (Attachment P.7.9.1); 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 Evaluation is an overall assessment of the projects identified in the QAPIP Plan and 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.

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.

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.

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.

CQS: Comprehensive Quality Strategy 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.

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.

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.

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.

MSV: Medicaid Services Verification 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.

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.

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.

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 assigned the PIHP Operations department with the PIHP oversight role of the regional Clinical Performance Team (CPT) Committee, and 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 CMHPSM 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 participate on 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 and the four CMHSP Executive Directors operating under a regional shared governance structure.

The CMHPSM 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 workgroups and how those projects are reported to CPT. 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 Health Record Operations Committee (EOC) 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 a shared governance culture in which the CMHPSM strategically delegates functions to CMHSPs to meet local needs, while regional decisions are made collaboratively between the 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 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 Health Record Operations Committee (EOC)
- 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 align with components of the QAPIP. The policies are implemented by the various regional committees, CMHPSM departments, CMHSPs, and contracted 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 provider network structure is implemented using various committees, work groups, and advisory groups. Regional committees are responsible for providing recommendations and reviewing regional policy's regarding related managed care operational decisions. Each committee develops and approves a committee 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 and contracted provider staff have the opportunity to participate in and to support the QAPIP through organization wide performance improvement initiatives. In general, the CMHSP and contracted 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 found on the CMHPSM website 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 directors and PIHP staff are appointed by the CMHPSM CEO to participate on CPT. 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 Critical Incident, Sentinel Event, & Risk Event 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 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 Substance Use Services 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 Health Record Operations Committee (EOC)

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 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,
    - 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,
    - 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,
    - 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. Evaluation of QAPIP Measures of Performance

A. Michigan Mission Based Performance Indicators

Project Description: MDHHS indicators are established in the MDHHS PIHP contract and reported by the CMHPSM, with the values of improving access to services and reducing inpatient recidivism. Data is cleaned monthly, aggregated, and reported quarterly to MDHHS.
Indicators 2a, 2b, and 3 continued to be baseline measures with no performance requirement percentages determined for FY2022. CMHPSM therefore tracked whether there was general improvement in these indicators over time, and CMHSPs reported any barriers to improvement that may be addressed.

MMBPIS FY2022 Performance Measures and Outcomes

Project Description	Indicator/Performance Measure	Goal/Benchmark	FY2022 Outcomes	Causes and Trends for Not Met
Pre-Admission Screening within 3 hours	**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	95%	Goal was met for all four quarters for both children and adults. Child Average: 99.35% Adult Average: 99%	N/A, outcome met for FY2022
Access/1st Request Timeliness	**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.	Base-line period	Child SED 65.44%IET Adult MI 57.19% Adult IDD 65/43% Child IDD 73.88%	N/A, no state measure required for FY2022. CMHPSM tracked general performance with internal goal of 70%
Access/1st Request Timeliness	**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.	Base-line Period	SUD 61.50%	N/A, no measure required yet for FY2022. CMHPSM tracked general performance with internal goal of 70%
Access/1st Service Timelines for all CMH populations and SUD	**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.	Base-line Period	See IET-AD Data of state reported 41.36% performance rate for CMHPSM	N/A, no measure required yet for FY2022. CMHPSM tracked general performance
Hospital Discharges Follow-up-Psychiatric Inpatient	**4.a.** 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).	95%	Child Q1 - 89.74% Q2 - 92.86% Q3 - 100.00% Q4 - 93.33% Adult Q1 - 95.43% Q2 - 93.90% Q3 - 98.72% Q4 - 94.44%	Child*: Benchmark was not met for Quarters 1, 2, and 4. Benchmark was met for Quarter 4. Adult*: Benchmark was met for Quarters 1 and 3.Benchmark was not met for Quarters 2 and 4.
Hospital Discharges	**4b** - The percentage of discharges from an SUD detox unit during the quarter that were	95%	Goal was met for all four quarters. Q1 - 98.77%	N/A, outcome met for FY2022

Follow-up – SUD Detox	seen for follow-up care within 7 days.		Q2 - 96.46% Q3 - 100.00 Q4 - 95.97%	
Inpatient Recidivism	**10-** The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	15% or less	Goal was met for all four quarters Child Q1 – 5.13% Q2 – 0% Q3 – 6.35% Q4 – 6.25% Adult Q1 – 12.39% Q2 – 8.81% Q3 – 9.95% Q4 – 13.2%	N/A, outcome met for FY2022

indicator (num/pop)	Type	2022_Q1		2022_Q2		2022_Q3		2022_Q4	
1Child	PIHP	(164/166)	98.80%	(149/150)	99.33%	(133/134)	99.25%	(90/90)	100.00%
1Adult	PIHP	(567/571)	99.30%	(585/592)	98.82%	(565/572)	98.78%	(568/573)	99.13%
2MIC	PIHP	(199/292)	68.15%	(259/370)	70.00%	(191/295)	64.75%	(166/282)	58.87%
2MIA	PIHP	(220/344)	63.95%	(327/618)	52.91%	(307/539)	56.96%	(340/619)	54.93%
2DDC	PIHP	(49/68)	72.06%	(80/101)	79.21%	(54/79)	68.35%	(63/83)	75.90%
2DDA	CMHSP	(20/36)	55.56%	(29/41)	70.73%	(25/40)	62.50%	(33/51)	64.71%
	PIHP	(19/32)	59.38%	(27/35)	77.14%	(23/37)	62.16%	(29/46)	63.04%
2SUD	PIHP	(621/998)	62.22%	(632/1006)	62.82%	(646/1084)	59.59%	(653/1064)	61.37%
3MIC	PIHP	(152/208)	73.08%	(188/280)	67.14%	(184/250)	73.60%	(134/198)	67.68%
3MIA	PIHP	(178/219)	81.28%	(245/322)	76.09%	(265/366)	72.40%	(284/388)	73.20%
3DDC	PIHP	(58/68)	85.29%	(69/86)	80.23%	(59/65)	90.77%	(58/72)	80.56%
3DDA	PIHP	(16/28)	57.14%	(24/34)	70.59%	(28/30)	93.33%	(33/37)	89.19%
4Child	PIHP	(35/39)	89.74%	(26/28)	92.86%	(41/41)	100.00%	(28/30)	93.33%
4Adult	CMHSP	(167/175)	95.43%	(154/164)	93.90%	(154/156)	98.72%	(153/162)	94.44%
	PIHP	(166/173)	95.95%	(151/161)	93.79%	(151/153)	98.69%	(150/159)	94.34%
4SUD	PIHP	(80/81)	98.77%	(109/113)	96.46%	(107/107)	100.00%	(119/124)	95.97%
10Child (less than 15%)	CMHSP	(2/39)	5.13%	(0/33)	0.00%	(3/48)	6.25%	(2/32)	6.25%
10Adult (less than 15%)	PIHP	(28/226)	12.39%	(20/227)	8.81%	(21/211)	9.95%	(28/215)	13.02%
5All	CMHSP	(106/632)	16.77%	(129/877)	14.71%	(62/781)	7.94%	(60/777)	7.72%

***Analysis of Indicators Not Met:**

The majority of indicators requiring a review or corrective action plan were relates to indicators 2 and 3, and 4

While indicators 2a, 2b, and 3 don't yet have a state required measurement, CMHPSM reviewed trends and sought interventions for general improvements in the performance of these indicators.

<u>Trends (in order of significance/occurrence) related to these indicators 2, 3 and 4:</u>

- Individual not showing for scheduled appointment.
- Individual/guardian wanting a different appointment outside the timeframe.
- Staff error in ensuring timeframe or in documenting reasons for not meeting the indicator.

Regional trends included:

- Ongoing challenges with receiving all notifications (ADT or otherwise) of a discharge.
- Whether individual was actively open within the CMHPSM or new to the system, especially related to SUD provider system .
- Ongoing challenges related to long term effects of the COVID pandemic with people's ability or willingness to make appointments.

Primary interventions for improvements included:

- staff training,
- an increase in more frequent internal audits,
- and offering same day appointments,
- more telehealth options where applicable, or
- transportation assistance.
- Access to real-time data for more accurate internal auditing

There was an increase in performance over the year as a result of these interventions.

B. 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.
- The causes of negative statistical outliers when they occurred.
- Region-wide trends when indicators did not meet the MMBPIS performance standards.

C. 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 FY2022 MDHHS transitioned to two new PI project requirements. 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 FY2022-25 cycle, MDHHS and HSAG recommended the FY2022-25 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 conducting a literature review 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

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.

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).

FY2022 PIP Measures

1. Completion of PIP submission to HSAG by due date.
2. Passing score of HSAG PIP submission.
3. Development of interventions for PIP during FY2022.

FY2022 PIP Outcomes

1. The PIP submission was completed and submitted to HSAG by the due date.
2. CMHPSM received a score of 100% on the PIP after resubmission.
3. Barriers were identified and interventions were developed to reduce disparities and increase overall performance, for full implementation scheduled 1/1/2023 as required by the MDHHS/HSAG project requirements. Interventions to be analyzed for FY2023 include same day appointments and providing transportation assistance.

D. 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. 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.
Critical incidents that are also risk events are reviewed and monitored for whether they require review. CMHPSM, through the Regional CPT Committee, Regional EOC Committee, and SUD workgroups, ensure policies and reporting structures are in place 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 to determine if the incident is sentinel within three days of the occurrence. 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 FY2023 CMHPSM will convene a regional workgroup with representation of staff with varying credentials who are responsible for event reporting to conducting a quarterly analysis of the data; reviewing the appropriateness of RCAs and corrective actions; making recommendations

for improvement when trends are identified and determining educational needs for staff and providers. The workgroup will report and make recommendations to Regional CPT Committee as a component to monitoring compliance of delegated functions related to critical incidents, sentinel events, and risk events.

FY2022 Critical Events Measures

1. CMHPSM to submit timely and accurately Critical Events on a monthly basis or more immediately if required
2. Conduct analysis on critical events to monitor compliance with reporting, trends, and opportunities for performance improvements. CMHPSM will complete data analysis of critical events and develop a baseline for areas of improvements that will result in:
   - More accurate and timely reporting of events
   - CIs for residential treatment providers.
   - Include all unexpected deaths (those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect), including aggregated mortality data over time to identify possible trends.
   - Include events that put individuals at risk of harm. These events minimally 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; and 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.
3. Submission CMH Sentinel Events (MDHHS CRM) immediate notification) to CMHPSM based on notification requirements of the event (24 hour, 48 hours, 5 days) with 100% compliance.

FY2022 Critical Events Outcomes

Analysis of critical events and BTC data was completed for FY2022.

Affiliate	Quarter	Emergency Medical Treatments	Hospitalization	Deaths (Non-suicide)	Deaths (Suicide)
Lenawee	Q1	0	0	1.73	0
	Q2	0	0	1.73	0
	Q3	0	0	0.86	0
	Q4	0	0	0	0.85
Lenawee Average		*0*	*0*	*1.08*	*0.21*
Livingston	Q1	0	0	0	0
	Q2	0	2.02	0	0
	Q3	0	1.37	0	0.68
	Q4	0	0.70	0	0
Livingston Average		*0*	*1.02*	*0*	*0.17*
Monroe	Q1	0	0.00	0	0.56
	Q2	0	0.00	0	0
	Q3	0	0.00	0	0
	Q4	0	0.00	0	0
Monroe Average		*0*	*0.00*	*0*	*0.14*
Washtenaw	Q1	0	0.24	0.24	0.24
	Q2	0	0	0.46	0
	Q3	0	0	0.67	0

	Q4	0.22	0.22	0	0
Washtenaw Average		*0.06*	*0.12*	*0.34*	*0.06*

Residential Living Arrangements in CE Data	**Total**
Institutional Setting	1
Living in a private residence not owned or controlled by the PIHP, CMHSP or the contracted provider, alone or with spouse or non-relative(s).	9
Living in a private residence that is owned and/or controlled by the PIHP, CMHSP or the contracted provider, alone or with spouse or non-relative	1
Living in a private residence with natural or adoptive family member(s). 'Family member' means parent, stepparent, sibling, child, or grandparent of the primary consumer or an individual upon whom the primary consumer is dependent.	4
Specialized Residential Home including any adult foster care facility certified to provide a specialized program or Licensed Children's Therapeutic Group Home	9
Grand Total	24

- The most frequent Critical Event was Non-Suicide Unexpected Deaths (11 reported, 0.31 incidences per 1000 members served)
- The least frequent Critical Event was Emergency Medical Treatments (1 reported, 0.03 incidences per 1000 members served)
- Total Critical Events trended around the same for Q1-Q3 (6-7 recorded, average 0.76 incidences per 1000 members served) and decreased in Q4 (4 reported, 0.44 per 1000 members served).
- There were no sentinel events that occurred at SUD residential providers in FY2022.
- Outside of hospitalizations related to self harm there were no identified events that put individuals at risk of harm.
- Events that were identified as occurring in a residential setting: 2
- CMHSP sentinel events data was insufficient in the number of reported events for statistically significant data analysis. Findings related to the review of compliance with sentinel events timeframes and review showed a delay in the reporting of an event and its determination of being a sentinel event based on dependence of external medical information/verification.
- CMHPSM found significant errors and inaccurate overreporting of SUD sentinel events by SUD providers that required data cleaning and the developed of a SUD sentinel events reporting policy and training of SUD provider staff.
- Development of an event workgroup for FY2023 was completed.

Critical Events Recommendations

Initial findings are minimally statistically significant due to small samples and time frames. More meaningful data may be trended over time, such as:

- Specific types of precipitating events/factors and correlations between significant events and Critical Events (especially sudden or unexpected deaths including suicide)
- Implementation of specific strategies for precautions/prevention

- Outcomes measurement for corrective interventions/actions and precautionary measures
- Specific needs or differences within consumer care populations (i.e., demographics, SUD/DD/MI).

E. 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.

Regional Policy:
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.

FY2022 Behavioral Treatment Measures

1. Consistent and accurate quarterly reporting of BTC data (100%)
2. Consistent data analysis of BTC data (100%)
3. Development of BTC data baselines at the completion of BTC quarterly reporting and data analysis in FY2022

FY2022 Behavioral Treatment Outcomes
All four CMHSPs submitted BTC data for FY2022.
CMHPSM completed BTC data analysis of for FY2022.

Cases Per 1000	Q1	Q2	Q3	Q4	Average
Lenawee CMH	18.1	20.8	20.6	19.6	19.8
Livingston CMH	12.6	15.5	16.4	17.4	15.5
Monroe CMH	14.0	17.6	17.3	15.5	16.1
Washtenaw CMH	25.7	12.2	20.9	12.0	17.7
Regional Totals	20.01	21.15	19.35	20.55	20.27

- Total number of BTC interventions per 1000 members served oscillated around 20.3 for all four quarters, with a very slight decrease noted in Q3 (19.4 incidences per 1000 members served)
- The average number of interventions per consumer across the region is 1.5.
- The most frequent BTC intervention reported was restrictions on freedom of movement (292 reported, 8.2 incidences per 1000 members served).
    - The use of this intervention trended upward throughout the year, with a marked increase in Q4 regionally.
    - The use of interventions encroaching on personal space also saw a marked upward trend throughout the fiscal year.
- The least frequent BTC interventions reported were emergency use of law enforcement and restrictions placed on communication (7 reported each, 0.2 incidences per 1000 members served).

- The most common time frame set for review of interventions was quarterly (88%).
    - Approximately 1% of cases were marked with timeframe "Other" and no additional details.
- Regional compliance metrics display mixed adherence and some missing data.
    - 97.8% of cases documented that positive behavioral supports had been used prior to the intrusive/restrictive/emergency intervention.
    - 17.2% of cases did not document whether less intrusive interventions had been used prior to the intrusive/restrictive/emergency intervention.
    - 23% of cases did not report attainment of written informed consent.
    - 21% of cases did not report that the behavior control plan had been documented fully in the IPOS.
    - 16% of cases did not report that analysis of possible harm or restriction to others had been conducted.

CMHPSM found the BTC data template that was created during FY2021 for reporting had inaccuracies and inconsistencies that affected the completeness and the reliability of the data. Therefore, the BTC data template was updated in FY2022 for the FY2023 reporting year, with plans to meet and train CMHSP staff responsible for BTC data reporting to improve the reliability and validity of the data.
As FY2022 was a baseline year with the new BTC template, no comparisons could be made for previous fiscal years.

Behavioral Treatment Measures Recommendations
Meet and train CMHSP staff responsible for BTC data reporting to improve the reliability and validity of the data.
CMHPSM to incorporate BTC specific audits in FY2023 monitoring of CMHSPs.
Increase improvement in all elements completed for BTC reporting based on FY2022 outcomes.
Increase improvement interventions used (no blank data) for FY2023 reporting (95% accuracy).
Increase frequency of BTC data reporting and analysis to at least quarterly.

F. Clinical Practice Guidelines

Structure
The Regional CPT Committee ensures review and updates to clinical practice guidelines. Adherence to provider 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 annually 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.

FY2022 Clinical Practice Guidelines Measures
1. Ensure Clinical Practice guidelines are reviewed and updated at least annually 100% by 9/30/22.
2. Identify by 9/30/22 in the CPG review where guidelines are being used in the region/system of care with 100% completion.

FY2022 Clinical Practice Guidelines Outcomes
1. Ensure Clinical Practice guidelines are reviewed and updated at least annually 100% by 9/20/22.
For FY2022 CPGs were reviewed and approved by Regional CPT on 8/16/22 and approved by ROC on 8/29/22. This was consistent with guidelines being reviewed in FY2021.
2. Identify by 9/30/22 in the CPG review where guidelines are being used in the region/system of care with 100% completion.
FY2022 CPGs that were reviewed and approved by Regional CPT on 8/16/22 and approved by ROC on 8/29/22 and included if used in CMH/Behavioral Health, SUD Prevention, SUD Treatment, and/pr CCBHCs as well as the endorsement source. This was an improvement from FY2021.

G. Shared Metrics Projects Between the PIHP and Michigan Medicaid Health Plans

1. Care Coordination for High Consumer Utilizers Project

CMHPSM, the Medicaid Health Plans (MHP), and the CMHSPs meet monthly to review consumers with high risk or high utilization of services. Meetings discuss who to include in the project and potential interventions to better serve and stabilize them. Persons identified for review are based on the top 20 utilizers from on the past 6 months regarding: 1. # of ED visits or

admissions; and 2. # of chronic conditions based on CMHPSM EHR and MDHHS Care Connect 360 data extraction.

FY2022 Shared Metrics Measure

CMHPSM will participate in the identification of highest utilizers, attend monthly meetings with MHPs to develop care strategies to assist individuals in stabilizing their care needs, and complete coordination of care reporting to MDHHS at 100% compliance.

FY2022 Shared Metrics Outcomes

For FY2022 CMHPSM, the MHPs, and the CMHSPs continued to meet this indicator at 100% compliance by pulling monthly reports from CC360, identifying those with high risk or high utilization of services to include in reviews, and meeting monthly to review potential interventions to better serve and stabilize those consumers.

Areas of focus included ways interventions can be created to improve sustained outcomes for consumers and reduce the need for urgent/emergent services, addressing care coordination challenges related to maintaining SUD confidentiality laws in 42CFR Part 2.

2. Follow-Up after Hospitalization for Mental Illness (30 days) (FUH)

This project monitors follow up after hospitalization for individuals (aged 6 and older) with a mental illness or self-harm diagnosis. Data is provided by MDHHS through Care Connect 360. The Regional CPT and EOC Committees analyze this data when it becomes available and takes the following actions to assess how performance may be improved:

1. Collect, review and evaluate the timeliness of outcome data.
2. Intervene on a local level to address any barriers to timely data.
3. Ensure adherence to project protocols.
4. Consult data exchange vendors such as PCE and/or Great Lakes Health Connect (health highway data exchange vendor) and Medicaid Health Plans

FY2022 FUH Measure:

The percentage of discharges for individuals age six and older, who were hospitalized for mental illness or intentional self-harm diagnoses, and who had a follow-up visit with a mental health practitioner within 30 days of discharge.

Benchmarks: ages six (6) to 17= at least 70%; ages 18 and older = at least 58%.

FY2022 FUH Outcomes

The state database has a significant lag time, with the most recent data for FY2022 ending 6/30/22.

Rate cell colors are based on a comparison to the median State Medicaid Total (for the given measure) over time. Rates greater than the typical statewide value are green hued. Rates lower than the typical statewide value are red hued.

CMHPSM performance in this indicator was greater than the typical statewide value for both age factors.

Report: 6/30/2022 (CY22)

- FUH-Children
    - Region is above the 70% benchmark at 84%

- FUH Adults
  - Region is above the 58% benchmark at 64%
  - About half of the MHPs did not meet the benchmark

By Health Plan		FUH-30AD			FUH-30CH		
End date	Organization	demon	num	rate	denom	num	rate
6/30/22	CMHPSM Total	1086	690	0.6354	199	171	0.8593
	AETNA BETTER HEALTH OF MICHIGAN	34	24	0.7059	2	2	1.0000
	BLUE CROSS COMPLETE	373	234	0.6273	67	55	0.8209
	HAP EMPOWERED HEALTH PLAN	1	1	1.0000			
	MCLAREN HEALTH PLAN	63	41	0.6508	8	7	0.8750
	MERIDAN HEALTH PLAN	290	198	0.6828	65	57	0.8769
	MOLINA HEALTH CARE	106	68	0.6415	18	16	0.8889
	UNITED HEALTHCARE COMMUNITY PLAN	100	63	0.6300	22	19	0.8636
3/31/22	CMHPSM Total	1093	705	0.6450	198	173	0.8737
	AETNA BETTER HEALTH OF MICHIGAN	40	28	0.7000			
	BLUE CROSS COMPLETE	357	234	0.6555	62	51	0.8226
	MCLAREN HEALTH PLAN	66	39	0.5909	3	2	0.6667
	MERIDAN HEALTH PLAN	277	194	0.7004	60	55	0.9167
	MOLINA HEALTH CARE	105	71	0.6762	11	11	1.0000
	UNITED HEALTHCARE COMMUNITY PLAN	106	63	0.5943	18	15	0.8333
12/31/21	CMHPSM Total	1109	727	0.6555	216	190	0.8796
	AETNA BETTER HEALTH OF MICHIGAN	36	23	0.6389	1	1	1.0000
	BLUE CROSS COMPLETE	369	253	0.6856	77	65	0.8442
	MCLAREN HEALTH PLAN	61	35	0.5738	1	1	1.0000
	MERIDAN HEALTH PLAN	256	187	0.7305	71	64	0.9014
	MOLINA HEALTH CARE	89	60	0.6742	19	16	0.8421
	UNITED HEALTHCARE COMMUNITY PLAN	100	62	0.6200	22	22	1.0000

While the CMHPSM performed above the benchmark in FY2022, this is a joint metric shared with the Medicaid Health Plans (MHPs) and the PIHP received partial incentive due to a lower percentage performance with one of the MHPs.
The CMHPSM and partner MHPs started meeting more frequently in FY2022 to coordinate and improve the MHPs performance in this metric.

3. Follow-Up after Emergency Department (ED) Visit for Alcohol and Other Drug Dependence—(FUA)

This project monitors follow up after an emergency department visit for individuals (aged 13 and older) with an alcohol or other drug abuse diagnosis. The Regional CPT and EOC Committees explore how performance may be improved. This indicator is reported from the MDHHS database by calendar year (CY) instead of fiscal year (FY).

FUA Measure

The percentage of emergency department (ED) visits for individuals age 13 and older with a principle diagnosis of alcohol or other drug (AOD) abuse or dependence, who also had a follow up visit for AOD within 30 days of the ED visit.

While MDHHS has proposed a CY2022 benchmark of 27%, the state has not finalized a benchmark for this indicator in FY2022 and continues to seek improvements validation efforts with the data. For FY2022 the state included an incentive for PIHPs and MHPs to reduce racial/ethnic disparities. Data is extracted from the CMHPSM EHR and MDHHS Care Connect 360.

FUA Outcomes

By Health Plan		FUA-30		
End date	Organization	denom	num	rate
6/30/22	CMHPSM Total	1099	274	0.2493
	AETNA BETTER HEALTH OF MICHIGAN	76	14	0.1842
	BLUE CROSS COMPLETE	344	74	0.2151
	HAP EMPOWERED HEALTH PLAN			
	MCLAREN HEALTH PLAN	76	19	0.2500
	MERIDAN HEALTH PLAN	309	83	0.2686
	MOLINA HEALTH CARE	116	31	0.2672
	UNITED HEALTHCARE COMMUNITY PLAN	107	30	0.2804
3/31/22	CMHPSM Total	1140	271	0.2377
	AETNA BETTER HEALTH OF MICHIGAN	71	12	0.1690
	BLUE CROSS COMPLETE	350	69	0.1971
	MCLAREN HEALTH PLAN	81	19	0.2346
	MERIDAN HEALTH PLAN	317	83	0.2618
	MOLINA HEALTH CARE	122	33	0.2705
	UNITED HEALTHCARE COMMUNITY PLAN	118	30	0.2542
12/31/21	CMHPSM Total	1186	282	0.2378
	AETNA BETTER HEALTH OF MICHIGAN	64	11	0.1719
	BLUE CROSS COMPLETE	327	60	0.1835
	MCLAREN HEALTH PLAN	85	20	0.2353
	MERIDAN HEALTH PLAN	326	89	0.2730
	MOLINA HEALTH CARE	151	47	0.3113
	UNITED HEALTHCARE COMMUNITY PLAN	114	28	0.2456

- The state database has a significant lag time, with the most recent data for FY2022 ending 6/30/22.
- FUA data is maintained by MDHHS and reported to PIHPs, with the last data set provided 6/30/2022.
    - **Report: 6/30/2022 (CY22):** CMHPSM is slightly below the *proposed* CY22 benchmark of 27% at 25%

- There is a wider array of MHP services that count towards this measure as compared to CMHPSM covered services.
- CMHPSM services that have been effective in assisting persons being followed up post ER visit, such as recovery peer supports, are not included as encounters that meet this measure.

Recommendations to Improve FUA Outcomes

CMHPSM to meet more frequently with MHPs on ways to coordinate care and improve identification of persons covered by CMHPSM in emergency rooms (ERs) while maintaining 42CFR Part 2 compliance.

CMHPSM will continue to advocate with MDHHS for the inclusion of recovery peer supports in this measure.

H. PIHP-only Performance Bonus/Pay for Performance Measures

1. Behavioral Health Treatment Episode Data Set (BHTEDS) and Veteran Services Navigator (VSN) Data Collection

This project aims to use BHTEDS to:

1. Identify persons eligible for services through the Veterans' Administration by verifying elements required for military/veteran status.
2. Evaluate and review timeliness and accuracy of BHTEDS data
3. Conduct interventions on a local level to address barriers to timely data
4. Examine data to ensure adherence to project protocols

Regional EOC and CPT Committees monitor records showing "not collected" and compare the number of veterans reported on BHTEDS and the VSN. The CMHPSM Chief Information Officer and Regional EOC Committee submit a 1–2-page narrative report on regional findings and any actions taken to improve data quality on BH-TEDS military and veteran fields (July 1st).

Errors are discussed and addressed in the Regional EOC Committee and Encounter Data Information (REDI) Workgroup.

BHTEDS Performance Measures

1. 95% compliance with accuracy of reported BHTEDS encounters
    - Must be an active BHTEDS associated with an encounter, within 15 months of that encounter.
2. Identification of people eligible for Veteran Services Navigator within BHTEDS data.
3. Submission of a 1–2-page narrative report on regional findings and any actions taken to improve data quality on BH-TEDS military and veteran fields.

FY2022 BHTEDS Outcomes

1. 95% compliance with reported BHTEDS encounters

In FY2022 CMHPSM maintained BHTEDS completion rates over 95% compliance for crisis and non-crisis encounters.

MDHHS Report Data	Crisis BHTEDS	Non-Crisis BHTEDS
6/30/2022	96.59%	97.36%
11/30/2022	96.08%	95.99%

2. Identification of people eligible for Veteran Services Navigator (VSN) within BHTEDS data.

In FY2022 a Veteran Peer Support Specialist (VPSS) was hired to work alongside the VSN, increasing capacity in numbers and in expertise. The program began training and tracking potential referrals through the electronic health record (EHR) with CMH Access Departments. The VSN and VPSS had ongoing contact with 451 individuals (not unduplicated), including an increase of 176 new unique contacts for FY2022.

The VN program provided care coordination services directly with the Veteran's Administration, with their Veterans Service Officer, as well as referrals for legal services. During FY2022 the CMHPSM VSN and VPSS continued working with the Walking with Warriors campaign, which will continue into FY2023.

3. Submission of a 1–2-page narrative report on regional findings and any actions taken to improve data quality on BH-TEDS military and veteran fields.

This report was submitted to MDHHS by the 7/1/22 due date, was a passing finding.

2. IET-AD: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

This project monitors the percentage of beneficiaries ages 18 to 64 with a new episode of alcohol or other drug (AOD) abuse or dependence during the measurement period who ***Initiated*** and ***Engaged*** treatment. (HEDIS measures used). The Regional CPT and EOC Committees and the SUD Workgroup:

a) Collect, review, and evaluate the timeliness of outcome data.
b) Establish Interventions for barriers to timely data.
c) Examine data to ensure adherence to project protocols

IET-AD Performance Measures

1. Initiation of AOD Treatment: Percentage of beneficiaries who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis.
2. Engagement of AOD Treatment: Percentage of beneficiaries who initiated treatment *and* who had two or more additional AOD services or medication treatment within 34 days of the initiation visit.

IET-AD Outcomes

This project remained informational only with no determined benchmarks for FY2022. CMHPSM completed all state requirements of validation activities in CY2022. The CMHPSM continued to track and trend overall percentages and statistically significant disparities in racial or ethnic groups. This data includes all SUD services, including those not funded by the PIHP and covered by Medicaid Health Plans.

By Health Plan		IET14-TOT			IET34-TOT		
End date	Organization	denom	num	rate	denom	num	rate

6/30/22	CMHPSM Total	3349	1385	0.4136	3349	455	0.1359
	AETNA BETTER HEALTH OF MICHIGAN	128	50	0.3906	128	14	0.1094
	BLUE CROSS COMPLETE	1073	459	0.4278	1073	135	0.1258
	HAP EMPOWERED HEALTH PLAN						
	MCLAREN HEALTH PLAN	190	83	0.4368	190	35	0.1842
	MERIDAN HEALTH PLAN	1005	413	0.4109	1005	147	0.1463
	MOLINA HEALTH CARE	346	137	0.3960	346	41	0.1185
	UNITED HEALTHCARE COMMUNITY PLAN	333	117	0.3514	333	44	0.1321
3/31/22	CMHPSM Total	3373	1335	0.3958	3373	428	0.1269
	AETNA BETTER HEALTH OF MICHIGAN	131	51	0.3893	131	14	0.1069
	BLUE CROSS COMPLETE	1010	421	0.4168	1073	141	0.1314
	MCLAREN HEALTH PLAN	169	67	0.3964	169	23	0.1361
	MERIDAN HEALTH PLAN	998	381	0.3818	997	134	0.1344
	MOLINA HEALTH CARE	362	135	0.3729	362	27	0.0746
	UNITED HEALTHCARE COMMUNITY PLAN	352	124	0.3523	352	43	0.1222
12/31/21	CMHPSM Total	3407	1318	0.3869	3407	436	0.1280
	AETNA BETTER HEALTH OF MICHIGAN	125	38	0.3040	125	9	0.0720
	BLUE CROSS COMPLETE	997	388	0.3892	1033	132	0.1278
	MCLAREN HEALTH PLAN	174	70	0.4023	174	25	0.1437
	MERIDAN HEALTH PLAN	1066	388	0.3640	1066	138	0.1295
	MOLINA HEALTH CARE	371	152	0.4097	375	44	0.1173
	UNITED HEALTHCARE COMMUNITY PLAN	345	125	0.3623	331	41	0.1239

1) Percentage who initiated treatment within 14 days of an SUD diagnosis (initial assessment): The 6/30/2022 state report shows a 41.36% performance rate for CMHPSM. This rate was comparable to the highest MHP rates.
Performance last fiscal year (FY2021) was 41.5% compared to state Medicaid total of 41.39%

2) Percentage of beneficiaries who received services within 34 days of the initiation visit
The 6/30/2022 state report shows a 13.59% performance rate for CMHPSM. Two of the seven MHPs performed above this rate.
Performance last fiscal year (FY2021) was 13.59% compared to state Medicaid total of 15.85%.

Accurate encounter reporting of this data remained a challenge to date based on allowable state parameters/services that count for this indicator.

IET-AD Recommendations
Develop data reporting and analysis structure of CMHPSM SUD provider network performance of priority population timeframes.

I. 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 Michigan Mental Health Code and the Michigan 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.
Supports Intensity Scale (SIS) – for individuals age 16 and older with an intellectual/developmental disability or cognitive impairment.

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 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 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 Utilization Review 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 FY2020-FY2022 and implemented at the onset of FY2023 by the Regional Parity Workgroup.

The committee determined a need to monitor the LOCUS as this parity-required assessment has less external fidelity assurances compared to other parity population assessments and hence poses a higher risk of error.

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 FY2023 the committee will review data relevant to service decisions or service utilization that are high cost highly utilized services such as Community Living Supports (CLS), or high risk in terms of persons served not receiving needed services.

With the regional implementation of a parity program in FY2023, the UM/UR Committee will also 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.

FY2022 Utilization Management/Review Measures

1. Assess overutilization of services
    a. Identify any services by population that indicate overutilization.
    b. Where indicated develop interventions to address overutilization to decrease overutilization.
    c. Incorporate LTSS, c waiver utilization, trends over time, provider stability factors.
    d. Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person-centered plan.

2. Assess underutilization of services
    a. Identify any services by population that indicate underutilization.
    b. Where indicated develop interventions to address underutilization.
    c. Incorporate LTSS, c waiver utilization, trends over time, provider stability factors.
    d. Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person-centered plan.

3. Assess validity and reliability of LOCUS application across the region.
    a. Increase in timely completion of LOCUS (at intake, before annual BPS signed
    b. Increase of percentage of LOCUS score changes over time – Medical necessity is evident when a significant score change occurs.
    c. Percentage of LOCUS overrides do not exceed 10%
    d. Improvement in clear documentation of overrides
    e. LOCUS score is accurately reflected in parity Level of Care in clinical record

4. Compliance with adverse benefit determination requirements (Analyze type of denial, accuracy of service and denial decision explanation, and compliance with timeframes)
    a. Correct timeframes used for advance action notice (Target 100%)
    b. Accurate use of reduction, suspension, or termination decisions. (Target 100%)
    c. Improvement in ABDs providing service denial reasons in language understandable to person served. 300 cases reviewed per county, 150 each of standard and advanced action).

FY2022 Utilization Management/Review Outcomes

All aspects of over and underutilization data analysis were not completed for FY2022 based on the time and resources needed to develop reports and incorporate the parity program, as there was no sufficient parity data in FY2022 to assess for these trends. The FY2023 QAPIP Plan will include data analysis for FY2023 that incorporates those areas not addressed in FY2022:

- Incorporate LTSS, c waiver utilization, trends over time, provider stability factors.
- Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person-centered plan.

1. Overutilization

Monthly data mining of IBNR reporting and significant increases in CLS services billed was conducted monthly for risks of overutilization with no findings or risks that would indicate further investigation.

2. Underutilization

Monthly data mining of IBNR reporting and significant increases in CLS services billed was conducted monthly for risks of underutilization.

Trends in ABDs and appeals for services authorized but not provided or delays in service due to provider capacity that would indicate potential underutilization was reviewed

FY2022 Q1: 0 /468 ABDs related to provider capacity delays
Q2: 4/527 related to delays in providing service within 14 days
Q3: 0/411 ABDs related to provider capacity delays

Q4: 2/382 relayed to provider capacity issues (CLS and personal care in specialized residential)

3. Assess validity and reliability of LOCUS application across the region.

FY2021 to FY2022 Comparison Data

In FY2021 the LOCUS data analysis conducted was prior to a report developed in the CMHPSM EHR therefore analysis was done manually with a smaller sample size

- 37/40 (92.5%) were completed at least annually; 3/40 (7.5%) were not completed annually
- 28/40 (70%) of LOCUS assessments had overrides; 14/28 (50%) overrides did not clearly document medical necessity reason.
- 7/28 (25%0 of LOCUS scores had significant score change, and of those with a significant change 5/7 (71%) had documented reason/IPOS update.

In FY2022 a report was developed whereby all LOCUS data could be reviewed based on identified timeframes. FY2022 findings include:

- 2967/4055 (73%) were completed at least annually; 1088/4055 (27%) were not completed annually.
- Of those LOCUS assessment where an override occurred, 607/4055 or 15% of LOCUSs completed had an override. Of those overrides, 594/608 (98%) did have the override sufficiently explained, and 14/608 (2%) did not have the override sufficiently explained. This is a significant increase from FY2021, based on system changes and staff training interventions.
- FY2023 data will need to be updated to include significant scores changes and whether the IPOS was amended as a result, and reasons for not having annual LOCUS assessments completed.

J. 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.

In preparation for the lifting of MDHHS waivers of recertification requirements for Habilitation Supports Waiver (HSW) based on the COVID pandemic, CMHPSM began monitoring and training of CMHSP staff responsible for local HSW recertification to ensure vulnerable individuals in need of this level of care maintain their HSW enrollment.

FY2022 Measures for Oversight of Vulnerable Individuals

Ensure utilization of Habilitation Supports Waiver enrollment for those in need of HSW level of care.
Ensure individuals with continued need for HSW are recertified in a timely way (95%) and meet compliance and documentation requirements (100%).

FY2022 Outcomes for Oversight of Vulnerable Individuals

Monthly monitoring was completed with the following outcomes:

Habilitation Support Waiver	Total Enrolled	# of recerts past due	Percentage Compliance
Q1	719	85	11%
Q2	724	109	15%
Q3	712	86	12%
Q4	701	40	5.7%

Regular training and monitoring resulted in a decrease in past due recertifications. This project will be continued in FY2023.

K. 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. The 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.

The CMHPSM has identified the means by which LTSS will be incorporated 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.

FY2022 LTSS Measures

Ensure those receiving LTSS are captured and included in the data reporting and analysis of all relevant performance measures at 100% completion by FY2023.

FY2022 LTSS Outcomes

- During FY2022 LTSS was included in the following QAPIP activities and/or performance measures: member satisfaction results credentialing and recredentialing, verification of Medicaid services, over- and underutilization, provider network capacity and monitoring.
- LTSS was included in the oversight and data reporting for Home and Community Based Services waiver monitoring and upcoming and FY2023 MDHHS required 1915(i) enrollment, including if services are being provided and those in need of LTSS are accurately reported.
- CMHPSM staff were trained in the identification of those needing or receiving LTSS for MDHHS 1915i enrollment requirements.
- As FY2022 was a baseline year for this performance measure there are no previous years for comparative analysis.

LTSS Recommendations

- Develop HCBC auditing system that incorporates and identifies providers that serve persons in need of LTSS.
- Identify baseline, performance measures, and interventions for FY2023 related to outcomes for persons served.
- Improve accuracy in identification of LTSS in the data reporting and analysis of critical incidents, sentinel events, risk events, behavior treatment, practice guidelines, trends in service delivery and health outcomes over time, and monitoring of progress on performance goals and objectives.

L. 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 and Data

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.

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.

FY2022 Measures and Outcomes of Persons Served Experiences

A. Customer Satisfaction Survey Data

FY2022 Survey Measures:

1. Percentage of children and/or families indicating satisfaction with mental health services. (Standard 80%/)
2. Percentage of adults indicating satisfaction with mental health services. (Standard 80%)
3. Percentage of individuals indicating satisfaction with long-term supports and services. (Standard 80%)

For FY2022 random samples of individuals served from all populations of children and adults (SED, MI, IDD/CI) were pulled and at least 30 individuals from each population were surveyed using the same questions/statements.

Areas that had outcomes of 80% or less were reviewed for causes, trends, and potential interventions to improve performance.

The assessment included the following statements:

1. I feel the agency is a comfortable place.
2. I feel respected when I call or see my CMH staff.
3. My phone calls are returned by the next day.
4. I saw my CMH staff within 15 minutes of my appointment.
5. I decide what is important when working with my CMH staff.
6. I understood what my CMH staff said today.
7. My CMH staff helps to achieve my goals.
8. My CMH staff follow up about my physical health needs.
9. I feel able to complain or disagree with my CMH staff.
10. I know how to file a complaint.

11. Would you like for Customer Services staff to call you?

FY2022 Survey Outcomes

- All items with the exception of item #10 – I know how to file a complaint – performed at 80% satisfaction or higher. Item #10 scored at 64%, indicating a need to intervene to ensure individuals were aware of how they can express their dissatisfaction and who to contact.
- In analyzing the answers to item #10, the causes were not clear, making interventions difficult to ascertain.
- The FY2022 survey could not be compared to FY2021 or FY2020 as these surveys focused on the impacts of the COVID pandemic and people's experience with the increase in telehealth services.

Survey Data Recommendations

The Regional Customer Services Committee therefore made the following recommendations FY2023:

1. Include more specific follow-up questions to item #10 – I know how to file a complaint to ascertain causes from which interventions and baseline performance can be developed.
2. Increase information in lobbies and websites about how to contact someone at the CMH/CMHPSM about concerns.
3. Seek feedback from the RCAC on the development of the revised survey for FY2023 and potential ways to provide education to individuals served.

For FY2023 the CMHPSM will also 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 evaluation.

B. Recovery Self-Assessment (RSA) Survey Data

CMHPSM distributes 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 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. 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.

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 and include a comment box.

Survey or assessment results are included in the annual CMHPSM QAPIP Evaluation and presented to CMHSPs, SUD Providers, the CMHPSM governing body and Regional Consumer

Advisory Council including recommendations and pursuit of governing body feedback on recommendations.

Each survey was broken down into six domains:	Each survey question contained an answer choice based on a 5-point Likert Scale:
1. Life Goals	1 = Strongly Disagree
2. Involvement	2 = Disagree
3. Diversity of Treatment Options	3 = I am neutral
4. Choice	4 = Agree
5. Individually Tailored Services	5 = Strongly Agree
6. Inviting Space	

FY2022 Recovery Self-Assessment (RSA) Survey Measures

1. Achieve at least an Agree (Likert score of 4) for Client responses in all domains.
2. Achieve improvement in Involvement domain from FY2021.

FY2022 Recovery Self-Assessment (RSA) Survey Outcomes

A total of 632 individuals participated in this analysis:

Participant	Total	Lenawee	Livingston	Monroe	Washtenaw
Clients	484	79	71	259	75
Provider Staff	120	23	47	15	36
Administrators	28	4	8	3	13

For FY2022 Lenawee County was rated highest in the Choice domain. Livingston County was rated highest in the Diversity and Inviting Space domains. Monroe County was rated highest in Choice and Inviting Space domains. Washtenaw County was rated highest in Inviting Space and Choice domains.

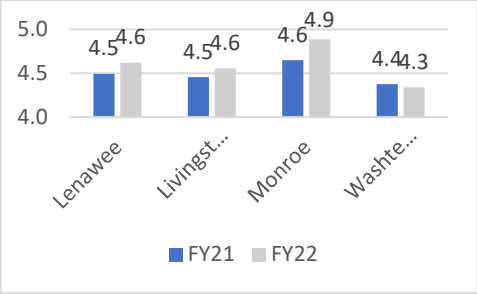
When comparing Community Mental Health to Substance Use Disorder providers, no significant differences have been identified. The most notable differences in client responses between the service providers in each county were in the Involvement Domain:

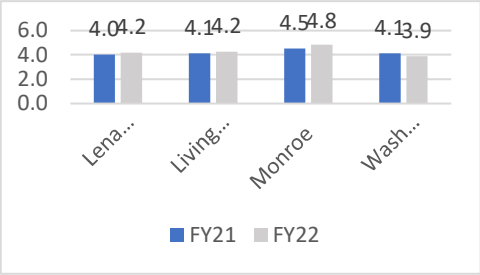
- Lenawee County: Involvement Domain: CMH 4.69 vs. SUD 4.09
- Livingston County: Involvement Domain: CMH 4.09 vs. SUD 4.36
- Monroe County: Involvement Domain: CMH 4.05 vs. SUD 4.84
- Washtenaw County: Involvement Domain: CMH 3.11 vs. SUD 3.96

Comparison of domains from FY2017 to FY2020: Domains remained stable or had a slight increase for all domains. Involvement continues to be a domain with the most opportunity for improvement in a specific county, however it's regional average score remains above 4.

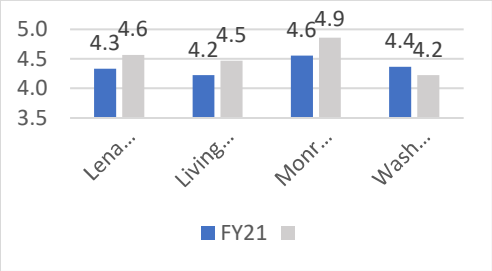
The graphs below show comparisons of client surveys for domains from FY2021 and FY2022:

Life Goals **Involvement**

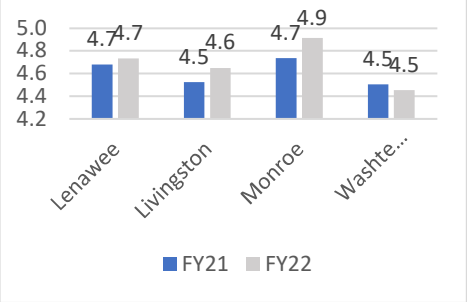




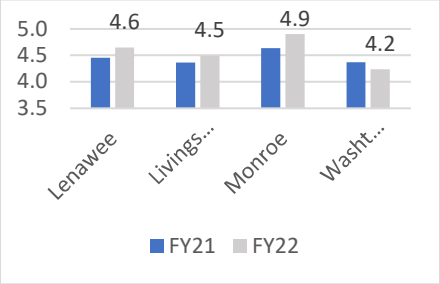
Diversity of Treatment Options



Choice



Client Version Individually Tailored Services



RSA Recommendations for FY2023

As MDHHS no longer requires use of the RSA, the CMHPSM will determine if another survey measure can be implemented to meet the requirements in reviewing persons experiences with SUD services, or if the RSA will be continued for FY2023.

C. Grievance Data

FY2022 Grievance Data Measures

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%).

Below is the FY2022 analysis of grievances per county with trends reported by Regional Customer Services staff.

Grievances	Len	Liv	Mon	Wash	Timeframes Met	Timeframes Not Met
Access and Availability	8	7	24	8	47	0
Accommodations	1	0	0	0	1	0
Financial or Billing Matters	0	0	0	1	1	0

Provider Choice	14	2	0	4	20	0
Quality of Care	17	30	56	12	115	0
Service Environment	1	1	0	0	2	0
Service Timeliness	0	2	0	0	2	0
Other	0	7	0	0	7	0
Grand Total	**41**	**49**	**80**	**25**	**195**	**0**

FY2022 Grievance Data Outcomes

- There was an average of 1.1 grievances per 1000 members served regionally (or 10.1 per 100)
- There was an overall downward trend for the region, with one CMH having a slight increase in Q3 and Q4.
- Of the total grievances 88% were substantiated (there was some evidence to support what the individual was concerned about) and 12% were unsubstantiated
- Most common interventions were to assign a new provider/care manager/supports coordinator (44 cases; 25.5%)
- The regional average to resolve a grievance was 5.7 days, which all fall under the internal regional value of resolving grievances in 10 days, and far exceed the federal requirements of resolution in 90 days.

Grievance Data Recommendations for FY2023

- Need to ensure all cases have at least one intervention added.
- Retrain staff as some cases met the definition of an inquiry not a grievance, and staff entering data were initially misinterpreting the definition of substantiated.
- Identify in FY2023 if there are specific needs or differences within consumer care populations (i.e., demographics, SUD/DD/MI) in type of grievance or intervention used.
- Explore trends with categories of grievances by different locations/providers.
- A procedure will be developed in FY2023 to further train staff on the accuracy of the data and use of the data reporting system.

D. Appeals Data

Consumer appeals data is maintained and monitored by the Fair Hearings Officers and regional representatives of the CMHPSM Utilization Management/ Review Committee. Data is shared with the Regional Customer Services Committee and the CPT Committee to address any trends or recommendations.

FY2022 Appeals Data Measures

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%)

FY2022 Appeals Data Outcomes

Type	Upheld	Reversed	Withdrawn/ Dismissed	SUD Cases (within data)	Timeframes Met (Local)	Timeframes Not Met (Local)	Total	LTSS

Local Appeals	15	13	0	1	22	6	28	16
State Level Appeals	2	3	5	1	N/A	N/A	10	Data not available in FY2022

Local Appeals per 1000 served	**Q1**	**Q2**	**Q3**	**Q4**
Lenawee CMH	4.3	2	1	
Livingston CMH	0.7	1	0	
Monroe CMH	2.2	1	0	
Washtenaw CMH	1.7	0	1	

Comparison to FY2021 Data: Appeal requests continued to decline as the COVID-19 pandemic continued, from a total of 40 local appeals and 11 state level appeals in FY2021.
A procedure that includes compliance with local appeals documentation and timeframes, as well as data entry into the appeals module of the region wide EHR was completed and relevant staff were trained on this procedure in 2022. Therefore, this FY2022 data will be used as a baseline by which further improvements will be measured.

Appeals Data Recommendations
Baseline data for meeting timeframes will continue for analysis in FY2023. Additional analysis will be explored in FY2023 to include:

- Trends in services appealed.
- Most common determination reasons and any implications for populations or services including LTSS. The system has been updated for FY2023 to identify services and persons receiving LTSS.

E. National Core Indicators/Benchmarks

The National Core Indicators (NCI) program is a voluntary effort by state developmental disability agencies to track their performance using a standardized set of consumer and family/guardian surveys with nationally validated measures. The NCI provides an in-Person Survey to be used with adults with IDD age 18 and older. Areas included in the survey are: Residential Designation, Choice and Decision-Making, Work, Self-Direction, Community Inclusion, Participation and Leisure, Relationships, Satisfaction, Service Coordination, Community Access, Health, Wellness, Safety, Rights and Respect. The data was reviewed for any trends that apply to our region for which recommendations could be made to improve consumer experience in those areas.
For FY2022 the MDHHS Quality Improvement Council is incorporating the use of NCI to address potential improvements for PIHPs. CMHPSM was recognized as one of 3 PIHPs in the state that took proactive measures to incorporate this data in PI efforts in FY2021.

FY2022 National Core Measures

Review National Core Indicators (NCI) for any relevance to CMHPSM areas identified in satisfaction surveys, grievances, recipient rights, or appeals data.

Incorporated measures and interventions for any NCI identified areas not currently addressed in regional data relevant to individual experience with CMHPSM supports and services.

FY2022 National Core Outcomes

National Core Indicators have a one-year time lag therefore FY2021 data was reviewed. While the NCI data showed opportunities in Michigan for employment opportunities and people's interest in seeking meaningful work, this was not an area noted locally in member experience survey results collected in our region, nor has it been a factor of grievances or appeals.

CMHSPM will seek guidance from MDHHS in FY2023 on what applications this data could provide in local measures.

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 network 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), 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 provider network that meets the service array and needs of the populations served.
- 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.
- 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.

FY2022 Provider Qualifications Measures

1. Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements.
2. Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements.
3. Network Adequacy plan completed per state requirements and timeframes.

FY2022 Provider Qualifications Outcomes

1. Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements.

This measure was conducted through auditing of providers through Medicaid Services Verification, monitoring of CMHSPs, and auditing of staff qualifications through credentialing and recredentialing reviews of providers. Random samples of licensed providers for Access and direct operated services were reviewed, with corrective action plans required if requirements were not met. Outcomes for FY2022 are as follows:

- Medicaid Services Verification: 100% of cases pulled showed evidence of licensed providers in compliance with staff qualifications.
- Monitoring of CMHSPs FY: *Monitoring includes the CMHSPs opportunity to provide additional evidence therefore some data may be pending finalization:*

Lenawee	100% compliance
Livingston:	1 staff was missing evidence staff did not have record of Grievance and Appeals training. 2 staff did not have record of Bloodborne Pathogens related training. All other qualifications were met.
Monroe	3 staff were missing evidence of master degree or transcript for having an LLMSW

	2 staff were missing evidence of ASAM training 3 staff were missing evidence of updated Rights training All other qualifications were met.
Washtenaw	4 staff were missing evidence of Grievance and Appeals training. 6 staff were missing evidence of Medicaid Integrity training 1 staff was missing evidence of Bloodborne Pathogens/IC training All other qualifications were met.

- Credentialing and Recredentialing of Providers:

20 CMHPSM organizational providers were credentialed or recredentialed during FY2022, with 95% (19/20) meeting compliance upon initial review, and 100% meeting compliance within the 90 days timeframe of post credentialing auditing.
21 LIP providers were credentialed or recredentialed during FY2022, with 95% (19/20) meeting compliance upon initial review.

2. Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements.

This measure was conducted through auditing of providers through Medicaid Services Verification, monitoring of CMHSPs, and auditing of staff qualifications through credentialing and recredentialing reviews of providers. Random samples of non-licensed providers for Access and direct operated services were reviewed, with corrective action plans required if requirements were not met. Outcomes for FY2022 are as follows:

- Medicaid Services Verification: 100% of cases pulled showed evidence of non- licensed providers in compliance with staff qualifications.
- Monitoring of CMHSPs: auditing of non-licensed providers was included in the MEV review and outcomes/CMHPSM oversight of the MDHHS waiver review for FY2022.
- Credentialing and Recredentialing of Providers: 20 CMHPSM organizational providers were credentialed or recredentialed during FY2022, with 95% (19/20) meeting compliance upon initial review, and 100% meeting compliance within the 90 days timeframe of post credentialing auditing.

3. Network Adequacy plan completed per state requirements and timeframes.

The Network Adequacy plan and additional reporting requested by MDHHS was completed and submitted by the state due date.
While there has been trending of providers having insufficient staffing capacity related to the COVID pandemic and prior provider stability challenges reported to MDHHS, the adequacy of the provider network in terms of array of providers and array of services was not determined to be a risk in relationship to network adequacy.
Provider capacity issues are most prominent in services related to community living supports (CLS), specialized residential homes, and skill-building/vocational services.

Provider Qualifications Recommendations

- CMHPSM will continue to advocate for the needs of provider stability including tracking data on when services have been suspended or delayed related to provider capacity, or when providers decline referrals or terminate their contractual relationship with the CMHPSM.
- Increase data reporting of compliance with provider qualifications from CMHSP monitoring of sub contractual providers as a delegated function.

- Include analysis trends in service delivery and health outcomes over time, including whether there have been improvements and barriers impacting in the quality of health care and services for members as a result of the activities and the incorporation of LTSS.

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 FY2023 additional performance improvement projects will be conducted and reported to the Regional Network Management Committee will 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.

FY2022 Provider Credentialing and Recredentialing Measures

1. Credentialing and re-credentialing of organizational providers meet all state/federal requirements and timelines.
2. 100% of organizational providers audited show evidence that physicians and other health care professionals, and non-licensed providers are qualified to perform their services.
3. Recredentialed providers meet quality performance measures, with no issues related to grievances, performance indicators, utilization, appeals, member satisfaction, provider monitoring that would disqualify provider for re credentialing.
4. Credentialing and re-credentialing of LIP providers meet all state/federal requirements and timelines.

FY2022 Provider Credentialing and Recredentialing Outcomes

1. Credentialing and re-credentialing of organizational providers meet all state/federal requirements and timelines.
   For FY2022 83% of timeframes were met (174/203 providers)
2. 95% of organizational providers audited show evidence that physicians and other health care professionals, and non-licensed providers are qualified to perform their services.
3. Recredentialed providers meet quality performance measures, with no issues related to grievances, performance indicators, utilization, appeals, member satisfaction, provider monitoring that would disqualify provider for re credentialing.
   100% of SUD providers were recredentialed with no findings that required denial of credentialing application
4. Credentialing and re-credentialing of LIP providers meet all state/federal requirements and timelines.
   For FY2022 Quarters 1-2 showed 88% compliance (8/9), and Quarters 3-4 showed 100% compliance (5/5).
5. Credentialing of CMH direct operated staff was added to the report mid-year in FY2022 as a result of HSAG EQR findings, and as such data was insufficient to develop a baseline for FY2022.

Provider Credentialing and Recredentialing Recommendations

Ensure accurate reporting of CMH staff, including the development of baseline data, procedures and training of staff reporting the data, and random sample monitoring of credentialing and recredentialing records.

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 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

FY2022 Service Verification Measures

1. CMHPSM will meet or exceed a 95% rate of compliance of Medicaid delivered services in accordance with MDHHS requirements.
2. CMHPSM will complete Medicaid Event verification reviews in accordance with CMHPSM policy and procedure.
3. CMHPSM will achieve 100% compliance with MDHHS contract requirements by completing and submitting the MEV Annual Methodology Report as required and by the due date, including identifying trends, patterns, strengths and opportunities for improvement to MDHHS.

FY2022 Service Verification Outcomes

1. CMHPSM will meet or exceed a 95% rate of compliance of Medicaid delivered services in accordance with MDHHS requirements.

The FY2022 MEV review resulted in meeting the 95% rate of compliance.

2. CMHPSM will complete Medicaid Event verification reviews in accordance with CMHPSM policy and procedure.

All elements of the MEV were completed, 100% compliance.

3. CMHPSM will achieve 100% compliance with MDHHS contract requirements by completing and submitting the MEV Annual Methodology Report as required and by the

due date, including identifying trends, patterns, strengths and opportunities for improvement to MDHHS.

The MEV was completed and submitted to MDHHS by the 12/31/22 due date.
Number of providers tested: 4 CMHSPs, statistically significant random sample from 408 MH and SUD sub contractual providers for all Medicaid funded CPT codes.
Number of providers put on corrective action plans for Medicaid Service Verification issues: 0
Number of providers on corrective action for repeat / continuing for Medicaid Service Verification issues: 0
Number of providers taken off corrective action plans related to Medicaid Service Verification issues: N/A
These findings were consistent with the current MDHHS requirements since FY2017.

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.

In FY2022 CMHPSM created a training platform through Learnworlds that made trainings such as cultural competence more accessible to providers and easier to review by the CMHSPs.

FY2022 Cultural Competence Measures

Providers are trained in cultural competence at 100% rate as monitored through provider qualifications and provider credentialing and recredentialing QAPIP measures.
Reviews of cultural competence training will be incorporated into Provider Credentialing, Provider Qualifications, and Provider Monitoring Performance measures and outcomes (see sections of this QAPIP Evaluation for details).

FY2022 Cultural Competence Outcomes

Provider Credentialing Measures/Outcomes: No findings related to Cultural Competence training.
Provider Qualifications Measures/Outcomes: No findings related to Cultural Competence training.
Provider Monitoring Measures/Outcomes: No findings related to Cultural Competence training.

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.

In FY2022 an additional component of CMHPSM monitoring CMHSP Access systems for both CMH and SUD access services was initiated to support assessments of potential barriers related to the FY2022-25 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 FY2023.

FY2022 Provider Monitoring Measures

1. Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP. 100% completion of planned audits. 100% of providers will have remedial action sufficient wherein no contractual action needs to be taken.
2. 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. 100% of corrective action plans are completed and submitted as required.

FY2022 Provider Monitoring Outcomes

Monitoring tools were updated for FY2022 based on external audit findings, for the monitoring of MH and SUD provider networks.
SUD provider monitoring was completed for FY2022 with no outcomes requiring any contractual action, thus maintaining the provider network.
CMHSPM completed monitoring of CMHSP Access functions including staff qualifications and compliance with SUD and MH access standards to address potential risks, as well as the shift to SUD Access functions transitioning to Washtenaw CCMH. There were no outcomes requiring any contractual action for these functions, with all 4 CMHSPs (100%) receiving a passing score and corrective action plans to address findings that will be monitored in FY2023.

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.

FY2022 Measures External Quality Review Measures

1. Score of Met for all applicable EQR Medicaid Managed Care standards reviewed by HSAG for FY2022.
2. Substantial compliance with MDHHS waiver requirements.

FY2022 External Quality Review Provider Outcomes

1. Score of Met for all applicable EQR Medicaid Managed Care standards reviewed by HSAG for FY2022.

While the scoring was a reduction in performance from the last review of these elements in FY2018, the areas of correction were more so related to, and corrections in structure and reporting were already in process for, the majority of these standards with some aspects of the pandemic affecting

A corrective action plan was submitted within the required timeframes and approved by HSAG. Findings from this review are incorporated into the FY2023 QAPIP Plan and Workplan.

FY2022 Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VII—Provider Selection	16	16	12	4	0	75%
Standard VIII—Confidentiality[1]	11	11	10	1	0	91%
Standard IX—Grievance and Appeal Systems	38	38	29	9	0	76%
Standard X—Subcontractual Relationships and Delegation	5	5	4	1	0	80%
Standard XI—Practice Guidelines	7	7	6	1	0	86%
Standard XII—Health Information Systems	12	11	9	2	1	82%
Standard XIII—Quality Assessment and Performance Improvement Program	30	30	22	8	0	73%
Total	119	118	92	26	1	78%

Summary of FY2017–2018 Compliance Monitoring Review Results

FY2018 Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*N/A*	
Standard VI—Customer Service	39	34	5	0	**87%**
Standard VII—Grievance Process	26	26	0	0	**100%**
Standard IX—Subcontracts and Delegation	11	10	1	0	**91%**
Standard X—Provider Network	12	10	2	1	**83%**
Standard XII—Access and Availability	19	17	2	0	**89%**
Standard XIV—Appeals	54	47	7	0	**87%**
Standard XV—Disclosure of Ownership, Control, and Criminal Convictions	14	14	0	0	**100%**
Standard XVII—Management Information Systems	12	12	0	2	**100%**
Total Compliance Score	**187**	**170**	**17**	**3**	**91%**

2. Substantial compliance with MDHHS waiver requirements.

The FY2021 MDHHS site review of waiver services extended into FY2022 for the corrective action plan submissions and responses to that review.
At the final report, out of a total of sixty-seven (67) measures reviewed between the Habilitation Services Waiver (HSW), the Children's Waiver Program (CWP) and the waiver for children with Severe Emotional Disturbances (SEDW). Of those sixty-seven measures, MDHHS noted lack of remediation/sufficient remediation for the following three (3) performance measures in the final report:
CWP: P.1.2: The IPOS addresses all service needs reflected in the assessments.
One case in which the family wished to receive ABA services. MDHHS did not consider ABA services to meet the habilitative requirements of the Children's Waiver Program and did not consider documented efforts to discuss options supported other available services.

HSW: B.2 and Q.2.
B.2. Behavior treatment plans are developed in accordance with the Technical Requirement for Behavior Treatment Plan Review Committees.
One (1) case in which the family declined behavioral support services and preferred medications for behavior management. While this decision was discussed with the family and reviewed in BTC, MDHHS did not think documentation sufficiently included steps in advising family of BTC conditions with use of PRN of medications.

Q.2.4 All HSW providers meet staff training requirements.
One (1) staff for one individual did not have evidence of being trained in the person's plan of service or in CPR, though this remained compliant within the PH emergency waiver. The original finding for this same staff/individual case was they did not have evidence of recent CPR and First Aid trainings submitted; both these trainings had been submitted in the corrective action plan process.

There was insufficient evidence to support the need for changes in the current provider monitoring structure or the FY2023 QAPIP work plan which will already address ensuring staff meet provider qualifications.

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, DEFINITIONS/EXPLANATION OF TERMS, (current FY2022/FY2023).

MDHHS PIHP CONTRACT, ATTACHMENT, *Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans* (current version).

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

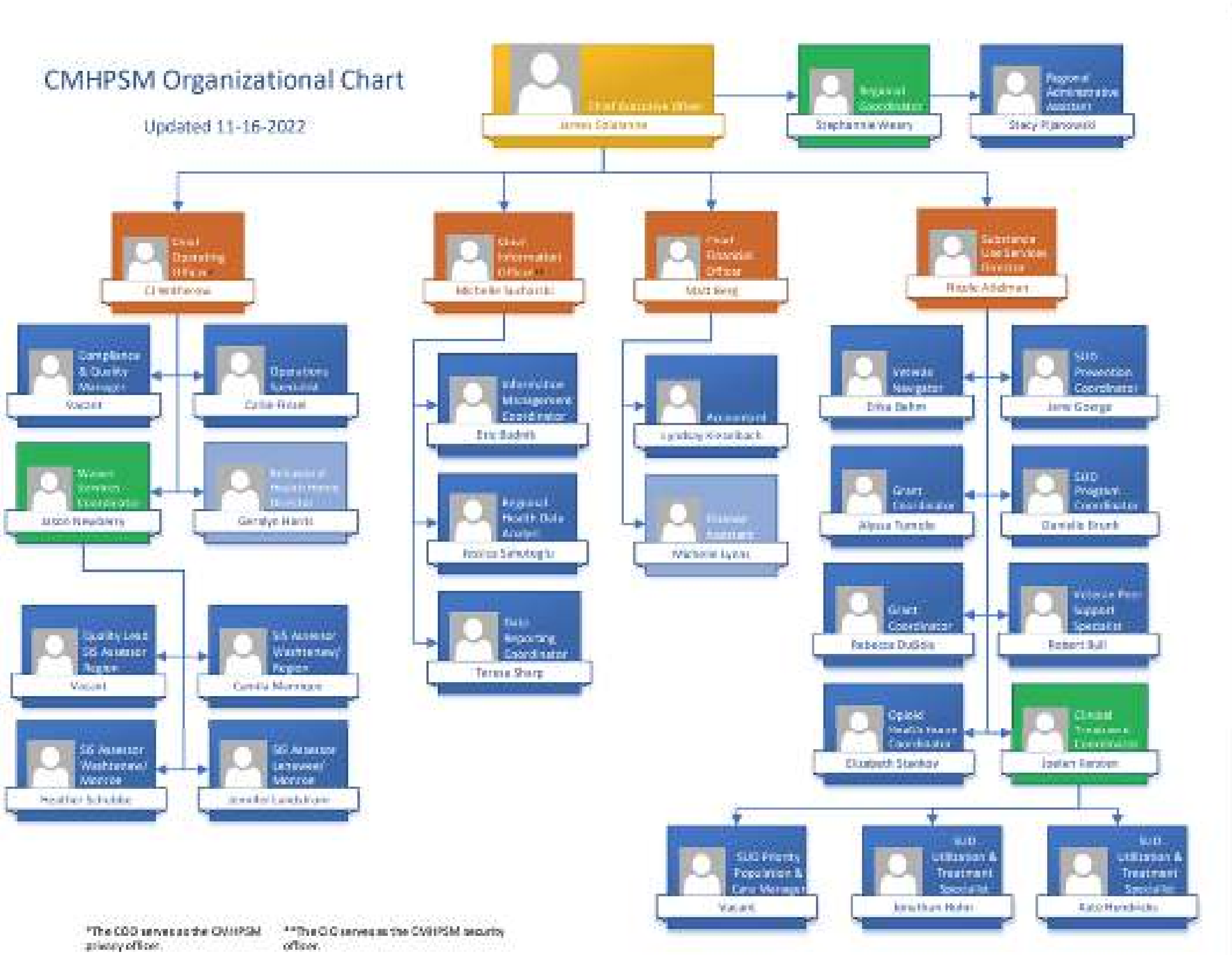
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN RESOURCES, HRSA. Clinical Quality Improvement Resources https://bphc.hrsa.gov/technical-assistance/clinical-quality-improvement

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. Attachments

A. Attachment A:



B. *Attachment B:*