COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

BOARD MEETING

Patrick Barrie Room

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

Wednesday, February 12, 2025, 6:00 PM

To join by telephone:
1-616-272-5542
Phone conference ID: 432 410 964#

To join by computer:
Click here to join the meeting
Meeting ID: 270 663 910 263, Passcode: SkJqHU

Agenda

		Guide
I.	Call to Order	1 min
II.	Roll Call	2 min
III.	Consideration to Adopt the Agenda as Presented	2 min
IV.	Consideration to Approve the Minutes of the 12-11-2024 Meeting and Waive the Reading Thereof {Att. #1}	2 min
V.	Audience Participation (3 minutes per participant)	
VI.	Old Business a. Board Information: Milliman Internal Service Fund Analysis {Att. #2} b. Board Information: FY2025 CMHPSM Finance Report through {Att. #3}	30 min
VII.	New Business a. Board Action: FY2024 QAPIP Evaluation {Att. #4} b. Board Action: Contracts {Att. #5} c. Board Actions: Proclamations for Stephannie Weary (10-yr) {Att. #6a}, Matt Berg (5-year) {Att. #6b}, Kate Hendricks (5-year) {Att. #6c}, and CJ Witherow (5-year) {Att. #6d}	45 min
VIII.	Reports to the CMHPSM Board a. Information: CEO Report to the Board {Att. #7}	15 min
IX.	Additional Information: a. Full QAPIP FY2024 Evaluation {Att. #8}	
X.	Adjournment	

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN
REGULAR BOARD MEETING MINUTES
December 11, 2024

Members Present for In-Person Quorum:	Judy Ackley, Rebecca Curley, LaMar Frederick, Bob King, Rebecca Pasko, Alfreda Rooks, Mary Serio, Holly Terrill
Members Not Present For In-Person Quorum:	Patrick Bridge, Molly Welch Marahar, Mary Pizzimenti, Annie Somerville, Ralph Tillotson
Staff Present:	Stephannie Weary, James Colaianne, Matt Berg, Nicole Adelman, Lisa Graham, Trish Cortes, CJ Witherow, Michelle Sucharski, Connie Conklin, Kathryn Szewczuk
Guests Present:	Attorneys Greg Moore (phone) and Chris Ryan from Taft Law

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

II. Roll Call
- Quorum confirmed.

III. Consideration to Adopt the Agenda as Presented
Motion by R. Curley, supported by A. Rooks, to approve the agenda
Motion passed unanimously
- Agenda addition: new item VII – Closed Session Action Request

IV. Consideration to Approve the Minutes of the October 9, 2024 Meeting and Waive the Reading Thereof
Motion by J. Ackley, supported by R. Pasko, to approve the minutes of the 10/9/2024 meeting and waive the reading thereof
Motion passed unanimously

V. Consideration to Approve the Minutes of the October 30, 2024 Meeting and Waive the Reading Thereof
Motion by M. Serio, supported by H. Terrill, to approve the minutes of the 10/30/2024 meeting and waive the reading thereof
Motion passed unanimously

VI. Audience Participation
None

VII. Revised: Closed Session
Motion by R. Pasko, supported by H. Terrill, to move the CMHPSM Board meet in closed session under section 8(1)(e) of the Open Meetings Act, to consult with our attorneys related to the following legal actions:
- **The Northcare Network Mental Health Care Entity, Northern Michigan Regional Entity and Region 10 PIHP v. State of Michigan, 24- -MZ, Michigan Court of Claims**
- **The Waskul et al v. Washtenaw County Community Mental Health et al, Case Number 2:16-cv-10936-PDB-EAS, Eastern District of Michigan**

Motion passed unanimously

Roll Call Vote
Yes: J. Ackley, R. Curley, L. Frederick, B. King, R. Pasko, A. Rooks, M. Serio, H. Terrill
No:
Not present for in-person vote: P. Bridge, M. Welch Marahar, M. Pizzimenti, A. Somerville, R. Tillotson

- The meeting entered into closed session at 6:06 p.m.
- After returning to open session at 6:53 p.m.:

Motion by M. Serio, supported by A. Rooks, for the CMHPSM to join the Northcare Network Mental Health Care Entity, Northern Michigan Regional Entity and Region 10 PIHP lawsuit v. State of Michigan, 24- -MZ, Michigan Court of Claims
Motion passed unanimously
Roll Call Vote
Yes: J. Ackley, R. Curley, L. Frederick, B. King, R. Pasko, A. Rooks, M. Serio, H. Terrill
No:
Not present for in-person vote: P. Bridge, M. Welch Marahar, M. Pizzimenti, A. Somerville, R. Tillotson

VIII. Old Business

a. Information: FY2024 Finance Report September 2024
M. Berg presented.

b. Information: CEO Contract Committee Update
- The committee met this evening and would like the board to treat the CEO with the same consideration as the rest of the staff regarding the cost of living adjustment (COLA).
- The committee recommended a 3% COLA increase effective 1/1/25, and a 3% COLA effective 1/1/26, to be amended in the CEO contract.

Motion by J. Ackley, supported by A. Rooks, to authorize Board Chair B. King to sign an amended CEO contract to include a 3% COLA effective 1/1/25 and another 3% COLA effective 1/1/26, with legal review prior to signing
Motion passed unanimously
Roll Call Vote
Yes: J. Ackley, R. Curley, L. Frederick, B. King, R. Pasko, A. Rooks, M. Serio, H. Terrill
No:
Not present for in-person vote: P. Bridge, M. Welch Marahar, M. Pizzimenti, A. Somerville, R. Tillotson

IX. New Business

a. Board Action: FY2025 QAPIP Plan
Motion by R. Curley, supported by H. Terrill, to approve the annual plan for quality assessment and improvement plan activities during FY2025
Motion passed unanimously

b. Board Action: Proclamations for Joelen Kersten (10-yr) and James Colaianne
Motion by L. Frederick, supported by R. Curley, to approve the Issuance of the formal proclamation acknowledging the 10 years of service by Joelen Kersten to the PIHP region as a CMHPSM employee, signed by all CMHPSM Board members.
Motion passed unanimously

Motion by L. Frederick, supported by R. Curley, to approve the Issuance of the formal proclamation acknowledging the 10 years of service by James Colaianne to the PIHP region as a CMHPSM employee, signed by all CMHPSM Board members.
Motion passed unanimously

c. Board Action: Contracts
Motion by L. Frederick, supported by H. Terrill, to authorize the CEO to execute the contracts/amendments as presented
Motion passed unanimously

X. Reports to the CMHPSM Board

a. Information: CEO Report to the Board
For FY18-19, all payments between the PIHP and the CMHs are complete. FY18-22 are now closed.
FY25 contract: Region 6 will join the other 3 PIHPs in the lawsuit versus the state.
The 2025 benefits enrollment period for staff is this week.
The PIHP Directors met with the state this month. There was no update on conflict free access and planning; the state says a plan is coming.
J. Colaianne will continue to send out the lame duck notifications to the board.

XI. Adjournment

Motion by A. Rooks, supported by J. Ackley, to adjourn the meeting
Motion carried

- The meeting was adjourned at 7:39 p.m.

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Rebecca Pasko, CMHPSM Board Secretary

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Eric P. Goetsch, FSA, MAAA
Principal and Consulting Actuary

eric.goetsch@milliman.com

February 6, 2025

James Colaianne
Chief Executive Officer
Community Mental Health Partnership of Southeast Michigan
3005 Boardwalk, Suite 200
Ann Arbor, MI 48108
Sent via email: colaiannej@cmhpsm.org

Re: Results of ISF Analysis for Medicaid / HMP Mental Health and Substance Abuse Services

Dear James:

We completed our funding analysis for the Community Mental Health Partnership of Southeast Michigan (CMHPSM) Internal Services Fund (ISF) related to its shared risk contract with the State of Michigan to provide mental health and substance abuse services. This analysis should assist CMHPSM by illustrating the annual ISF balances that may be required to adequately protect against potential future deficits and the additional capital funding that may be required to maintain these balances.

Please note, in this letter we refer to "Medicaid" costs, revenue amounts, and member months. These "Medicaid" amounts referenced are the combined Medicaid and Healthy Michigan Plan (HMP) amounts. In addition, our use of "mental health" in this letter encompasses both mental health and substance abuse services.

The ISF is intended to reasonably protect CMHPSM from unexpected cost fluctuations related to its risk contract with the State. CMHPSM's agreement with the State limits its risk under this program each fiscal year (FY) to 7.5% of its operating income from the State. The appropriate level of the ISF should reflect this contractual arrangement and the level of risk CMHPSM is willing to accept. Our analysis assumes any surplus made by CMHPSM in a given year will be used as savings or added to the ISF and be used to offset higher than expected treatment costs in future years. Similarly, we assumed any loss sustained by CMHPSM in a given year will be offset using prior year savings or funds from the ISF, to the extent the funds are available.

RESULTS

The scenarios we tested imply that CMHPSM's Medicaid ISF should continue to be funded with annual surpluses that occur. While the ISF balance and savings may be sufficient in the near term, projected annual deficits in certain scenarios suggest there is potential that the ISF dollars will be needed to offset these deficits in the long term. Therefore, we recommend, based on our various trend scenarios, contributions of available Medicaid surpluses such that the total FY 2024 ISF balance is between $29,800,000 and $49,700,000 and the total FY 2025 ISF balance is between $33,200,000 and $49,200,000. These results are dependent on the projection assumptions contained in this letter. Different assumptions will lead to different results; therefore, this letter should only be considered in its entirety.

The remainder of this letter discusses the process used to determine the recommended ISF funding level, the components of the financial analysis performed, and three scenarios of future potential outcomes that CMHPSM should consider when making ISF funding decisions.

SETTING INTERNAL SERVICE FUND LEVEL

In order to fund the ISF for future Medicaid mental health costs, CMHPSM will have to decide how much risk it wants to assume. To help CMHPSM make this decision, we analyzed the distribution of costs for Medicaid mental health and substance abuse services.

Table 1 includes the average per enrollee per month (PEPM) mental health treatment costs between October 2022 and September 2023 ($118.62). Using the distribution of claims in the 24-month period between October 2021 and September 2023, we also included in Table 1 estimated PEPM amounts for which there was a 70.0%, 80.0%, 90.0%, 95.0% or 97.5% probability that actual mental health treatment costs would not have exceeded these levels in the October 2022 to September 2023 time period. These PEPM amounts were translated into percentages of expected treatment costs, which can be used in future years as the expected PEPM claim costs change (e.g., due to utilization trends and changes in cost per procedure). Administrative costs are NOT included in Table 1.

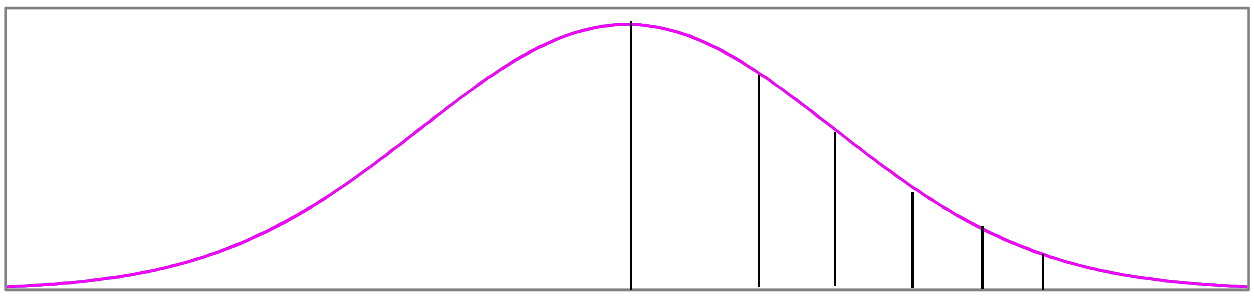
Table 1
Community Mental Health Partnership of Southeast Michigan
Medicaid Mental Health Services
Thresholds for Various Levels of Risk in Funding Internal Services Fund
October 2022 through September 2023

Probability Threshold	PEPM Treatment Costs	Percentage of Average Treatment Costs
Average Cost (i.e., 50% threshold)	$118.62	100.0%
70.0% Threshold	123.21	100.8%
80.0% Threshold	123.86	101.4%
90.0% Threshold*	125.06	102.4%
95.0% Threshold	126.05	103.2%
97.5% Threshold	126.92	103.9%

** For example, based on the experience period from October 2021 through September 2023, there was approximately a 90.0% probability that CMHPSM's actual Medicaid mental health and substance abuse costs would have been below 102.4% of the average cost for the year.*

The following graph illustrates the distribution of expected mental health costs presented in Table 1. We used the shape of the normal probability distribution for illustrative purposes. The horizontal axis contains the range of possible PEPM costs from smallest (left side) to largest (right side). The vertical axis contains the probabilities that each of the possible PEPMs actually occurs. The taller the line, the greater the chance that the corresponding PEPM will occur. The area underneath the curve represents all the possible PEPM results. In other words, the total area underneath the curve is equivalent to a probability of 100%.

FIGURE 1: DISTRIBUTION OF EXPECTED MENTAL HEALTH COSTS



Expected Cost: 70.0%, 80.0%, 90.0%, 95.0%, 97.5%

< ---------- *Range of Possible PEPM Costs* ---------- >

The vertical line in the middle of the graph indicates the expected PEPM cost for the distribution. The Table 1 cost associated with this point on the horizontal axis is $118.62 PEPM. For future years, the costs associated with this point will be 100% of the expected PEPM treatment costs for the year. By definition, it is almost as likely for actual costs to be *above* the expected cost as it is for them to be *below* the expected cost. This is illustrated by the size of the area underneath the curve to the left of the expected cost line (where actual costs are lower than expected costs) being about 50% of the total area underneath the curve. Therefore, the size of the area underneath the curve to the right of the expected cost line (where actual costs are higher than expected costs) is also approximately 50% of the total area underneath the curve.

The lines labeled 70.0%, 80.0%, 90.0%, 95.0%, or 97.5% represent the points at which 70.0%, 80.0%, 90.0%, 95.0%, or 97.5% of the area underneath the curve is to the left of the line. The values associated with these points are the PEPMs at which there is a 70.0%, 80.0%, 90.0%, 95.0%, or 97.5% chance that actual costs on a PEPM basis will be below these values. For example, based on the Table 1 data, there is a 90% probability that the actual Medicaid mental health cost will be below 102.4% of the expected PEPM treatment cost for the year.

The PEPM values in Table 1 are only appropriate for the 12-month experience period ending September 30, 2023. Amounts for future periods should be increased by an assumed trend level. The scenarios contained in Appendix 1 are based on the trend and other assumptions contained in Exhibit 1. The shape of the cost distribution is unlikely to change significantly from year to year, but should be monitored periodically.

Depending on the desired level of risk that CMHPSM wants to take, the PEPM costs at the 70.0%, 80.0%, 90.0%, 95.0%, or 97.5% levels for the projection year may be used to determine the required ISF contribution for the current year.

COMPONENTS OF FINANCIAL ANALYSIS

Our financial analysis consists of three different scenarios of varying annual eligible counts, revenue increases, treatment cost increases, and administration cost increases from the present through FY 2028. Exhibit 1 contains a summary of the critical assumptions for each scenario.

In general, each scenario in Appendix 1 contains the following:

Eligible Months Exposed

CMHPSM provided the FY 2023 eligible months of 1,896,510. CMHPSM also provided FY 2024 total eligibles of 180,620. Using historic eligible counts and eligible months, we estimated FY 2024 eligible months to be 1,888,194. The FY 2024 eligible months estimates are projected to future years based on varying assumptions specific to each scenario.

Gross Revenue PEPM

Gross Medicaid revenue for FY 2023 and FY 2024 equaled $229,927,433 ($121.24 PEPM) and $238,433,166 ($126.28 PEPM), respectively, per the FY 2023 and FY 2024 Financial Status Reports (FSRs) provided by CMHPSM. The FY 2024 revenue is projected to future years based on varying assumptions specific to each scenario.

PIHP Provider Insurance Assessment Tax PEPM

The PIHP Provider Insurance Assessment Tax for FY 2023 and FY 2024 equaled $2,099,550 ($1.11 PEPM) and $2,204,554 ($1.17 PEPM), respectively, per the FY 2023 and FY 2024 FSRs provided by CMHPSM. We are assuming the average PIHP Provider Insurance Assessment Tax will be 1% of gross revenue in FY 2025 and beyond for all scenarios.

Gross Revenue Dollars

Gross revenue dollars equal the eligible months exposed times gross revenue PEPM.

PIHP Provider Insurance Assessment Tax Dollars

PIHP Provider Insurance Assessment Tax dollars equal the eligible months exposed times the PIHP Provider Insurance Assessment Tax PEPM.

Revenue Available for Total Costs PEPM

The revenue available for total costs PEPM equals the gross revenue dollars PEPM minus the PIHP Provider Insurance Assessment Tax dollars PEPM.

Revenue Available for Total Costs

The revenue available for total costs equal the eligible months exposed times the revenue available for total costs PEPM.

Administration Cost

Administration costs related to Medicaid mental health equaled $3,071,548 in FY 2023, per the FY 2023 FSR and EQI report provided by CMHPSM. The FY 2023 mental health administration cost is projected to future years based on varying assumptions.

Revenue Available for Mental Health Treatment Costs

Revenue available for mental health treatment costs equals revenue available for total costs less CMHPSM administrative costs and less non-mental health costs.

Mental Health Treatment Cost PEPM

Total Medicaid mental health treatment costs (including costs for Medicaid services and the Psychiatric Hospital Rate Adjuster) equaled $224,756,335, or $118.62 PEPM, per the FY 2023 FSR and EQI report provided by CMHPSM.

This amount is reported as the “expected” treatment cost for FY 2023 in Appendix 1 and is used to project expected treatment costs for future years. Given the expected costs for each year, Appendix 1 also contains the PEPM cost levels for which there is a 70.0%, 80.0%, 90.0%, 95.0%, or 97.5% probability that actual mental health costs will not exceed these levels in a given year.

Total Mental Health Treatment Costs

Total mental health and substance abuse costs equal the eligible months exposed times the mental health and substance abuse cost PEPM.

Surplus / Deficit

The surplus / deficit amounts equal the net revenue less the respective treatment cost, adjusted, as necessary, based on CMHPSM’s risk arrangement with the State. CMHPSM’s risk arrangement with the State leaves it fully responsible for the first 5.0% of treatment costs and expenses over revenue (up to 105%) and 50% responsible for the next 5.0% over revenue (from 105% to 110%). The state covers excess costs above 110% of revenue.

Projected Savings / ISF Balance

The starting FY 2023 projected savings / ISF balance of $22,306,904 equals the FY 2023 ISF balance of $17,349,533 plus the FY 2023 savings of $4,957,371. The projected savings / ISF balance for future years assumes (1) all surpluses for the given year are added to the prior year's suggested savings / ISF balance, (2) all deficits for the given year are subsidized by the prior year's suggested savings / ISF balance, and (3) all the surpluses and deficits for prior years are assumed to be at expected levels.

Suggested ISF Balance

The suggested ISF balance for any given year is based on the projected gross revenue for the year and various assumptions as described in the Scenario Analyses section below.

SCENARIO ANALYSES

We examined three scenarios to help quantify the economic impact of changing assumptions. The base scenario (Scenario 1) is based on information from the State or based on Milliman’s best estimate of what may happen in the near future in terms of changes in eligible count, revenue, treatment costs, and administration costs. The other scenarios reflect different patterns of changes, one more optimistic (Scenario 2) and one more pessimistic (Scenario 3).

In each scenario, we assumed that an increase in eligible count would result in a corresponding increase in treatment costs. The results may change significantly if we assumed there is capacity available for CMHPSM's salaried professionals to absorb a portion of the increase in treatment costs.

Scenario 1 – Base Scenario

For the base scenario, we assumed eligible months would increase 3.0% annually beginning in FY 2025.

Total Medicaid revenue for FY 2023 and FY 2024 were provided to us by CMHPSM. We assumed a 2.0% annual increase in net Medicaid revenue PEPM beginning with FY 2025 for the base scenario.

FY 2023 treatment costs were provided to us by CMHPSM. Based on general growth of the cost of Medicaid mental health services, we estimated treatment costs would increase 3.0% annually on a PEPM basis, reflecting both the change in cost and utilization of services.

We estimated no annual increase in administrative costs PEPM for FY 2024 and beyond.

The treatment cost and CMHPSM administrative cost trend assumptions are independent of the revenue available in any given year to fund these costs. In other words, we assumed projected costs for a given year could be greater than the revenue received from the State in that year.

Using the various assumption underlying the base scenario and the resulting projections, we would suggest an ISF balance each year that is equal to two months of gross revenue.

Scenario 2 – Optimistic Trend Scenario

Under this scenario, Medicaid eligible month counts were increased 6.0% annually beginning in FY 2025. This level of membership increase could strengthen the financial position of CMHPSM, as compared to the base scenario, from the perspective of having revenue from more eligibles over which to spread fixed costs.

For the optimistic scenario, we reflected a 5.0% annual increase in Medicaid revenue PEPM beginning in FY 2025.

We estimated a 2.0% annual decrease in administrative costs PEPM for FY 2024 and beyond.

Using the various assumption underlying the optimistic scenario and the resulting projections, we would suggest an ISF balance each year that is equal to one and a half months of gross revenue.

Scenario 3 – Pessimistic Trend Scenario

Under this scenario, we assumed no annual increase in Medicaid eligible month counts beginning in FY 2025. This level of membership increase could weaken the financial position of CMHPSM, as compared to the base scenario, from the perspective of having revenue from less eligibles over which they can spread fixed costs.

For the pessimistic scenario, we reflected an annual 1.0% decrease in Medicaid revenue PEPM beginning in FY 2025.

We estimated a 2.0% annual increase in administrative costs PEPM for FY 2024 and beyond.

For this scenario, we reflected an estimated 5.0% annual increase in treatment costs PEPM for FY 2024 and beyond.

Using the various assumption underlying the pessimistic scenario and the resulting projections, we would suggest an ISF balance each year that is equal to two and a half months of gross revenue.

ISF FUNDING POLICY

The scenarios we tested imply that CMHPSM's Medicaid ISF should continue to be funded with annual surpluses that occur. While the ISF balance and savings may be sufficient in the near term, projected annual deficits in certain scenarios suggest there is potential that the ISF dollars will be needed to offset these deficits in the long term. Therefore, we recommend, based on our various trend scenarios, contributions of available Medicaid surpluses such that the total FY 2024 ISF balance is between $29,800,000 and $49,700,000 and the total FY 2025 ISF balance is between $33,200,000

and $49,200,000. However, you should review and evaluate the assumptions in each scenario. Other assumption scenarios may be appropriate. We can evaluate additional scenarios at your request.

CAVEATS AND LIMITATIONS

The information in this letter is intended to support our ISF analysis for CMHPSM. It may not be appropriate for other purposes and is intended for CMHPSM's internal use only. Therefore, please do not distribute this letter outside CMHPSM or its auditors without Milliman's written permission. In any event, this information is not intended to benefit any third parties.

We accepted the data provided by CMHPSM without audit, though we reviewed the information provided for reasonableness. The claim and eligibility files provided by CMHPSM were used to estimate the probability distribution of expected aggregate treatment costs. Our estimates may change with additional data or if the data provided changes or is inaccurate or incomplete.

Milliman developed certain models to estimate the values included in this letter. The intent of the models was to estimate probability thresholds for projected expenditures. We reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOPs).

The models rely on data and information as input to the models. In preparing this information, we relied on information provided by CMHPSM, including member level claim detail. We accepted this information without audit, but reviewed the information for general reasonableness. Our results and conclusions may not be appropriate if this information is not accurate

The values contained in this letter are estimates based on the information provided by CMHPSM. Actual results will vary from these estimates. The estimates should be updated periodically as additional experience becomes available.

Please keep in mind that the probabilities estimated in this letter represent only the statistical chance of actual results being different than expected results. These probabilities assume all the income and expense assumptions are accurate and appropriate. For example, actual utilization and cost trends could differ from our assumptions.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet the qualification standards for performing the analyses in this correspondence.

❖ ❖ ❖ ❖ ❖

James, please call me at 262 796 3433 at your convenience if you would like to discuss these results.

Sincerely,

Eric Goetsch

Eric P. Goetsch, FSA, MAAA
Principal and Consulting Actuary

EPG/tm

Attachments

Milliman

EXHIBIT 1

Exhibit 1
Community Mental Health Partnership of Southeast Michigan
Medicaid Mental Health and Substance Abuse
Financial Analysis
Summary of Scenario Assumptions

	Scenario 1 Milliman Base	Scenario 2 Milliman Optimistic	Scenario 3 Milliman Pessimistic
Medicaid Eligible Months	3.0% annual increase beginning in FY 2025	6.0% annual increase beginning in FY 2025	0.0% annual increase beginning in FY 2025
Revenue Available per Eligible	2.0% annual increase beginning in FY 2025	5.0% annual increase beginning in FY 2025	1.0% annual decrease beginning in FY 2025
CMHPSM Total Administration Cost	0.0% annual increase beginning in FY 2024	2.0% annual decrease beginning in FY 2024	2.0% annual increase beginning in FY 2024
Treatment Cost per Eligible	3.0% annual increase beginning in FY 2024	1.0% annual increase beginning in FY 2024	5.0% annual increase beginning in FY 2024
Suggested ISF Balance	Two months of gross revenue	One and a half months of gross revenue	Two and a half months of gross revenue

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APPENDIX 1

Appendix 1
Scenario 1
Community Mental Health Partnership of Southeast Michigan
Base Trend Scenario

	Historical	Projected				
	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027	FY 2028
A. Eligible Months Exposed	1,896,510	1,888,194	1,944,840	2,003,185	2,063,281	2,125,179
B. Gross Revenue PEPM [1]	$121.24	$126.28	$128.90	$131.47	$134.10	$136.79
C. PIHP Provider Insurance Assessment Tax PEPM [2]	($1.11)	($1.17)	($1.29)	($1.31)	($1.34)	($1.37)
D. Gross Revenue Dollars (A x B)	229,927,433	238,433,166	250,689,876	263,358,732	276,685,982	290,703,235
E. PIHP Provider Insurance Assessment Tax Dollars (A x C)	(2,099,550)	(2,204,554)	(2,508,844)	(2,624,172)	(2,764,797)	(2,911,495)
F. Revenue Available for Total Costs PEPM (B + C)	$120.13	$125.11	$127.61	$130.16	$132.76	$135.42
G. Revenue Available for Total Costs (A x F)	$227,827,883	$236,228,612	$248,181,032	$260,734,560	$273,921,186	$287,791,740
H. Administration Cost	3,071,548	$3,071,548	$3,071,548	$3,071,548	$3,071,548	$3,071,548
I. Non-MH/SA Costs	0	0	0	0	0	0
J. Revenue Available for MH / SA Treatment Costs (G - H - I)	$224,756,335	$233,157,064	$245,109,484	$257,663,012	$270,849,638	$284,720,192
K. MH / SA Treatment Cost PEPM						
1. Expected (50% Probability Threshold)	$118.62	$122.18	$125.85	$129.63	$133.52	$137.53
2. 70.0% Probability Threshold		123.21	126.91	130.72	134.64	138.68
3. 80.0% Probability Threshold		123.86	127.58	131.41	135.36	139.42
4. 90.0% Probability Threshold		125.06	128.82	132.69	136.67	140.77
5. 95.0% Probability Threshold		126.05	129.83	133.73	137.74	141.88
6. 97.5% Probability Threshold		126.92	130.73	134.66	138.70	142.87
L. Total MH / SA Treatment Costs (A x K) [1]						
1. Expected (50% Probability Threshold)	$224,965,230	$230,699,543	$244,758,114	$259,672,872	$275,489,279	$292,275,868
2. 70.0% Probability Threshold		232,644,383	246,819,644	261,856,343	277,800,154	294,719,824
3. 80.0% Probability Threshold		233,871,709	248,122,687	263,238,541	279,285,716	296,292,456
4. 90.0% Probability Threshold		236,137,542	250,534,289	265,802,618	281,988,614	299,161,448
5. 95.0% Probability Threshold		238,006,854	252,498,577	267,885,930	284,196,325	301,520,397
6. 97.5% Probability Threshold		239,649,582	254,248,933	269,748,892	286,177,075	303,624,324
M. Surplus / Deficit (J - L, subject to contract limits)						
1. Expected (50% Probability Threshold)	($208,895)	$2,457,521	$351,370	($2,009,860)	($4,639,641)	($7,555,676)
2. 70.0% Probability Threshold		512,681	(1,710,160)	(4,193,331)	(6,950,516)	(9,999,632)
3. 80.0% Probability Threshold		(714,645)	(3,013,203)	(5,575,529)	(8,436,078)	(11,572,264)
4. 90.0% Probability Threshold		(2,980,478)	(5,424,805)	(8,139,606)	(11,138,976)	(14,441,256)
5. 95.0% Probability Threshold		(4,849,790)	(7,389,093)	(10,222,918)	(13,346,687)	(15,667,683)
6. 97.5% Probability Threshold		(6,492,518)	(9,139,449)	(12,085,880)	(14,580,868)	(16,719,647)
N. Projected Savings / ISF Balance [3,4]						
1. Expected (50% Probability Threshold)	$22,306,904	$24,764,425	$25,115,795	$23,105,935	$18,466,294	$10,910,618
2. 70.0% Probability Threshold		22,819,585	$23,054,265	$20,922,464	$16,155,419	$8,466,662
3. 80.0% Probability Threshold		21,592,259	$21,751,222	$19,540,266	$14,669,857	$6,894,030
4. 90.0% Probability Threshold		19,326,426	$19,339,620	$16,976,189	$11,966,959	$4,025,038
5. 95.0% Probability Threshold		17,457,114	$17,375,332	$14,892,877	$9,759,248	$2,798,610
6. 97.5% Probability Threshold		15,814,386	$15,624,976	$13,029,915	$8,525,067	$1,746,647
O. Suggested ISF Balance [5]	$38,321,239	$39,738,861	$41,781,646	$43,893,122	$46,114,330	

[1] *Reflects all Medicaid related components including mental health, substance abuse, and psychiatric hospital rate adjuster and use / claims tax.*

[2] *The PIHP Provider Insurance Assessment tax was equal to approximately 1% of combined Medicaid and Healthy Michigan revenue for FY 2024. We assumed it would be 1% of combined Medicaid and Healthy Michigan revenue in future years.*

[3] *The year-end FY 2023 projected savings / ISF balance of $22,306,904 equals the FY 2023 ISF balance of $17,349,533 plus the FY 2023 savings of $4,957,371.*

[4] *The projected savings / ISF balance for any given year assumes (1) all surpluses for the year are added to the prior year's suggested savings / ISF balance, (2) all deficits for the year are subsidized by the prior year's suggested savings / ISF balance, and (3) all the surpluses and deficits for prior year's are assumed to be at expected levels.*

[5] *The suggested ISF balance for any given year equals two months of gross revenue.*

Assumptions:

-- *A 3.0% annual increase in member months beginning in FY 2025.*

-- *A 2.0% annual increase in Medicaid revenue PEPM beginning in FY 2025.*

-- *No annual increase in administration costs beginning in FY 2024.*

-- *A 3.0% annual increase in Medicaid treatment costs PEPM beginning in FY 2024.*

Appendix 1
Scenario 2
Community Mental Health Partnership of Southeast Michigan
Optimistic Trend Scenario

	Historical	Projected				
	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027	FY 2028
A. Eligible Months Exposed	1,896,510	1,888,194	2,001,486	2,121,575	2,248,870	2,383,802
B. Gross Revenue PEPM [1]	$121.24	$126.28	$132.69	$139.32	$146.29	$153.61
C. PIHP Provider Insurance Assessment Tax PEPM [2]	($1.11)	($1.17)	($1.33)	($1.39)	($1.46)	($1.54)
D. Gross Revenue Dollars (A x B)	229,927,433	238,433,166	265,577,177	295,577,829	328,987,192	366,175,825
E. PIHP Provider Insurance Assessment Tax Dollars (A x C)	(2,099,550)	(2,204,554)	(2,661,976)	(2,948,989)	(3,283,350)	(3,671,055)
F. Revenue Available for Total Costs PEPM (B + C)	$120.13	$125.11	$131.36	$137.93	$144.83	$152.07
G. Revenue Available for Total Costs (A x F)	$227,827,883	$236,228,612	$262,915,201	$292,628,840	$325,703,842	$362,504,770
H. Administration Cost	$3,071,548	$3,010,117	$2,949,915	$2,890,917	$2,833,099	$2,776,437
I. Non-MH/SA Costs	0	0	0	0	0	0
J. Revenue Available for MH / SA Treatment Costs (G - H - I)	$224,756,335	$233,218,495	$259,965,286	$289,737,923	$322,870,743	$359,728,333
K. MH / SA Treatment Cost PEPM						
1. Expected (50% Probability Threshold)	$118.62	$119.81	$121.01	$122.22	$123.44	$124.67
2. 70.0% Probability Threshold		120.82	122.03	123.25	124.48	125.72
3. 80.0% Probability Threshold		121.46	122.67	123.90	125.14	126.38
4. 90.0% Probability Threshold		122.64	123.86	125.10	126.35	127.61
5. 95.0% Probability Threshold		123.60	124.84	126.09	127.35	128.61
6. 97.5% Probability Threshold		124.46	125.71	126.96	128.23	129.51
L. Total MH / SA Treatment Costs (A x K) [1]						
1. Expected (50% Probability Threshold)	$224,965,230	$226,224,523	$242,199,821	$259,298,897	$277,600,513	$297,188,595
2. 70.0% Probability Threshold		228,131,599	244,241,337	261,484,119	279,939,338	299,691,587
3. 80.0% Probability Threshold		229,340,043	245,522,288	262,863,143	281,423,592	301,264,897
4. 90.0% Probability Threshold		231,568,112	247,904,056	265,409,033	284,144,725	304,196,973
5. 95.0% Probability Threshold		233,380,778	249,865,512	267,509,392	286,393,595	306,580,775
6. 97.5% Probability Threshold		235,004,625	251,606,805	269,355,162	288,372,600	308,726,197
M. Surplus / Deficit (J - L, subject to contract limits)						
1. Expected (50% Probability Threshold)	($208,895)	$6,993,972	$15,522,162	$22,168,337	$24,674,039	$27,463,187
2. 70.0% Probability Threshold		5,086,896	14,501,404	21,516,348	24,674,039	27,463,187
3. 80.0% Probability Threshold		3,878,452	13,860,928	20,826,836	24,674,039	27,463,187
4. 90.0% Probability Threshold		1,650,383	12,061,230	19,553,891	24,674,039	27,463,187
5. 95.0% Probability Threshold		(162,283)	10,099,774	18,503,711	24,674,039	27,463,187
6. 97.5% Probability Threshold		(1,786,130)	8,358,481	17,580,826	24,674,039	27,463,187
N. Projected Savings / ISF Balance [3,4]						
1. Expected (50% Probability Threshold)	$22,306,904	$29,300,876	$44,823,038	$66,991,375	$91,665,415	$119,128,601
2. 70.0% Probability Threshold		27,393,800	$43,802,280	$66,339,386	$91,665,415	$119,128,601
3. 80.0% Probability Threshold		26,185,356	$43,161,804	$65,649,874	$91,665,415	$119,128,601
4. 90.0% Probability Threshold		23,957,287	$41,362,106	$64,376,929	$91,665,415	$119,128,601
5. 95.0% Probability Threshold		22,144,621	$39,400,650	$63,326,749	$91,665,415	$119,128,601
6. 97.5% Probability Threshold		20,520,774	$37,659,357	$62,403,864	$91,665,415	$119,128,601
O. Suggested ISF Balance [5]	$28,740,929	$29,804,146	$33,197,147	$36,947,229	$41,123,399	

[1] *Reflects all Medicaid related components including mental health, substance abuse, and psychiatric hospital rate adjuster and use / claims tax.*

[2] *The PIHP Provider Insurance Assessment tax was equal to approximately 1% of combined Medicaid and Healthy Michigan revenue for FY 2024. We assumed it would be 1% of combined Medicaid and Healthy Michigan revenue in future years.*

[3] *The year-end FY 2023 projected savings / ISF balance of $22,306,904 equals the FY 2023 ISF balance of $17,349,533 plus the FY 2023 savings of $4,957,371.*

[4] *The projected savings / ISF balance for any given year assumes (1) all surpluses for the year are added to the prior year's suggested savings / ISF balance, (2) all deficits for the year are subsidized by the prior year's suggested savings / ISF balance, and (3) all the surpluses and deficits for prior year's are assumed to be at expected levels.*

[5] *The suggested ISF balance for any given year equals one and a half months of gross revenue.*

Assumptions:

-- A 6.0% annual increase in member months beginning in FY 2025.

-- A 5.0% annual increase in Medicaid revenue PEPM beginning in FY 2025.

-- A 2.0% annual decrease in administration costs beginning in FY 2024.

-- A 1.0% annual increase in Medicaid treatment costs PEPM beginning in FY 2024.

Appendix 1
Scenario 3
Community Mental Health Partnership of Southeast Michigan
Pessimistic Trend Scenario

	Historical	Projected				
	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027	FY 2028
A. Eligible Months Exposed	1,896,510	1,888,194	1,888,194	1,888,194	1,888,194	1,888,194
B. Gross Revenue PEPM [1]	$121.24	$126.28	$125.11	$123.86	$122.62	$121.39
C. PIHP Provider Insurance Assessment Tax PEPM [2]	($1.11)	($1.17)	($1.25)	($1.24)	($1.23)	($1.21)
D. Gross Revenue Dollars (A x B)	229,927,433	238,433,166	236,231,951	233,871,709	231,530,348	229,207,870
E. PIHP Provider Insurance Assessment Tax Dollars (A x C)	(2,099,550)	(2,204,554)	(2,360,243)	(2,341,361)	(2,322,479)	(2,284,715)
F. Revenue Available for Total Costs PEPM (B + C)	$120.13	$125.11	$123.86	$122.62	$121.39	$120.18
G. Revenue Available for Total Costs (A x F)	$227,827,883	$236,228,612	$233,871,709	$231,530,348	$229,207,870	$226,923,155
H. Administration Cost	3,071,548	3,132,979	3,195,639	3,259,552	3,324,743	3,391,238
I. Non-MH/SA Costs	0	0	0	0	0	0
J. Revenue Available for MH / SA Treatment Costs (G - H - I)	$224,756,335	$233,095,633	$230,676,070	$228,270,796	$225,883,127	$223,531,917
K. MH / SA Treatment Cost PEPM						
1. Expected (50% Probability Threshold)	$118.62	$124.55	$130.78	$137.32	$144.19	$151.40
2. 70.0% Probability Threshold		125.60	131.88	138.47	145.40	152.67
3. 80.0% Probability Threshold		126.26	132.58	139.21	146.17	153.48
4. 90.0% Probability Threshold		127.49	133.86	140.56	147.59	154.97
5. 95.0% Probability Threshold		128.49	134.92	141.66	148.75	156.19
6. 97.5% Probability Threshold		129.38	135.85	142.65	149.78	157.27
L. Total MH / SA Treatment Costs (A x K) [1]						
1. Expected (50% Probability Threshold)	$224,965,230	$235,174,563	$246,938,011	$259,286,800	$272,258,693	$285,872,572
2. 70.0% Probability Threshold		237,157,166	249,015,025	261,458,223	274,543,408	288,270,578
3. 80.0% Probability Threshold		238,403,374	250,336,761	262,855,487	275,997,317	289,800,015
4. 90.0% Probability Threshold		240,725,853	252,753,649	265,404,549	278,678,552	292,613,424
5. 95.0% Probability Threshold		242,614,047	254,755,134	267,481,562	280,868,858	294,917,021
6. 97.5% Probability Threshold		244,294,540	256,511,155	269,350,874	282,813,697	296,956,270
M. Surplus / Deficit (J - L, subject to contract limits)						
1. Expected (50% Probability Threshold)	($208,895)	($2,078,930)	($14,036,769)	($17,540,378)	($17,364,776)	($17,190,590)
2. 70.0% Probability Threshold		(4,061,533)	(15,075,276)	(17,540,378)	(17,364,776)	(17,190,590)
3. 80.0% Probability Threshold		(5,307,741)	(15,736,144)	(17,540,378)	(17,364,776)	(17,190,590)
4. 90.0% Probability Threshold		(7,630,220)	(16,944,588)	(17,540,378)	(17,364,776)	(17,190,590)
5. 95.0% Probability Threshold		(9,518,414)	(17,717,396)	(17,540,378)	(17,364,776)	(17,190,590)
6. 97.5% Probability Threshold		(11,198,907)	(17,717,396)	(17,540,378)	(17,364,776)	(17,190,590)
N. Projected Savings / ISF Balance [3,4]						
1. Expected (50% Probability Threshold)	$22,306,904	$20,227,974	$6,191,205	$0	$0	$0
2. 70.0% Probability Threshold		18,245,371	$5,152,698	$0	$0	$0
3. 80.0% Probability Threshold		16,999,163	$4,491,830	$0	$0	$0
4. 90.0% Probability Threshold		14,676,684	$3,283,386	$0	$0	$0
5. 95.0% Probability Threshold		12,788,490	$2,510,578	$0	$0	$0
6. 97.5% Probability Threshold		11,107,997	$2,510,578	$0	$0	$0
O. Suggested ISF Balance [5]	$47,901,549	$49,673,576	$49,214,990	$48,723,273	$48,235,489	

[1] *Reflects all Medicaid related components including mental health, substance abuse, and psychiatric hospital rate adjuster and use / claims tax.*

[2] *The PIHP Provider Insurance Assessment tax was equal to approximately 1% of combined Medicaid and Healthy Michigan revenue for FY 2024. We assumed it would be 1% of combined Medicaid and Healthy Michigan revenue in future years.*

[3] *The year-end FY 2023 projected savings / ISF balance of $22,306,904 equals the FY 2023 ISF balance of $17,349,533 plus the FY 2023 savings of $4,957,371.*

[4] *The projected savings / ISF balance for any given year assumes (1) all surpluses for the year are added to the prior year's suggested savings / ISF balance, (2) all deficits for the year are subsidized by the prior year's suggested savings / ISF balance, and (3) all the surpluses and deficits for prior year's are assumed to be at expected levels.*

[5] *The suggested ISF balance for any given year equals two and a half months of gross revenue.*

Assumptions:

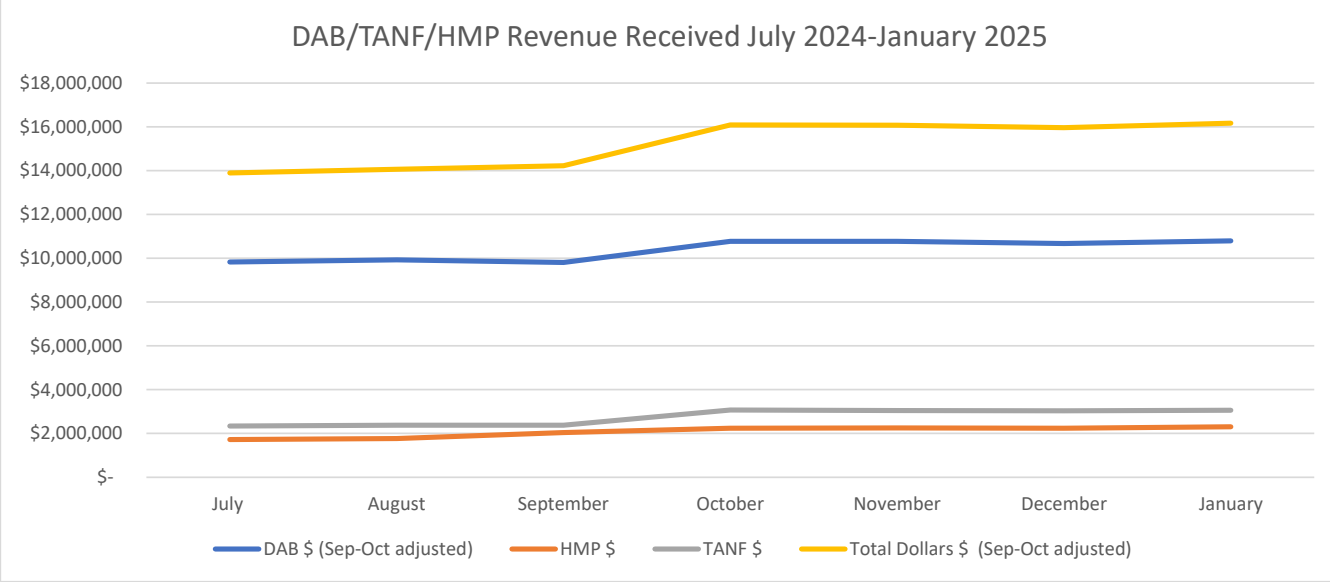
-- *No annual increase in member months beginning in FY 2025.*

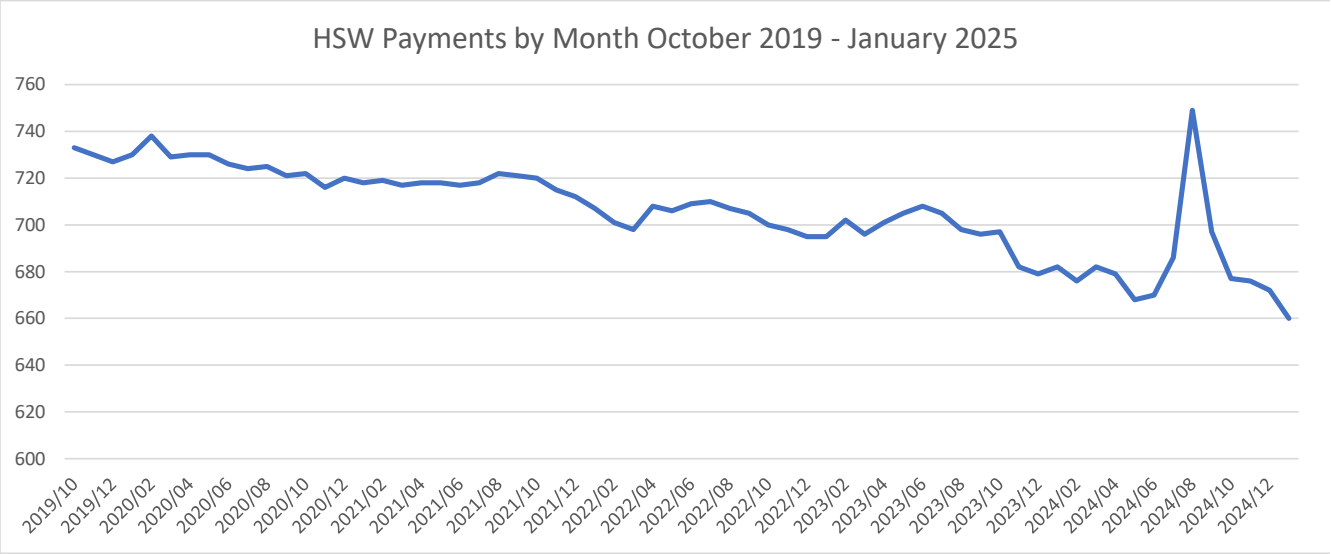
-- *A 1.0% annual decrease in Medicaid revenue PEPM beginning in FY 2025.*

-- *A 2.0% annual increase in administration costs beginning in FY 2024.*

-- *A 5.0% annual increase in Medicaid treatment costs PEPM beginning in FY 2024.*

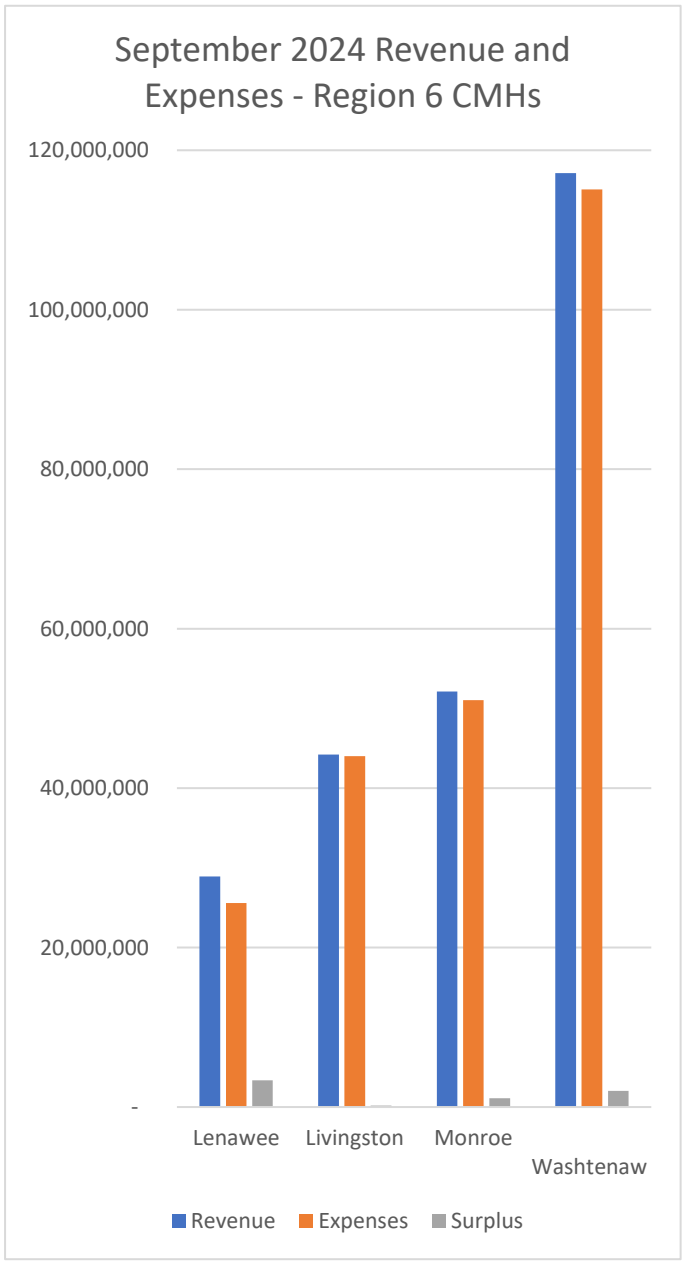
Community Mental Health Partnership of Southeast Michigan
Financial Summary for December 31, 2024

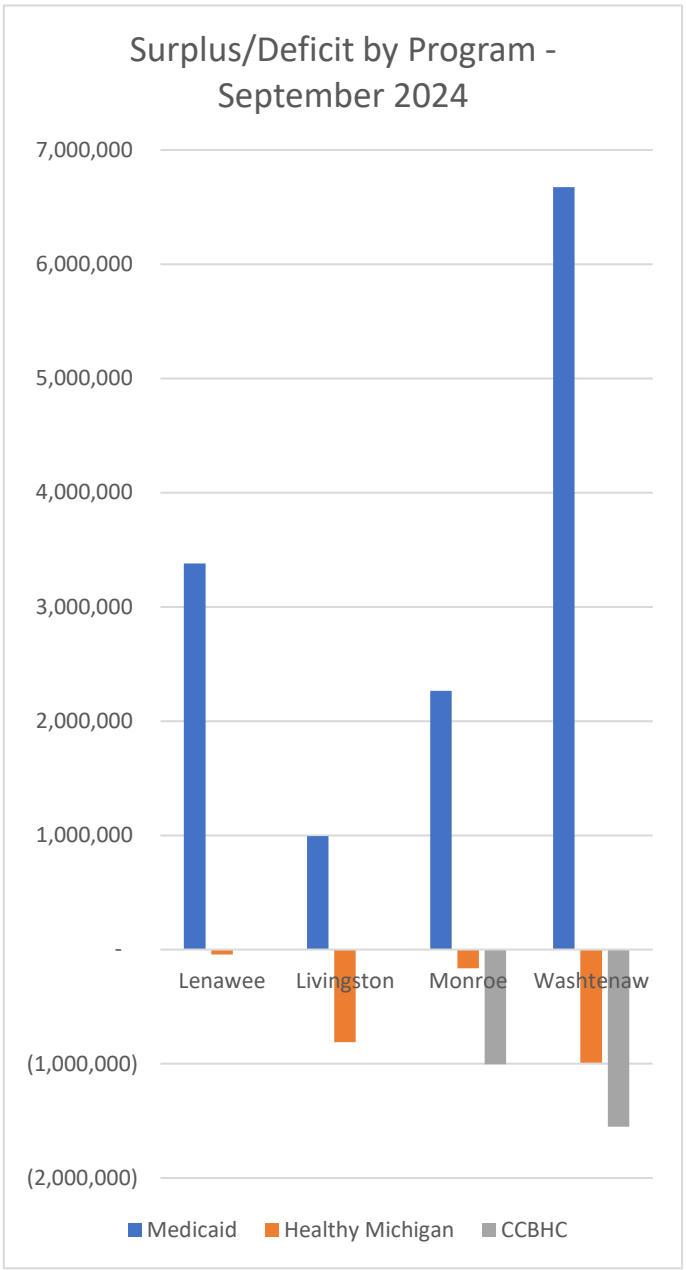




November 2024	FY 2025 Budget	YTD Budget	December 2024 Actual	Actual to Budget	Percent Variance	Projected Year-End	Projected to Budget
MH Medicaid Revenue	287,130,663	67,282,666	68,930,169	1,647,504	2.4%	287,130,663	-
MH Medicaid Expenses	276,792,340	65,931,760	68,799,846	(2,868,086)	-4.4%	276,792,341	-
MH Medicaid Net	10,338,323	1,350,906	130,323	(1,220,582)	-90.4%	10,338,322	-
SUD/Grants Revenue	29,680,656	7,261,977	6,280,000	(981,977)	-13.5%	29,680,656	-
SUD/Grants Expenses	26,192,153	6,524,394	5,145,261	(1,379,133)	-21.1%	26,192,153	-
SUD/Grants Net	3,488,503	737,583	1,134,739	397,156	-53.8%	3,488,503	-
PIHP							
PIHP Revenue	2,059,480	514,870	520,789	5,919	1.1%	2,059,480	-
PIHP Expenses	3,181,456	761,339	658,317	(103,022)	13.5%	3,181,456	-
PIHP Total	(1,121,976)	(246,469)	(137,528)	108,941	44.2%	(1,121,976)	0
Total Revenue	**318,870,799**	**75,059,513**	**75,730,959**	**671,446**	**0.9%**	**318,870,799**	**-**
Total Expenses	**306,165,949**	**73,217,494**	**74,603,424**	**(1,385,931)**	**-1.9%**	**306,165,949**	**-**
Total Transfers Out/ISF & PBIP			-			-	
Total Net	**12,704,850**	**1,842,019**	**1,127,534**	**(714,485)**	**-38.8%**	**12,704,849**	**(1)**

Regional CMH Revenue and Expenses
Regional Charts





Nov-24	Lenawee	Livingston	Monroe	Washtenaw	Region 6
Medicaid Revenue	26,371,732	41,728,173	41,559,717	99,024,210	208,683,832
Healthy Michigan Revenue	2,537,816	2,467,711	2,860,301	6,155,256	14,021,084
CCBHC Revenue			7,697,339	11,948,404	19,645,743
Revenue Subtotal	28,909,548	44,195,884	52,117,357	117,127,870	242,350,659
Medicaid Expenses	(22,991,723)	(40,735,532)	(36,638,232)	(83,848,570)	(184,214,057)
Healthy Michigan Expenses	(2,580,379)	(3,279,601)	(2,450,689)	(7,145,976)	(15,456,645)
CCBHC Expenses			(11,932,142)	(24,090,027)	(36,022,169)
Expense Subtotal	(25,572,102)	(44,015,133)	(51,021,063)	(115,084,573)	(235,692,871)
TotalMedicaid/HMP Surplus(Deficit)	3,337,446	180,751	1,096,294	2,043,297	6,657,788
Surplus Percent of Revenue	12.7%	0.4%	2.6%	2.1%	3.2%

1. The following chart compares the liquid assets of CMHPSM at the start of FY 2025 to the end of the reporting period, December 31, 2024.

Asset Type	Description	September 2024	November 2024
Cash	Operations	3,857,082	4,234,101
	Total Cash	3,857,082	4,234,101
Investments	Money Market	2,804,901	9,184,737
	US Treasuries	10,622,728	10,733,060
	Total Investments	13,427,630	19,917,797
Total Liquid Assets		17,284,711	24,151,898

The CMHs and PIHP cost settled through FY 2022. Funds received were transferred to the money market account.

Fiscal Year 2025 Update

Medicaid

The PIHP received a large retro Hab Support Waiver payment for the June through September service months in December. This payment along with strong CCBHC Supplemental Revenue helped Medicaid revenues exceed budget by 2.4%. The waiver and CCBHC revenue are passed through to the CMHs. This pass through caused the Medicaid expenses to exceed budget by 4.4%.

SUBSTANCE USE

Healthy Michigan SUD revenue is (9.5%) below budget. Grant revenue is also below budget due to usual start-up delays. In total, Substance Use revenue is (13.5%) below budget. For the same grant reasons, Substance Use expenses are (21.1%) below budget.

PIHP Administration

PIHP Revenue is 1.1% over budget due to estimated incentive based on Medicaid revenue. PIHP expenses are (13.5%) below budget due to unfilled positions and lower Contracts and Other Expenses.

Community Mental Health Partnership of Southeast Michigan
Preliminary Statement of Revenues, Expenditures Transfers
Preliminary December 31, 2024

	Budget FY 2025	YTD Budget	YTD Actual	Actual to Budget	Percent Variance	Projected Year-End	Projected O(U) Budget
MH/IDD/WAIVER SERVICES							
MEDICAID REVENUE							
Medicaid/Medicaid CCBHC	143,925,411	35,981,353	33,971,739	(2,009,614)	-5.6%	143,925,411	-
Medicaid Waivers	63,249,094	15,812,274	16,882,051	1,069,778	6.8%	63,249,094	-
HMP/HMP CCBHC	18,250,726	4,562,682	6,245,477	1,682,796	36.9%	18,250,726	-
Medicaid Autism	20,340,177	5,085,044	4,141,859	(943,185)	-18.5%	20,340,177	-
Prior Year Carry Forward	5,000,000	-	-	-		5,000,000	-
CCBHC	22,000,000	5,500,000	7,364,978	1,864,978	33.9%	22,000,000	-
Behavioral Health Home	1,365,255	341,314	324,065	(17,249)	-5.1%	1,365,255	-
HRA Revenue	13,000,000	-	-	-	0.0%	13,000,000	-
Medicaid Revenue	**287,130,663**	**67,282,666**	**68,930,169**	**1,647,504**	**2.4%**	**287,130,663**	**-**
						-	
MEDICAID EXPENDITURES						-	
IPATax	2,300,000	558,675	558,675	-	0.0%	2,300,000	-
HRA Payments	13,000,000	-	-	-	0.0%	13,000,000	-
Lenawee CMH							
Medicaid State Plan	19,736,600	4,934,150	4,934,150	(0)	0.0%	19,736,600	-
Medicaid Waivers	7,276,931	1,819,233	1,968,300	(149,068)	-8.2%	7,276,931	-
Healthy Michigan Plan	2,728,152	682,038	682,038	-	0.0%	2,728,152	-
Autism Medicaid	1,179,080	294,770	294,770	(0)	0.0%	1,179,080	-
Behavioral Health Homes	57,558	14,390	17,783	(3,393)	-23.6%	57,558	-
DHIP		-	-	-			-
Lenawee CMH Total	**30,978,321**	**7,744,580**	**7,897,041**	**(152,461)**	**-2.0%**	**30,978,321**	**-**
Livingston CMH							
Medicaid State Plan	28,217,708	7,054,427	7,054,427	(0)	0.0%	28,217,708	-
Medicaid Waivers	10,045,446	2,511,362	2,582,807	(71,446)	-2.8%	10,045,446	-
Healthy Michigan Plan	3,156,819	789,205	789,205	-	0.0%	3,156,819	-
Autism Medicaid	5,707,432	1,426,858	1,426,858	0	0.0%	5,707,432	-
Behavioral Health Homes	85,635	21,409	22,774	(1,366)	-6.4%	85,635	-
DHIP		-	-	-			-
Livingston CMH Total	**47,213,040**	**11,803,260**	**11,876,071**	**(72,811)**	**-0.6%**	**47,213,040**	**-**
Monroe CMH							
Medicaid State Plan	24,016,314	6,004,079	6,004,079	-	0.0%	24,016,314	-
Medicaid Waivers	11,937,044	2,984,261	3,003,366	(19,105)	-0.6%	11,937,044	-
Healthy Michigan Plan	3,659,040	914,760	914,760	-	0.0%	3,659,040	-
Autism Medicaid	2,221,455	555,364	555,364	-	0.0%	2,221,455	-
CCBHC Supplemental	8,624,000	2,156,000	2,077,886	78,114	3.6%	8,624,000	-
CCBHC Base Capitation	6,450,000	1,612,500	1,612,500	-	0.0%	6,450,000	-
Behavioral Health Homes	376,937	94,234	65,203	29,031	30.8%	376,937	-
DHIP		-	-	-			-
Monroe CMH Total	**57,284,790**	**14,321,198**	**14,233,158**	**88,040**	**0.6%**	**57,284,790**	**-**
							-
Washtenaw CMH							-
Medicaid State Plan	54,524,586	13,631,147	13,631,147	-	0.0%	54,524,586	-
Medicaid Waivers	32,991,767	8,247,942	9,062,529	(814,587)	-9.9%	32,991,767	-
Healthy Michigan Plan	7,874,111	1,968,528	1,968,528	(0)	0.0%	7,874,111	-
Autism Medicaid	7,980,152	1,995,038	1,995,038	(0)	0.0%	7,980,152	-
CCBHC Supplemental	12,936,000	3,234,000	5,139,792	(1,905,792)	-58.9%	12,936,000	-
CCBHC Base Capitation	9,137,500	2,284,375	2,284,375	0	0.0%	9,137,500	-
CCBHC Incentive		-	-				-
Behavioral Health Homes	572,074	143,019	153,492	(10,474)	-7.3%	572,074	-
DHIP			-	-			-
Washtenaw CMH Total	**126,016,190**	**31,504,048**	**34,234,901**	**(2,730,853)**	**-8.7%**	**126,016,190**	**-**
Medicaid Expenditures	**276,792,341**	**65,931,760**	**68,799,846**	**(2,868,086)**	**-4.4%**	**276,792,341**	**-**
Medicaid Total	**10,338,322**	**1,350,906**	**130,323**	**(1,220,582)**	**-90.4%**	**10,338,322**	**-**

Community Mental Health Partnership of Southeast Michigan
Preliminary Statement of Revenues, Expenditures Transfers
Preliminary December 31, 2024

	Budget FY 2025	YTD Budget	YTD Actual	Actual to Budget	Percent Variance	Projected Year-End	Projected O(U) Budget
SUD/GRANTS							
SUD/GRANTS REVENUE							
Healthy Michigan Plan SUD	11,456,681	2,864,170	2,593,333	(270,837)	-9.5%	11,456,681	-
Medicaid SUD	4,645,222	1,161,306	1,164,727	3,421	0.3%	4,645,222	-
PA2 - Reserve Investment	179,082	44,771	3	(44,767)	-100.0%	179,082	
PA2 - Tax Revenue (Est)	1,824,100		-	0		1,824,100	-
PA2 - Use of Reserve (Est)	0	297,838	297,838	0	0.0%	0	-
Federal/State Grants	10,884,517	2,721,129	2,089,971	(631,158)	-23.2%	10,884,517	-
Opioid Health Homes	691,054	172,764	134,129	(38,635)	-22.4%	691,054	-
SUD/GRANTS REVENUE	**29,680,656**	**7,261,977**	**6,280,000**	**(981,977)**	**-13.5%**	**29,680,656**	**-**
SUD/GRANTS EXPENDITURES							
SUD Administration							
Salaries & Fringes	1,229,497	283,730	222,813	(60,917)	21.5%	1,229,497	-
Indirect Cost Recovery	(371,452)	(92,863)	(92,863)	0	0.0%	(371,452)	-
SUD Administration	**858,045**	**190,867**	**129,950**	**(60,917)**	**-31.9%**	**858,045**	**-**
HMP/MEDICAID SUD SRVCS							
Lenawee	1,677,180	419,295	419,295	0	0.0%	1,677,180	-
Livingston	1,135,797	283,949	283,949	0	0.0%	1,135,797	-
Monroe	3,584,825	896,206	767,994	(128,213)	-14.3%	3,584,825	-
Washtenaw	5,934,881	1,483,720	1,289,034	(194,686)	-13.1%	5,934,881	-
TOTAL	12,332,683	3,083,171	2,760,272	(322,899)	-10.5%	12,332,683	-
							-
GRANT/PA2 SUD SERVICES							-
ARPA Services	3,891,413	972,853	510,209	(462,645)	-47.6%	3,891,413	-
Block Grant Services	3,616,666	904,167	821,061	(83,105)	-9.2%	3,616,666	
State Opioid Response	2,300,000	575,000	415,099	(159,901)	-27.8%	2,300,000	-
PA2 Services	1,824,100	456,025	297,838	(158,187)	-34.7%	1,824,100	-
Other Grants	397,131	99,283	32,394	(66,888)	67.4%	397,131	-
Gambling Prevention Grant	227,273	56,818	7,051	(49,767)	87.6%	227,273	-
Veteran Navigation	192,000	48,000	51,257	3,257	-6.8%	192,000	-
TOTAL	12,448,583	3,112,146	2,134,909	(977,237)	-31.4%	12,448,583	-
SUD Health Homes	552,843	138,211	120,131	(18,080)	13.1%	552,843	-
SUD/Grants Expenditures	**26,192,153**	**6,524,394**	**5,145,261**	**(1,379,133)**	**-21.1%**	**26,192,153**	**-**
SUD/Grants Total	**3,488,503**	**737,583**	**1,134,739**	**397,156**	**-53.8%**	**3,488,503**	**-**
PIHP							
PIHP REVENUE							
Incentives (Est)	1,900,000	475,000	480,994	5,994	1.3%	1,900,000	-
Local Match	159,180	39,795	39,795	-	0.0%	159,180	-
Other Income	300	75	-	(75)		300	-
PIHP Revenue	**2,059,480**	**514,870**	**520,789**	**5,919**	**1.1%**	**2,059,480**	**-**
PIHP EXPENDITURES							
PIHP Admin							
Local Match	159,180	39,795	39,795	-	0.0%	159,180	-
Salaries & Fringes	1,769,276	408,294	382,780	(25,515)	-6.2%	1,769,276	-
Contracts & Other	1,250,000	312,500	235,421	(77,079)	-24.7%	1,250,000	-
PIHP Admin	**3,178,456**	**760,589**	**657,995**	**(102,594)**	**13.5%**	**3,178,456**	**-**
							-
Board Expense	3,000	750	322	(428)	-57.1%	3,000	-
PIHP Expenditures	**3,181,456**	**761,339**	**658,317**	**(103,022)**	**-13.5%**	**3,181,456**	**-**
PIHP Total	**(1,121,976)**	**(246,469)**	**(137,528)**	**108,941**	**-44.2%**	**(1,121,976)**	**-**
Organization Total	**12,704,849**	**1,842,019**	**1,127,534**	**(714,485)**	**-38.8%**	**12,704,849**	**-**
Totals							
Revenue	318,870,799	75,059,513	75,730,959	671,446	**-0.9%**	318,870,799	-
Expenses	306,165,950	73,217,494	74,603,424	(1,385,931)	**1.9%**	306,165,950	-
Net Before Transfers	12,704,849	1,842,019	1,127,534	(714,485)	**-38.8%**	12,704,849	-

CMHPSM Quality Assessment and Performance Improvement Program (QAPIP) Summary of FY2024 Workplan Priorities

The FY24 QAPIP Workplan includes completion of required elements of the QAPIP, growth areas based on external site reviews, and the review of effectiveness. Figure 1 provides the QAPIP Priorities and Quality Work Plan for FY24. Figure 2 provides the FY24 QAPIP Performance Measures.

FY2024 Workplan Priority Outcomes:	Green- Met Outcome	White – Partially Met Outcome.	Orange – Outcome Not Met.	Grey – No benchmark or establishing baseline.

A. Figure 1. FY2024 QAPIP Priorities and Work Plan

Governance	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**FY2024 Outcomes**
CMHPSM Board of Directors will approve the QAPIP Plan and Report	Submit the annual QAPIP Plan to the Board. Submit the annual QAPIP Evaluation to the Board	CMHPSM COO	12/14/23 02/08/24	Met
Board of Directors review QAPIP Progress Reports	Submit QAPIP progress reports to the Board.	CMHPSM COO	Quarterly	Met
CMHPSM QAPIP will be submitted to Michigan Department of Health and Human Services	Submit the Board approved QAPIP Plan, Report (Evaluation), and Governing Body Form to MDHHS (via MDHHS FTP Site)	CMHPSM Compliance/Quality Manager	2/28/24	Met
Communication of Process and Outcome Improvements	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**FY2024 Outcomes**
The QAPIP Plan and Report will be provided annually to network providers and to members upon request.	Post to the CMHPSM website. Ensure CMHSP contractors receive the QAPIP. Provide QAPIP Plan and Evaluation reporting at CMHPSM provider meetings. Communications to providers on the availability of QAPIP reports on the CMHPSM website. Communications to regional committees. Ensure Regional Customer Services Committee includes members' ability to request QAPIP documents in informational materials	CMHPSM Compliance/Quality Manager CMHPSM Network Management Committee Regional Customer Services Committee	03/03/2024	Met
Consumers & Stakeholders receive reports on key performance indicators, consumer satisfaction survey results	Present reports on QAPIP activities and performance measures to RCAC on Consumer Services reports on persons experience, satisfaction survey results,	CMHPSM Compliance/Quality Manager	Quarterly	Met

and performance improvement projects	grievances, appeals, PIPs, MMBPIS, event data, quality policies/procedures and Customer Service Reports to RCAC. Incorporate RCAC feedback in interventions and recommendations related to survey data and QAPIP activities.	Regional Customer Services Committee	Annually Annually	Met
Performance Measurement and Quality reports are made available to stakeholders and general public.	Post to the CMHPSM website. Ensure CMHSP contractors receive the QAPIP and inform communities of its availability on the website.	CMHPSM COO Regional NMC Committee	Annually	Met
MDHHS Performance Indicators	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**FY2024 Outcomes**
CMHPSM will meet or exceed the MMBPIS standards for Indicators 1, 4, 10 as required by MDHHS.	Complete quality checks on data prior to submission to ensure validity and reliability of data.	CMHSPs CPT leads	Quarterly	Met
	Verify Medicaid eligibility prior to MMBPIS submission. Submit MMBPIS data to MDHHS quarterly by due date.	CMHPSM Regional Data Coordinator CMHPSM CIO	Quarterly	Met Met
	Conduct quarterly analysis of CMHSP and CMHPSM provider MMBPIS performance. Require and review corrective action plans where standards were not met. Oversee effectiveness of corrective action plans through monthly review of subsequent data.	Regional CPT Committee CMHPSM Compliance/Quality Manager	Monthly QAPIP data review Quarterly CAP review Q1 Feb Q2 May Q3 August Q4 November	Met
CMHPSM will demonstrate an increase in compliance with access standards.	Monitor access requirements for priority populations, delineated by each priority population type. Establish a mechanism to monitor access requirements for persons enrolled in health homes (OHH, BHH, CCBHC).	Regional CPT Committee CMHPSM Compliance/Quality Manager CMHPSM SUD Services Director	Monthly QAPIP data review Quarterly CAP review Q1 Feb Q2 May Q3 August Q4 November	Met Met

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

CMHPSM will engage in two performance improvement projects for the FY22-25 PIP cycle: 1. Reducing Racial Disparities Specific to No-Shows for the Initial Biopsychosocial Assessment (BPS) in Individuals Accessing CMH services. 2. Overall increase in performance in new persons receiving a completed bio-psycho-social initial assessment within 14 calendar days of a non-emergency request for service.	Implement CMHPS specific interventions identified in causal barrier analysis in FY24. Conduct monthly trends and quarterly analysis of performance with PIP indicators. Determine casual barriers and factors where disparity was not reduced. Require and review corrective action plans and interventions where standards were not met. Oversee effectiveness of corrective action plans through monthly review of subsequent data.	Regional CPT Committee Regional EOC Committee CMHPSM Compliance/Quality Manager CMHPSM CIO CMHPSM Health Data Analyst	Monthly Quarterly	Met Met
	Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations). Review with relevant committees/councils.	Regional CPT Committee CMHPSM Compliance/Quality Manager	Monthly data review Quarterly reporting to Regional CPT RCAC, and CMHPSM Board	Met
	Complete and submit PIP 1 to HSAG as required for validation.	CMHPSM Compliance/Quality Manager	June/July 2024	Met
	Complete and submit PIP 1 to MDHHS as required.	CMHPSM Compliance/Quality Manager	2/28/2024	Met
Quantitative and Qualitative Assessment of Member Experiences	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**FY2024 Outcomes**
CMHPSM will obtain a qualitative and quantitative assessment of member experiences for all representative populations, including members receiving LTSS, and take specific action as needed, identifying sources of dissatisfaction, outlining systematic action steps and interventions, evaluating for	Develop surveys for all populations. Incorporate identification of persons receiving LTSS in survey data	Regional Customer Services Committee CMHPSM SUD Services Director	03/31/2024	Met
	Incorporate the analysis of Michigan specific National Core Indicator Data to identify trends and areas for improvement.	Regional Customer Services Committee CMHPSM Compliance/Quality Manager	09/30/2024	Met

effectiveness to improve satisfaction, communicating results.	Complete annual assessment of the member experience report to include the trends, causal sources of dissatisfaction, and interventions in collaboration with relevant committees/councils. Report the results of the member satisfaction survey to RCAC and CMHPSM Board for input and feedback on planned interventions.	Regional Customer Services Committee CMHPSM SUD Services Director	09/30/2024	Partially met Partially met
	Conduct analysis of a potential new SUD community survey tool to replace the RSA. Continue RSA for FY24 if new survey undetermined.	CMHPSM SUD Services Director	04/30/2024	Met
CMHPSM will meet or exceed the standard for Grievance resolution in accordance with federal and state standards.	CMHPSM will conduct quarterly monitoring of compliance with data collection/documentation that meets state and federal grievance standards, providing retraining and interventions, as needed.	CMHPSM COO CMHPSM Compliance/Quality Manager Regional Customer Services Committee	12/31/2024 Monthly Quarterly Q1 February Q2 May Q3 August Q4 November	Met
Event Monitoring and Reporting	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**FY2024 Outcomes**
CMHPSM will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths) are collected, monitored, reported, and followed up on as specified in the PIHP Contract.	Submit Critical Events monthly timely and accurately. Conduct analysis of Behavior Treatment Committee data quarterly.	CMHSPs CMHPSM Compliance /Quality Manager CMHPSM COO	Monthly Quarterly Q1 February Q2 May Q3 August Q4 November	Partially met Met
	Submit CMH Sentinel Events (MDHHS CRM) immediate notification) to CMHPSM based on notification requirements of the event. (24 hour, 48 hours, 5 days)	CMHSPs SUD Providers	As Needed	Met
	Submit SUD Sentinel events bi-annually as required	CMHPSM SUD Providers (Residential, Recovery Housing)	April 2023 October 2023	Met
	Conduct oversight through SE data review and provider monitoring to ensure appropriate follow up is occurring for all events dependent on the type and	CMHPSM Compliance/Quality Manager	Quarterly Q1 February Q2 May	Met

	severity of the event, including a root cause analysis, mortality review, immediate notification to MDHHS as applicable, and meeting required timeframes. Conduct primary source verification of critical incidents and sentinel events.	CMHPSM COO Regional CPT Committee	Q3 August Q4 November	
CMHPSM will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths) are monitored and followed up on as specified in the PIHP Contract.	Conduct analysis on critical events to monitor compliance with reporting, trends, and opportunities for performance improvements.	CMHPSM Compliance/Quality Manager CMHPSM COO Regional CPT Committee	Quarterly Q1 February Q2 May Q3 August Q4 November	Met
Medicaid Services Verification	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**FY2024 Outcomes**
CMHPSM will meet or exceed a 95% rate of compliance of Medicaid delivered services in accordance with MDHHS requirements.	Complete Medicaid Event verification reviews in accordance with CMHPSM policy and procedure.	CMHPSM COO CMHPSM CFO	12/31/2024	Met
	Complete the MEV Annual Methodology Report identifying trends, patterns, strengths and opportunities for improvement.	CMHPSM COO	12/31/2024	Met
	Submit the Annual MEV Methodology Report to MDHHS as required	CMHPSM COO	12/31/2024	Met
Utilization Management Plan	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**FY2024 Outcomes**
CMHPSM will establish a Utilization Management Plan in accordance with the MDHHS requirements	Complete performance summary quarterly reviewing trends, patterns of under / over utilization, medical necessity criteria, and the process used to review and approve provision of medical services. Identify CMHSPs/SUDPs requiring improvement and present/provide to relevant committees/ councils.	Regional UM/UR Committee	Quarterly Q1 February Q2 May Q3 August Q4 November	Partially met
	Ensure utilization of parity screening tools and admission criteria. LOCUS, CAFAS, PECFAS DECA, MCG, ASAM.	Regional UM/UR Committee Regional CPT Committee	Quarterly (parity)	Met

	Complete analysis of parity program compliance with LOC and LOC exceptions.	Regional UM/UR Committee		Met
CMHPSM will demonstrate full compliance with timeframes of service authorization decisions in accordance with the MDHHS requirements.	Oversight of compliance with policy through primary source verification during CMHPSM reviews of ABD state data reports and reviews of delegated functions of CMHSPs.	Regional UM/UR Committee	Quarterly Q1 February Q2 May Q3 August Q4 November	Met
	Analysis of ABD data reports in meeting service decision timeframes.			Met
CMHPSM will meet or exceed the standard for compliance with the adverse benefit determination notices completed in accordance with the 42 CFR 438.404 Includes assurance that ABDs accurately provide service denial reasons in language understandable to person served, type of denial, accuracy of service and denial decision explanation, and compliance with timeframes	Revise ABD training for staff based on outcomes of state data reporting. Staff to complete training.	Regional UM/UR Committee	03/30/2024	Met
	Oversight of compliance with policy through primary source verification during CMHPSM reviews of ABD state data reports and reviews of delegated functions of CMHSPs.	Regional UM/UR Committee	Quarterly Q1 February Q2 May Q3 August Q4 November	Met
CMHPSM will meet or exceed the standard for Appeal resolution in accordance with federal and state standards.	CMHPSM will conduct quarterly monitoring of compliance with data collection/documentation that meets state and federal appeals standards, providing retraining and interventions, as needed.	CMHPSM COO CMHPSM Compliance/Quality Manager Regional UM/UR Committee	Quarterly	Met
Practice Guidelines	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**FY2024 Outcomes**
CMHPSM will adopt, develop, implement nationally accepted or mutually agreed upon (CMHPSM/ MDHHS) clinical practice guidelines/ standards, evidenced based practices,	Review of CPGs for any updates or revisions to CPGs being utilized in the region.	Regional CPT Committee	Bi-annually or as needed if new CPGs are adopted	Met
	Update CPG list, including providers that implement/offer CPGs.	CMHPSM COO	Bi-annually	Met

best practice, and promising practices relevant to the individual served.	Communicate available CPGs to provider networks	Regional NMC Committee	March 2024 December 2024	Met
CMHPSM will demonstrate full compliance with MDHHS required practice guidelines.	Oversight during CMHPSM reviews of managed care delegated functions to ensure providers adhere to practice guidelines as required.	CMHPSM COO CMHPSM Compliance/Quality Manager	Annually	Met
Oversight of Vulnerable Individuals and Long Term Supports and Services	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**FY2024 Outcomes**
CMHPSM will evaluate health, safety and welfare of persons served considered vulnerable and receiving LTSS order to determine opportunities for improving oversight of their care and their outcomes.	Ensure the identification of LTSS remains in all regional quality/health and safety data reporting including events data, behavior treatment data, survey data of persons experience, performance measures. Ensure LTSS populations served are incorporated in measures of provider monitoring, service authorization, and reviews of outcomes data.	CMHPSM COO CMHPSM Health Data Analyst Regional CPT Committee	Quarterly data review Q1 February Q2 May Q3 August Q4 November	Met
Assure accurate identification of persons served within HCBS, 1915i services, and LTSS.	Conduct data analysis of completion and accuracy of HCBS and 1915i assessment and documentation in the clinical record. 90% compliance with clinical documentation of those persons qualified for HCBS/1915i identified in the EHR. 100% of 1915i recipients enrolled in MDHHS WSA Maintain identification of LTSS in data analysis.	CMHPSM COO CMHPSM Health Data Analyst Regional CPT Committee	Report analysis Quarterly Q1 February Q2 May Q3 August Q4 November	Met Met Not Met
CMHPSM will assess the quality and appropriateness of care furnished to members (vulnerable people) receiving LTSS including an assessment of care between care settings, a comparison of services and supports received	Include analysis of regional committee performance reports (including barriers, improvement efforts, recommendations, and status of recommendations) for efforts to support community integration. Critical incidents, sentinel events, risk events, behavior treatment plans, member satisfaction results, practice guidelines, credentialing and recredentialing, verification of Medicaid services, over and underutilization, provider network monitoring	CMHPSM COO CMHPSM Compliance/Quality Manager Regional CPT Committee Regional CS Committee Regional NMC Committee	Quarterly Q1 February Q2 May Q3 August Q4 November	Met

Behavior Treatment	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	FY2024 Outcomes
CMHPSM will demonstrate an increase in compliance with Behavior Treatment data collection and analysis.	Submit data on Behavior Treatment Plans where intrusive and/or restrictive techniques have been approved by the behavior treatment committee and where emergency interventions have been used	CMHPSM BTC Chairs CMHPSM Compliance/Quality Manager	FY24 Quarterly February May August, November	Met
	Complete Behavior Treatment performance reports that analyze the use of emergency interventions, plans approved with restrictive and/or intrusive interventions, and adherence to the BTPR Standards (including barriers, improvement efforts, recommendations, and status of recommendations).	CMHPSM Compliance/Quality Manager Regional CPT Committee	FY24 Annual QAPIP Plan 2/28/24 FY24 QAPIP Evaluation 2/28/25 FY24 Quarterly February May August, November	Met
	CMHPSM will explore system abilities to report BTC data electronically more efficiently while maintaining security/privacy and reporting standards.	CMHPSM Compliance/Quality Manager Regional CPT Committee	FY24 Annual Report 2/28/23 FY24 quarterly February May August, November	Met
	CMHPSM will conduct quarterly analysis and reporting of BTC data to Regional CPT Committee for any corrective action measures to be taken, and incorporated into the CMHPSM QAPIP documents and reports	CMHSM COO CMHPSM Compliance/Quality Manager	FY24 Quarterly March May August, November	Met
Provider Monitoring	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**FY2024 Outcomes**
CMHPSM will be in compliance with PIHP Contract Requirements.	Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP. Coordinate quality improvement plan development,	Regional NMC Committee CMHPSM COO	Annual	Met

	incorporating goals and objectives for specific growth areas based on the site reviews, and submission of evidence for the follow up reviews.	CMHPSM SUD Services Director		
CMHPSM will demonstrate an increase in compliance with the External Quality Review (EQR) - Compliance Review	Implement corrective action plans for areas that were not in full compliance, and quality improvement plans for recommendations. See CAP for specific action steps. Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	CMHPSM COO CMHPSM Compliance/Quality Manager Regional Compliance Committee	Monthly Quarterly	Met
CMHPSM will demonstrate full compliance with the EQR - Performance Measure Validation Review	Implement quality improvement plans for recommendations provided by the external quality review team. Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	CMHPSM CIO CMHPSM COO CMHPSM Compliance/Quality Manager Regional CPT Committee Regional EOC Committee	9/30/2024	Met
CMHPSM will receive a score of "Met" for the EQR Performance Improvement Project Validation	Implement and comply with all PIP Validation submission requirements	CMHPSM CIO CMHPSM COO CMHPSM Compliance/Quality Manager Regional CPT Committee Regional EOC Committee	9/30/2024	Met
CMHPSM will demonstrate an increase in compliance with the MDHHS c waiver/1915 Reviews.	Monitor systematic remediation for effectiveness through delegated managed care reviews and performance monitoring through data.	CMHPSM COO CMHPSM Compliance/Quality Manager	09/30/24	Partially met
CMHPSM will demonstrate full compliance with the MDHHS Substance Use Disorder Protocols	Provide evidence to support SUD requirements	CMHPSM COO CMHPSM SUD Services Director	09/30/24	Met
CMHPSM will demonstrate assurances of adequate capacity and	Submit Network Adequacy Report to MDHHS	CMHPSM COO	02/28/24	Met

services for the region, in accordance with the MDHHS Network Adequacy standards.	Complete Network Adequacy Assessment including all required elements.	Regional NMC Committee	09/30/24	
Provider Qualifications	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**FY2024 Outcomes**
CMHPSM will ensure physicians, other healthcare providers, and non-licensed individuals are qualified to perform their jobs.	CMHPSM will conduct quarterly monitoring of compliance with Organizational credentialing and re-credentialing requirements, providing retraining and procedures revisions as needed. Data reports of progress will be included in the QAPIP report to the Regional CPT Committee and the CMHPSM governance bodies.	CMHPSM COO Regional NMC Committee	Quarterly	Met
CMHPSM will have credentialing policies/ procedures, in accordance with MDHHS Credentialing and Re-Credentialing Process, for ensuring that all providers rendering services to individuals are appropriately credentialed within the state and are qualified to perform their services.	CMHPSM will conduct quarterly monitoring of compliance with LIP credentialing and re-credentialing requirements providing retraining and procedures revisions as needed. Data reports of progress will be included in the QAPIP report to the Regional CPT Committee and the CMHPSM governance bodies.	CMHPSM COO Regional NMC Committee	Quarterly	Met
CMHPSM ensures all delegates performing credentialing functions comply with all initial (including provisional/temporary) credentialing requirements according to initial credentialing and re-credentialing monitoring tools for organizations and LIPs	Primary Source Verification and credentialing and recredentialing policy and procedure review will occur during CMHPSM reviews of CMHSP delegated functions and Medicaid Service Verification activities. CMHPSM will increase monitoring for providers scoring less than 90% on the file review and will be subject to additional review of credentialing and re-credentialing records.	CMHPSM COO Regional NMC Committee	Annually	Met
	Review semi-annual credentialing and re-credentialing report to ensure credentialing within the appropriate timeframes.	CMHPSM COO Regional NMC Committee	Semi Annually May 2024 November 2024	Met

Clinical service providers are credentialed by the CMHSP prior to providing services and ongoing.	CMHPSM will conduct quarterly monthly monitoring of compliance with credentialing and re-credentialing requirements for directly hired CMHSP staff as delegated to the CMHSPs, providing retraining and procedures revisions as needed	CMHPSM COO Regional NMC Committee	Quarterly reporting	Partially met
Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements.	CMHPSM Oversight and monitoring during CMHSP and SUD Provider reviews of delegated functions.	CMHPSM COOCMHPSM SUD Services Director Regional NMC Committee	Annually	Met
Non-licensed providers will demonstrate an increase in compliance with staff qualifications and training requirements.	CMHPSM Oversight and monitoring during CMHSP and SUD Provider reviews of delegated functions.	CMHPSM COO CMHPSM SUD Services Director Regional NMC Committee	Annually	Met

B. Figure 2. FY24 Performance Measures

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

FY2024 Performance Measure Outcomes:	Green- Meeting or Exceeding State Benchmark	White – in-process or data is not yet available as of this status report.	Orange – Not currently meeting benchmark as of this status report.	Grey – No benchmark, or establishing baseline, or is a baseline year.

***Continuous Quality Strategy Goal(s)**	**Michigan Mission Based Performance Indicator System**	**Committee/ Council**	**FY2024 Performance**
1	CMHPSM will meet or exceed the standard for Indicator 1: Percentage of Children who receive a Prescreen within 3 hours of request (Standard is 95% or above)	Regional CPT Regional EOC	Met

1	CMHPSM will meet or exceed the standard for Indicator 1: Percentage of Adults who receive a Prescreen within 3 hours of request (Standard is 95% or above)	Regional CPT Regional EOC	Met
1	CMHPSM will meet or exceed the standard for Indicator 2.A: Percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (reported by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children.) Performance measured by total % of all populations (total numerator/denominator) **CMHPSM FY22 Baseline = 61.3% = 50TH – 75TH Percentile** **FY24 Performance Measure: reach or exceed the 75th Percentile (62%)** **MDHHS Indicator 2 Percentile %s** **50th = 57.0%** **75th = 62.0%**	Regional CPT Regional EOC	Not met
1	CMHPSM will meet or exceed the standard for Indicator 2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders. Performance measured by total % of all populations (total numerator/denominator) **CMHPSM FY22 Baseline = 60.8% = Below 50TH Percentile** **FY24 Performance Measure: reach or exceed the 50TH Percentile (68.2%)** **MDHHS Indicator 2e Percentile %s** **50th = 68.2%** **75th = 75.3%**	Regional CPT Regional EOC	Not met
1	CMHPSM will meet or exceed the standard for Indicator 3: Percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (reported by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children). Performance measured by total % of all populations (total numerator/denominator) **CMHPSM FY22 Baseline = 74.5% = 50TH – 75TH Percentile** **FY24 Performance Measure: reach or exceed the 75TH Percentile (83.8%)** **MDHHS Indicator 3 Percentiles %s** **50th = 72.9%** **75th = 83.8%**	Regional CPT Regional EOC	Partially met
1, 3	CMHPSM will meet or exceed the standard for Indicator 4a1: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (Standard is 95% or above) (Child)	Regional CPT Regional EOC	Not met
1, 3	CMHPSM will meet or exceed the standard for Indicator 4a2: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (Standard is 95% or above) (Adult)	Regional CPT Regional EOC	Not met

1, 3	CMHPSM will meet or exceed the standard for Indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (Standard is 95% or above)	Regional CPT Regional EOC	Met
1, 3	CMHPSM will meet or exceed the standard for Indicator 10: Re-admission to Psychiatric Unit within 30 Days (Standard is 15% or less) (Child)	Regional CPT Regional EOC	Met
1, 3	CMHPSM will meet or exceed the standard for Indicator 10: Re-admission to Psychiatric Unit within 30 Days (Standard is 15% or less) (Adult)	Regional CPT Regional EOC	Not met
1, 3	CMHPSM will demonstrate and increase in compliance with access standards for the SUD priority populations. (Compared to FY23 Data)	Regional CPT Regional EOC	Met
Continuous Quality Strategy Goal(s)	**BH TEDS Data**	**Committee**	**FY2024 Performance**
2, 3	Analyze and monitor BHTEDS records to improve housing and employment outcomes for persons served. Maintain overall BHTEDS completion rates to state 95% standard during FY2024. Improve crisis encounter BHTEDs completion to 95% during FY2024.	Regional EOC Regional CPT	Met Met
Continuous Quality Strategy Goal(s)	**Performance Improvement Projects**	**Committee**	**FY2024 Performance**
1, 2, 3, 4	PIP 1: The racial disparities of no-shows for the initial Biopsychosocial Assessment (BPS) in individuals accessing CMH services will be reduced or eliminated. (FY2022 Baseline)	Regional EOC Regional CPT	Not met
1, 2, 3, 4	PIP 2: Overall increase in performance in new persons receiving a completed bio-psycho-social initial assessment within 14 calendar days of a non-emergency request for service.	Regional EOC Regional CPT	Not met
Continuous Quality Strategy Goal(s)	**Assessment of Member Experiences**	**Committee**	**FY2024 Performance**
1, 2, 3	Percentage of children and/or families indicating satisfaction with mental health services. (Standard 85%/) Percentage of adults indicating satisfaction with mental health services. (Standard 85%) Percentage of individuals indicating satisfaction with long-term supports and services. (Standard 85%) Create plan for improvement in areas that fell below the 85% threshold: My phone calls are returned by the next day 83.4	Regional Customer Services Committee	Met Met Met Met

	If I have a concern or a problem I know how to contact Customer Services to file a compliant 76.5		
1, 2, 3	Percentage of consumers indicating satisfaction with substance use services. (Standard 85% OR 2.5 Likert score)	CMHPSM SUD Director Regional Co-Occurring Workgroup	Met
Continuous Quality Strategy Goal(s)	**Member Appeals and Grievance Performance Summary**	**Committee**	**FY2024 Performance**
1, 2, 3	The percentage (rate per 100) of Medicaid appeals which are resolved in compliance with state and federal timeliness and documentation standards including the written disposition letter (30 calendar days) of a standard request for appeal. (Standard 95%) An improvement from FY2023 in the percentage of appeals cases that meet documentation requirements in the EHR.	Regional UM/UR Committee Regional CPT Committee	Met Met
1, 2, 3	The percentage (rate per 100) of Medicaid grievances are resolved with a compliant written disposition sent to the consumer within 90 calendar days of the request for a grievance. (Standard 95%) An improvement from FY2023 in the percentage of grievance cases that meet documentation requirements in the EHR.	Regional CS Committee Regional CPT Committee	Met Met
Continuous Quality Strategy Goal(s)	**Adverse Event Monitoring and Reporting**	**Committee**	**FY2024 Performance**
	The rate of critical incidents per 1000 persons served will demonstrate a decrease from previous year. (CMHSP) (excluding deaths)	Regional CPT Committee Regional EOC Committee	Partially met
	The rate, per 1000 persons served, of Non-Suicide Death will demonstrate a decrease from previous year. (CMHSP)(Natural Cause, Accidental, Homicidal) Ensure compliance with timely and accurate reporting of critical and sentinel events (100%) 100% CEs reporting 100% timely reporting	Regional CPT Committee Regional EOC Committee	Met Partially met Met Partially met
	Quarterly report and analysis of type, trends over time (including mortality), events per 1,000, regional trends over time for the fiscal year, analysis of trends by service,	Regional CPT Committee	Met

	engagement in treatment, precipitating events. Analysis of CE trends for potential PI projects	Regional EOC Committee	
	The rate, per 1000 persons served, of Sentinel Events will demonstrate a decrease from the previous year.	Regional CPT Committee Regional EOC Committee	Not met
	Individuals involved in the review of sentinel events must have the appropriate credentials to review the scope of care. 100% reported to PIHP and state 100% timeframes met 3-day review of critical events (CEs) that are sentinel events (SEs) 100% RCA completion	Regional CPT Committee Regional EOC Committee	Met Met Met Met Met
Continuous Quality Strategy Goal(s)	**Joint Metrics**	**Committee**	**FY2024 Performance**
	Collaboration meeting completed between entities for the ongoing coordination and integration of services. (100%)	Regional EOC Committee Regional CPT Committee	Met
	The percentage of discharges for adults (18 years or older) who were hospitalized for treatment of selected mental illness and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days. FUH Report, Follow-Up After Hospitalization Mental Illness **Adult (Standard-58%)** Measurement period will be calendar year 2023.	Regional EOC Committee Regional CPT Committee	Met
	The percentage of discharges for children (ages 6-17 years) who were hospitalized for treatment of selected mental illness and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days. FUH Report, Follow-Up After Hospitalization Mental Illness **Child (Standard-70%)** Measurement period will be calendar year 2023.	Regional EOC Committee Regional CPT Committee	Met
	Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days: Racial/ethnic group disparities will be reduced for beneficiaries six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an	Regional EOC Committee	Not met

	outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days. CMHPSM will reduce the racial/ethnic disparity between the index population and at least one minority group. (Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences). Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2022 with calendar year 2023.	Regional CPT Committee	
	Follow up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence: CMHPSM will reduce the disparity between the index population and at least one minority group. For beneficiaries 13 years and older with an Emergency Department (ED) visit for alcohol and other drug dependence that had a follow-up visit within 30 days. (Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences). Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2022 with calendar year 2023	Regional EOC Committee Regional CPT Committee	Not met
Continuous Quality Strategy Goal(s)	**PIHP Performance Based Incentive Payments**	**Committee**	**FY2024 Performance**
	Implement data driven outcomes measurement to address social determinants of health. Analyze and monitor BHTEDS records to improve housing and employment outcomes for persons served. Measurement period is prior fiscal year. Use most recent update or discharge BH-TEDS record during the measurement period, look back to most recent prior update or admission record. Submit completed report to state.	Regional EOC Committee Regional CPT Committee	Met
	Percentage of Adults Aged 18 and Older with Schizophrenia or Schizoaffective Disorder who were Dispensed and Remained on an Antipsychotic Medication for at Least 80 Percent of their Treatment Period (SAA-AD): CMHPSM will participate in DHHS-planned and DHHS provided data validation activities and meetings and return completed data validation template to state 120 calendar days from January 31, 2024.	Regional EOC Committee Regional CPT Committee	Met
	CMHPSM will reduce the disparity between the index population and at least one minority group regarding the percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who initiate treatment within 14 calendar days of the diagnosis received: (**1. Initiation of AOD Treatment)**	Regional EOC Committee Regional CPT Committee	Not met

	Data will be stratified and provided by the State by race/ethnicity Measurement period will be a comparison of calendar year 2022 with Calendar year 2023.		
	CMHPSM will reduce the disparity between the index population and at least one minority group regarding the percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment and who had two or more additional AOD services or Medication Assisted Treatment (MAT) within 34 calendar days of the initiation visit. **(2. Engagement of AOD Treatment)** Data will be stratified and provided by the State by race/ethnicity Measurement period will be a comparison of calendar year 2022 with Calendar year 2023.	Regional EOC Committee Regional CPT Committee	Not met
	CMHPSM will increase participation in patient-centered medical homes/health homes. (narrative report)	Regional CPT Committee	Met
Continuous Quality Strategy Goal(s)	**Priority Measures**	**Committee**	**FY2024 Performance**
	Clinical SUD		
	CMHPSM SUD providers will meet ASAM continuum completion rates (Target 75%) CMHPSM SUD providers will improve meeting priority population timelines (Target 75%) Screening requirement met 85.1% Admission requirement met 45.8% CMHPSM SUD providers will show a decrease in open SUD wrapper admissions without service and an increase in closed cases. (30%) Monthly data reviews and quarterly data analysis reporting**.** (Target 95%)	Regional CPT Committee	Met Met Met Met
Continuous Quality Strategy Goal(s)	**Utilization Management/LTSS**	**Committee**	**FY2024 Performance**
	Correct timeframes used for advance action notice (Target 100%) Accurate use of reduction, suspension, or termination decisions. (Target 100%) ABDs provide service denial reasons in language understandable to person served. Analyze type of denial, accuracy of service and denial decision explanation, and compliance with timeframes.	Regional UM/UR Committee	Q4 Pending, last Q3 review Met Not Met Met

	Assess overutilization of services: Review of inpatient recidivism as potential overutilization of higher level of care, using following factors: • Persons receiving LTSS, and/or on c waiver • Services/status, type, and service utilization before first admission • Type or change in the services/IPOS after the first and/or second admission • Engagement obstacles • If hospitalization known or managed by CMH • Compliance with MMBPIS Indicator 4a	Regional UM/UR Committee	Q4 Pending, last Q1-Q2 review Met
	Underutilization project: Assess HSW members not receiving monthly services that qualify them for HSW enrollment as potential underutilization, including potential risks of maintaining HSW enrollment with the ending of public health emergency and subsequent enrollment exceptions. Including following factors: • Utilization of monthly habilitative services • Authorized services vs utilized services • Service delays and proper ABD notice where applicable • Person given choice of provider and HSW services	Regional UM/UR Committee	Q4 Pending, last Q1-Q2 review Met
	Evidence of use of parity program for those with established LOC in CMHPSM reviews of CMHSPs clinical records for all populations (Standard 90%). A parity LOC is completed for each person served, including the accurate population The relevant and appropriate level of care assessment is completed for each person served prior to authorizations being completed. If the exception process is used, the reason for the exception is documented and reviewed at the supervisory level.	Regional UM/UR Committee	Partially met Partially met
	Consistent regional service benefit is achieved as demonstrated by the percent of outliers (exceptions) to level of care benefit packages (Standard <=5%). Measurement period is FY23	Regional UM/UR Committee	Met
	Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines. (Target 100%). Implement an inner rater reliability with the MCG Indicia parity system for psychiatric inpatient, crisis residential, and partial hospitalization service decisions. Baseline measurement period is Q1 of FY24	Regional UM/UR Committee	Partially Met Met
Continuous Quality Strategy Goal(s)	**Behavior Treatment**	**Committee**	**FY2024 Performance**

	Consistent quarterly reporting of BTC data (100%) Consistent data analysis of BTC data (100%)	Regional CPT Committee	Met Met
	The percentage of individuals who have an approved Behavior Treatment Plan which includes restrictive and intrusive techniques.	Regional CPT Committee	Met - baseline
Continuous Quality Strategy Goal(s)	**Clinical Practice Guidelines**	**Committee**	**FY2024 Performance**
	CPGs reviewed at least bi-annually.	Regional CPT Committee	Met
	CPGs published to both provider network and members.	Regional CS Committee Regional NMC Committee	Met
Continuous Quality Strategy Goal(s)	**Provider Monitoring**	**Committee**	**FY2024 Performance**
	Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements.	Regional NMC Committee	Met
	Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements.	Regional NMC Committee	Met
	Credentialing and re-credentialing of organizational providers meet all state/federal requirements and timelines.	Regional NMC Committee	Partially met
	Credentialing and re-credentialing of LIP providers meet all state/federal requirements and timelines.	Regional LIP Committee	Met
	Complete assessment of FY24 CMHPSM audits of CMHSP delegated functions and SUD services and development performance improvement projects where indicated based on findings and resultant CAPs.	CMHPSM COO Regional CPT Committee Regional Compliance Committee	Met
	CMHPSM will demonstrate an increase in applicable providers within the network that are "in compliance" with the HCBS rule (MDHHS HCBS CAP Guidance form).	Regional NMC Committee	Met
Continuous Quality	**Health Home (OHH, BHH, CCBHC) Performance Measures**	**Committee**	**FY2024 Performance**

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

Regional Board Action Request – Annual Summary and Evaluation of the Quality Assessment and Performance Improvement Program (QAPIP) for FY2024

Board Meeting Date:	February 12, 2025
Action Requested:	Approve the Annual Summary and Evaluation of the Quality Assessment and Performance Improvement Program (QAPIP) for FY2024.
Background:	The CMHPSM is committed to ensuring quality service provision through review of evidence and the monitoring of the health and welfare of the region's recipients by developing a quality management program. Some of the key functions of a Quality Management Program include developing and evaluating the QAPIP Program on an annual basis. The Annual Summary and Evaluation of the QAPIP is thoroughly reviewed by our regional committees and CMHSP partners.
Connection to:	PIHP/MDHHS Contract, AFP, Regional Strategic Plan and Shared Governance Model
Recommend:	Approval

Model Board Motion: *I move that the CMHPSM Regional Board approve the Annual Summary and Evaluation of the Quality Assessment and Performance Improvement Program (QAPIP) for FY2024.*

Attachment #5 – February 2025

Regional Board Action Request – Contracts

Board Meeting Date: February 12, 2025

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

Organization - Background	Term	Funding Level	Funding Source	Agreement Type
LEAF Harm Reduction: (LEAF-Liberation. Empathy. Advocacy. Future) LEAF Harm Reduction is an evidence-based program dedicated to reducing drug-related harms through a culturally humble, stigma-free, and compassionate approach. LEAF will deliver substance use trend training sessions to healthcare and social service providers, develop and disseminate updated harm reduction protocols to local healthcare and social service organizations, and establish a partnership opportunity and MOAs, to ensure accessibility to underserved communities with high overdose rates	1/1/2025 – 9/30/2025	Not to exceed $25,000.00	ARPA	New Contract

Recommend: Approval

Model Board Motion: *I move that the CMHPSM CEO be authorized to execute the contracts listed within this attachment.*

Regional Board Action Request – Ten-Year Service Proclamation

Board Meeting Date: February 12, 2025

Action Requested: Issuing the formal proclamation acknowledging the ten years of service by Stephannie Weary to the PIHP region as a CMHPSM employee, signed by all CMHPSM Board members.

Background: Stephannie has worked within our region for the last 15 years, first with the Washtenaw Community Health Organization, and for the last ten years with the CMHPSM. Stephannie has evolved with her role and is a key member of our CMHPSM management team. Stephannie's role covers Regional Board and Oversight Policy Board communications, human resources at the CMHPSM, and coordination of multiple regional projects. During her time at the CMHPSM Stephannie's role was expanded to cover human resource activities and she obtained a Society for Human Resource Management Certified Professional (SHRM-CP). Stephannie has been a longstanding member of multiple regional committees including the Regional Operations Committee and Clinical Performance Team and the EHR Operations Committee. Stephannie has recently added Complex Care coordination meeting administration to her portfolio.

Stephannie oversees Independent Provider Credentialing activities, website management and front desk responsibilities. Stephannie and her staff communicate with the general public by phone, fax, through the website and through the CMHPSM newsletter.

Stephannie is always willing to go the extra mile and is dedicated to the CMHPSM and our region. Stephannie is seemingly always available, and is a key sounding board to everyone at the CMHPSM, and an amazing resource to our Regional Board of Directors, our regional partners, the people we serve and the general public.

Recommend: Issuance of proclamation.

Model Board Motion: *I move the CMHPSM Regional Board issue the proclamation acknowledging Stephannie Weary's ten years of service to the CMHPSM region.*

WHEREAS, the Community Mental Health Partnership of Southeast Michigan through effective partnerships, ensures and supports the provision of quality integrated care that focuses on improving the health and wellness of people living in our region; and

WHEREAS, Stephannie Weary as of January 5, 2025 has been employed with the CMHPSM for ten years and has striven to accomplish the mission of the Community Mental Health Partnership of Southeast Michigan as the Human Resources and Regional Coordinator; and

Now, therefore, the Community Mental Health Partnership of Southeast Michigan Board of Directors does hereby proclaim their appreciation to Stephannie Weary for their ten years of service at the CMHPSM, today, February 12, 2025.

Regional Board Action Request – Five Year Service Proclamation

Board Meeting Date: February 12, 2025

Action Requested: Issuance of a formal proclamation by the CMHPSM Regional Board of Directors acknowledging the five years of service by Matt Berg to our PIHP region as a CMHPSM employee.

Background: Matt Berg joined the CMHPSM five years ago with an abundance of non-profit finance experience, but no public behavioral health finance experience. Matt used his skillset to dive headfirst into our complicated public behavioral health finance system. Matt adapted quickly and has successfully guided us through annual financial and compliance audits, state report submissions, an administrative/financial software implementation and revenue projection variability.

Matt has brought steady competence to our finance department during his five years at the CMHPSM. I have confidence in every report that Matt submits, and he has grown and adapted as the finance structure of our system changes (which is far too frequent). Matt has expressed an interest in ensuring the CMHPSM finance department continues to maintain a high level of excellence beyond his planned employment window with the CMHPSM. Matt's technical skillset has improved our regional financial reports and revenue projections over the years.

Recommend: Issuance of proclamation.

Model Board Motion: *I move that the CMHPSM Regional Board issue a proclamation acknowledging Matt Berg's five years of service to the CMHPSM region.*

WHEREAS, the Community Mental Health Partnership of Southeast Michigan through effective partnerships, ensures and supports the provision of quality integrated care that focuses on improving the health and wellness of people living in our region; and

WHEREAS, Matt Berg as of January 13, 2025 has been employed with the CMHPSM for five years and has striven to accomplish the mission of the Community Mental Health Partnership of Southeast Michigan as the Chief Financial Officer; and

Now, therefore, the Now, therefore, the Community Mental Health Partnership of Southeast Michigan Board of Directors does hereby proclaim their appreciation to Matt Berg for their five years of service at the CMHPSM, today, February 12, 2025.

Regional Board Action Request – Five Year Service Proclamation

Board Meeting Date: February 12, 2025

Action Requested: Issuing the formal proclamation acknowledging the 5 years of service by Katherine (Kate) Hendricks to the PIHP region as a CMHPSM employee, signed by all CMHPSM Board members.

Background: Kate Hendricks has shown her remarkable skills as a clinician and her deep passion for ensuring our consumers receive quality care in SUD treatment. She has had a role in creating professional bonds and relationships amongst not only the SUD Treatment Team, but also the SUS Team and the CMHPSM organization.

She started in January of 2020, just two months prior to the COVID outbreak. She showed incredible resilience during this time and helped to figure out how to operate completely remotely after starting her brand-new position. Over the last five years, she has repeatedly shown that she is a team player. Kate frequently accepts and quickly learns new tasks, making each transition for the SUD Team and the SUS Team, a smooth, seamless one.

She has taken roles in the organization's Employee Engagement Committee and has joined CMHPSM's DEI workgroup. She works with the finance department quite frequently, with each of the other departments within the SUS Team, and is always eager to learn new aspects of our EHR and our team's data reporting.

Kate is an asset to the CMHPSM organization, and she has grown immensely over the last 5 years. While at CMPHSM, Kate has obtained her CAADC (Certified Advanced Alcohol and Drug Counselor) credential, and she will apply for her CCS (Certified Clinical Supervisor) credential from MCBAP (Michigan Certification Board for Addiction Professionals) very soon.

Recommend: Issuance of proclamation.

Model Board Motion: *I move that the CMHPSM Regional Board issue the proclamation acknowledging Kate Hendrick's five years of service to the CMHPSM region.*

WHEREAS, the Community Mental Health Partnership of Southeast Michigan through effective partnerships, ensures and supports the provision of quality integrated care that focuses on improving the health and wellness of people living in our region; and

WHEREAS, Kate Hendricks as of January 13, 2025 has been employed with the CMHPSM for five years and has striven to accomplish the mission of the Community Mental Health Partnership of Southeast Michigan as a Utilization and Treatment Specialist; and

Now, therefore, the Community Mental Health Board of Directors does hereby proclaim their appreciation to Kate Hendricks for their five years of service to the region, today, February 12, 2025.

Regional Board Action Request – Five Year Service Proclamation

Board Meeting Date: February 12, 2025

Action Requested: Issuance of a formal proclamation by the CMHPSM Regional Board of Directors acknowledging the five years of service by CJ Witherow to our PIHP region as a CMHPSM employee.

Background: CJ joined the CMHPSM five years ago after multiple decades of service within our region at the WCHO and then Monroe CMHA. CJ utilizes her wealth of experience and expertise within her expansive role as our Chief Operating Officer. CJ oversees many operational elements of the CMHPSM, including quality, compliance, customer service, and provider network operations. CJ is a invaluable resource to employees at the CMHPSM, our regional partners, to our external providers and statewide PIHP colleagues.

CJ's operations department has unfortunately been understaffed at times, but CJ can always be counted on to complete all necessary activities. CJ is the primary spokesperson for our region in days long audits from Health Services Advisory Group (HSAG) and MDHHS. CJ is also our regional privacy officer and interacts with the Office of Inspector General for all potential fraud, waste and abuse complaints and investigations.

CJ's expansive public behavioral health system knowledge and experience, is met only by her dedication to our service population and work ethic.

Recommend: Issuance of proclamation.

Model Board Motion: *I move that the CMHPSM Regional Board issue a proclamation acknowledging C.J. Witherow's five years of service at the CMHPSM region.*

WHEREAS, the Community Mental Health Partnership of Southeast Michigan through effective partnerships, ensures and supports the provision of quality integrated care that focuses on improving the health and wellness of people living in our region; and

WHEREAS, CJ Witherow as of February 3, 2025 has been employed with the CMHPSM for five years and has striven to accomplish the mission of the Community Mental Health Partnership of Southeast Michigan as the Chief Operating Officer; and

Now, therefore, the Community Mental Health Partnership of Southeast Michigan Board of Directors does hereby proclaim their appreciation to CJ Witherow for their five years of service at the CMHPSM, today, February 12, 2025.

CEO Report

Community Mental Health Partnership of Southeast Michigan

Submitted to the CMHPSM Board of Directors

February 5, 2025 for its February 12, 2025 Meeting

CMHPSM Update

- Since the last report, an all staff meetings was conducted on January 13, 2025 as we cancelled our December 23rd meeting and January 26, 2025 meetings.
- A verbal update on our FY2025 contract status will be provided at the December Board meeting.
- The CMHPSM is working on implementing a new group email service that will allow us to more efficiently communicate as a region and communicate with groups of external contacts.
- The CMHPSM leadership team continues to meet on a weekly basis on Tuesday mornings. We have expanded the first meeting of each month to include the three additional staff that supervise staff at the CMHPSM. These leadership/manager meetings will allow the CMHPSM to ensure standardization of human resource efforts related to the supervision of CMHPSM staff.

CMHPSM Staffing Update

- The CMHPSM currently has one open position, we are actively recruiting for the Operations Assistant position.
- More information and links to job descriptions and application information can be found here: https://www.cmhpsm.org/interested-in-employment

Regional Update

- Our regional committees continue to meet using remote meeting technology and expect we will continue to do so until that option is no longer feasible.
- The Regional Operations Committee continues to schedule to meet on a weekly basis.
- We are wrapping up the regional administrative/finance software upgrade project. All four CMHSPs and the PIHP will be on separate installs of the same software platform to manage financial and general ledger activity. Previously three of our entities were on the same Microsoft platform with a fixed life cycle which is expiring and the other two partners were on separate software solutions.

- We have received preliminary information that the statewide Hospital Rate Adjuster payment rates will increase in FY2025 if/when CMS approves of the new rates. The additional daily HRA rate for FY2025 is proposed at $728/day, in FY2024 the rate was $622. The FY2024 and FY2025 rates reflect substantial increases from prior years, the rate in FY2023 was $308/day. All of these payments are passed through retroactively from the CMHPSM per MDHHS payment guidance. HRA payments reimburse hospitals beyond our CMHSP negotiated inpatient hospitalization daily rates.

Statewide Update

- The monthly PIHP statewide CEO meeting was canceled for January and we are meeting on February 11, 2025.
- The monthly PIHP CEO/MDHHS behavioral health leadership staff meeting is being revised by MDHHS BPHASA. Our January meeting was held on January 9, 2025. We have received notice that this meeting will transition to an every other month cadence moving forward. I provide a summary of those meetings to our regional CMHSP directors at our Regional Operations Committee meetings.
- The PIHP/MDHHS contracts negotiation and operation meeting will move from once every two months to every month in the near future.

Legislative Updates

- Lame duck reports from the Community Mental Health Association of Michigan legislative director were distributed by email over the last couple months.
- A number of bills that were passed at the end of a marathon session have yet to be delivered to the Governor. It was recently reported that a lawsuit has been filed by the Senate against the House of Representatives to force delivery of those bills to the Governor. One bill, HB6058 would alter the PA152 medical insurance cost caps for public employers in Michigan. The CMHPSM and our partner CMHSPs must follow PA152 requirements related to employer costs for employee medical insurance. Our medical plan cost increased substantially this year and we will be increasing the co-premium to be paid by staff if HB6058 isn't eventually signed into law by the Governor.

Future Updates

- We are planning to cover the following items at our upcoming CMHPSM Regional Board of Directors meetings:

  No scheduled March 2025 meeting.

  April 9, 2025
  - Strategic Plan Outcomes Status report
  - Potential Budget Revision
  - Board Governance Policies, Manual and Bylaws

  June 11, 2025
  August 13, 2025
  September 17, 2025

Respectfully Submitted,

James Colaianne, MPA

Community Mental Health Partnership of Southeast Michigan

2024 Quality Assessment and Performance Improvement Program Plan Evaluation

Fiscal Year 2024

Final Version Approved:

CMHPSM Clinical Performance Team: 1/16/2025
Reviewed by Regional Operations Committee: 1/27/2025
Approved by CMHPSM Board:
Submitted to MDHHS for Review: *2/28/2025*

Table of Contents

I. Overview/Mission Statement

The Community Mental Health Partnership of Southeast Michigan (CMHPSM), created in 2002 as part of a state consolidation plan, is one of Michigan's ten Medicaid Prepaid Inpatient Health Plans (PIHPs). The CMHPSM is a collaborative effort between four counties and offers oversight of the management and integration of Medicaid mental health services and substance use treatment services for adults with intellectual/developmental disabilities, adults with serious mental illness, and children with serious emotional disturbances residing in Lenawee, Livingston, Monroe, and Washtenaw counties. Mental health services are delivered through the Community Mental Health Service Providers (CMHSPs) 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. Substance use treatment services are delivered through a system of credentialed providers throughout the region, including two CMHSP core providers (Livingston and Lenawee) and other contracted agencies and community partners.

CMHPSM works to ensure consistent implementation and management of services provided. Our primary goal is to provide meaningful outcomes for the individuals we serve. CMHPSM operates according to a strategic plan guided by our vision, mission, and values statements, and evaluates and reports progress quarterly to the CMHPSM Board. The current FY24-26 CMHPSM Strategic Plan Metrics/Milestones document is available to MDHHS upon request. Strategic plan goals relative to the QAPIP work plan are identified in Figure 2.

Our mission, vision, and values statements 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 for Quality Improvement

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

Guiding Principle #2: The Quality Assurance and Performance Improvement Program (QAPIP) helps to ensure that our organization, providers, and CMHSPs improve quality of care for individuals served.

Guiding Principle #3: The QAPIP incorporates feedback and contribution from employees, departments, providers, and individuals served. Individuals served give feedback in the QAPIP process via membership in regional committees, participation in surveys and focus groups, data related to appeals, grievances, and inquiries to Customer Service, and 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 (descriptive) and quantitative (measurable) 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 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 cultivates a culture that encourages employees to identify deficiencies in processes and areas of improvement.

II. Scope of Plan

Michigan Department of Health and Human Services (MDHHS) requires each PIHP to have a QAPIP plan that meets standards established in the PIHP contract with MDHHS; the Balanced Budget Act of 1997 (BBA), Public Law 105-33; and the 42 Code of Federal Regulations (CFR) §438.358. This plan is based on contract and regulatory requirements, the previous year's quality assessment and performance improvement projects, and the CMHPSM mission, vision, and values. Annually, CMHPSM completes a QAPIP Plan for the current fiscal year, based on required performance improvement projects and local initiatives. Some of these projects are required at the state and federal levels; other local initiatives address areas of access to care and quality of care for individuals served in the region. All of the projects encompass access, quality, and cost of service delivery. The Plan outlines the current relationships and structures that exist to promote this performance improvement. Improvement activities target operational efficiencies, service delivery, and clinical care.

The QAPIP plan documentation consists of several parts. The QAPIP Workplan designates the specific metrics, tasks, and goals of the QAPIP, including the specific dates required for reporting on progress. The narrative QAPIP Plan is an overall assessment of the projects identified in the QAPIP Workplan. The narrative 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 individuals served in the QAPIP; and
4. the mechanisms or procedures used for adopting and communicating desired improvements.

III. Definitions/Acronyms

Behavioral Health: a system of care and supports that serves individuals with a mental illness, intellectual developmental disability, and/or substance use disorder or children with a serious emotional disturbance.

Behavior Treatment Plan Review Committee (BTPRC): The BTPRC 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.

Critical Incident Reporting System (CIRS): a digital system for reporting events required to be monitored and reported to MDHHS and the process in which this is completed. The current critical incidents categories included are listed below under **Critical Incident.** MDHHS currently houses its CIRS under the Michigan Crisis and Action Line (MiCAL) Customer Relations Management (CRM) system.

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

Comprehensive Quality Strategy (CQS): 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 Michigan CQS provides a framework to accomplish its overarching goals of designing and implementing a coordinated and comprehensive system to proactively drive quality across Michigan Medicaid managed care programs.

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

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

Critical Incident: defined as the following events: suicide death; non-suicide death; arrest of consumer; emergency medical treatment due to injury or medication error; and emergency hospitalization due to injury or medication error. Subcategories include suicide deaths, natural cause deaths, and/or deaths of unknown causes; and hospitalization or emergency medical treatment that resulted from falls or 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 prefers to use the term "individual(s) served" wherever possible based on our philosophy of anti-stigmatizing language and inclusion.

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

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

Medicaid Abuse: provider practices that are inconsistent with sound fiscal, business, or medical practices and which result in an unnecessary cost to the Medicaid program, 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 themself or another person (see 42 CFR §455.2). This definition is not meant to limit the meaning of fraud as it is defined under applicable federal or state laws.

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

Michigan Mission Based Performance Indicator System (MMBPIS): the MMBPIS is a group of metrics that includes domains for access to care, adequacy and appropriateness of services provided, 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 or supportive services.

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

Prepaid Inpatient Health Plan (PIHP): a Medicaid 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 §401 et al June 14, 2002, regarding Medicaid managed care; Medicaid regulations, §438; MHC §330.120(4)(b).

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 (QA): 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 Continuous Quality Improvement (CQI) identified as focusing on *processes* as well as *outcomes*.

QAPI: Quality Assurance Performance Improvement

QAPIP: Quality Assessment and Performance Improvement Program. The QAPIP 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 CFR §438.358 of 2002.

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; and 3) interventions for performance improvement.

Research: 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. (45 CFR §46.102.) 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; 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.

Root Cause Analysis (RCA): also notated as an 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): 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 consumers/individuals served, family members, guardians, staff, community members, and advocates.

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

Substance Use Disorder (SUD) Providers: SUD providers directly contracted with CMHPSM to provide substance use treatment and prevention services. CMHPSM prefers to use the term Substance Use Services (SUS) wherever possible based on our policy of anti-stigmatizing language and inclusion.

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): an individual employed by the PIHP whose role is to listen, support, offer guidance, and help connect Veterans to services they need.

Vulnerable Person: An individual with a functional, mental, and/or 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 review and approval of a QAPIP evaluation that reports the effectiveness of the quality management program and recommends priorities for improvement initiatives for the next year.
- Periodic review of 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 for the previous year's QAPIP 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 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 CMHPSM CEO serves as a regional committee coach to support implementation and oversight of QAPIP projects. The CEO ensures coordination occurs among members of the Regional Operations Committee (ROC) to maintain quality and consumer safety. Additionally, the CEO is committed to the goals of the quality improvement plan and to creating an environment that is conducive to the success of quality improvement efforts, ensuring affiliation involvement, removing barriers to positive outcomes, and monitoring results of the quality improvement program across the PIHP. The CEO reports to the PIHP Board of Directors recommending policies and/or procedures for action and approval. The CEO is responsible for managing contractual relationships with the CMHSP partners and Substance Use Services Providers and for issuing formal communications to the CMHSP/SUS Providers regarding performance that does not meet contractual requirements or thresholds. Similarly, the CEO is responsible for assuring ongoing monitoring and compliance with its MDHHS contract including provision of quality improvement plans as required.

CMHPSM Leadership Staff

The CMHPSM Leadership Staff oversee the regional committees that implement the QAPIP and address specific issues in need of remediation. (See Attachment A.) The CMHPSM Chief Operating Officer (COO), on behalf of the Regional Clinical Performance Committee, ensures all steps of the review and approval process are completed before submission of the QAPIP Plan to MDHHS. The CMHPSM Substance Use Services Director oversees the collection and evaluation of substance-use-specific metrics and corrective actions contained in the QAPIP.

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

CMHPSM Quality Manager and CMHPSM Compliance Manager

The CMHPSM Quality Manager and Compliance Manager work collaboratively to develop, evaluate, and take action to make improvements in the QAPIP program. Both the Quality Manager and Compliance Manager report to the regional CMHPSM Clinical Performance Team

(CPT) Committee, with the Quality position focusing on QAPIP-related metrics and data analysis and the Compliance position focusing on QAPIP-related compliance and corrective actions. The Quality Manager is responsible for the development, review, evaluation, and reporting of the QAPIP Plan, in collaboration with the CPT Committee and CMHPSM leadership, and oversees progress with the QAPIP workplan/benchmarks in collaboration with regional committees and PIHP staff. The Compliance Manager oversees any corrective actions needed for compliance or audit activity related to QAPIP areas, ensures any changes in compliance related rules/regulations are incorporated in the QAPIP, ensures outcomes of federal and state PIHPs audits, and ensures correctness and accuracy of reporting to state and federal entities.

Regional Operations Committee (ROC)

The ROC is comprised of the CMHPSM Chief Executive Officer, the four CMHSP Executive Directors, and the CMHPSM Substance Use Services Director and operates under a shared governance structure. ROC reviews and approves the QAPIP Plan prior to regional Board review. In addition, the four 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 individuals served. CPT reviews the annual QAPIP Plan and may make revision suggestions. PIHP staff involved include the CMHPSM Chief Operations Officer, Quality Manager, Compliance Manager, Chief Information Officer, Health Data Analyst, and Regional Data Coordinator.

CPT Committee responsibilities include:

- systematically gathering information from various stakeholders,
- defining performance standards,
- evaluating performance and/or gaps,
- completing root cause analyses,
- competing priority ranking of barriers,
- developing interventions,
- implementing interventions,
- evaluating effectiveness of the interventions, and
- determining the capacity to support and sustain improved performance.

The CPT Committee develops the structures for performance improvement project implementation. This includes recommendations for any work that would be allocated to other regional committees or ad-hoc workgroups and the structure of reporting those projects back to the CPT Committee. These performance improvement projects are based on the population health needs of the community. To assess these needs, the CPT Committee analyzes data from

performance measures, clinical records, and state and local indicators of health. The Committee also collaborates with providers and members, utilizing a variety of means to analyze individuals' direct experience with services, such as surveys, service requests, service utilization data, grievances, appeals, and direct stakeholder feedback. The CPT Committee works closely with the Regional Electronic Operations (EOC) Committee to provide leadership and support for this data collection, analysis, and report writing; compliance needs; system enhancements/development; and training to support QAPIP projects.

In its monthly meetings, the CPT Committee reviews progress on PI projects and ensures clear and consistent communication of that progress and any needs to staff, individuals served, and stakeholders. Each CMHSP is responsible for the local functions in implementing the QAPIP, and CMHSP CPT Committee representatives are responsible for the following:

- communicating the progress of PI projects to their staff, local Boards, individuals served, contractual providers, and community stakeholders;
- communicating local compliance requirements in QAPIP implementation;
- collecting and providing feedback from local stakeholders to the CPT committee.

Communication efforts include making information about QAPIP projects directly available to individuals served, providers, and community stakeholders. These communication methods may include local websites, newsletters, internal communications boards, staff meetings, consumer advisory boards, and provider or community meetings.

B. Committee Structure

CMHPSM structure is based on the principle of shared governance: wherever possible, CMHPSM and CMHSPs will make collaborative decisions, and the CMHPSM will delegate functions to CMHSPs to meet local needs. We believe this structure increases administrative efficiency and improves the quality of services for the individuals we serve. This shared governance structure is embodied in our development and practice of regional committees that operate under the ROC; these committees oversee and monitor delegated and shared functions. Any functions that cannot be delegated per state and federal regulation, or that do not meet the goal of administrative efficiency and quality improvement, are maintained at the PIHP leadership staff level.

Regional committees are comprised of CMHSP provider staff, individuals 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 (CPT) or directly to the Regional Operations Committee (ROC).

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

- Regional Clinical Practice Team
    - Children's Administrators Workgroup, Intellectual/Developmental Disability/Cognitive Impairment (IDD/CI) Administrators Workgroup, Co-Occurring (MI and SUS) Services Administrators Workgroup, Regional Parity Workgroup; Behavior Treatment Committee (BTC) Workgroup

- Regional Consumer Advisory Committee
  - Local CMHSP Advisory Committees
- Regional Utilization Review/Utilization Management Committee
- Regional Electronic Information Management Operations (EOC) Committee
- Regional Customer Services Committee
- Regional Network Management Committee
- Regional Compliance Committee
- Regional Finance Committee

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

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

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

C. Provider Network Structure

The majority of CMHPSM operational network structure is implemented using various committees, work groups, and advisory groups.

Committees are responsible for providing recommendations and reviewing regional policies regarding related managed care operational decisions. Each committee develops and approves a formal charge and work plan that identifies the committee's:

- purpose;
- decision-making scope;
- specific goals supporting CMHPSM and QAPIP;
- monitoring, reporting, and communication plan;
- membership, roles, and responsibilities; and
- meeting frequency.

The Regional Operations Committee approves all committee charges. Each committee makes recommendations, which ROC evaluates and decides on based on a consensus or simple majority vote of the four CMHSPs representatives. The CMHPSM CEO retains authority for final decisions or for recommending action to the CMHPSM Board.

In relation to the QAPIP, these committees identify, receive, and respond on a regular basis to opportunities and recommendations for system improvements arising from QAPIP implementation, reporting on the progress of accomplishments and goals.

CMHSPs/SUS Provider staff have the opportunity to participate in and to support the QAPIP through organization-wide performance improvement initiatives. In general, the CMHSP/SUS 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.
- Providing representatives on organization-wide standing councils, committees, and work groups.
- Reporting clinical care errors, informing consumers of risks, and making suggestions to improve the safety of consumers.
- Maintaining communication between the Regional CPT Committee and the SUS provider network.

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

Regional Clinical Practice Team (CPT) Committee

CPT Committee members represent the needs of all individuals, local communities, and populations served to inform, advise, and work with the CMHPSM to bring local perspectives, local needs, and greater vision to regional clinical operations. Committee members ensure 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 CPT Committee also provides functions of the implementation and oversight of the QAPIP, as described in Section IV, B and C of this plan.

Each CMHSP CEO appoints one quality staff representative and one clinical staff representative to participate in the CPT committee. In collaboration with the Customer Services manager for their county, each CMHSP CEO also appoints primary consumer (an individual served) and/or secondary consumer (family/loved one of the individual served) representatives to the committee. CMHPSM Substance Use Services (SUS) Program staff members serve as representatives for SUS Treatment Providers.

The CPT Committee oversees population-specific workgroups comprised of PIHP lead staff and CMHSP clinical experts, which meet regularly to address population-specific trends, needs, and upcoming initiatives. Workgroup projects include those assigned by the CPT Committee. Members are appointed by their respective CMHSP/PIHP CEO. These workgroups report to the Regional CPT Committee:

- Children's Administrators Workgroup
- IDD/CI Administrators Workgroup
- Co-Occurring (MI and SUS) Services Administrators Workgroup
- Regional Parity Workgroup
- Behavior Treatment Committee Workgroup

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

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

Substance Use Disorder Services Oversight Policy Board (OPB)
Pursuant to §287(5) of Public Act 500 of 2012, CMHPSM established a Substance Use Disorder Services Oversight Policy Board (OPB) with membership appointed by each of the four counties served. The SUD-OPB is responsible for approving an annual budget inclusive of local funds for treatment and prevention of substance use. It also advises the CMHPSM Board on other areas of SUS strategic priority, local community needs, and performance improvement opportunities. The CMHPSM SUS Director and SUS Team are responsible for policy development and revisions approved by the SUD-OPB.

Regional Policies: The committee is responsible for the implementation of 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 Naloxone Overdose	SUD Media Campaigns SUD Outpatient Treatment and Recovery Continuum SUD Recipient Rights SUD Residential Room and Board SUD Residential Treatment Services SUD Sentinel Event Policy Welcoming Policy Women's Specialty Treatment Services

Regional Customer Services (CS) Committee
Each CMHSP CEO appoints the Customer Services manager to participate in the Customer Services Committee. In addition, the CEOs and Customer Services Managers may appoint primary and/or secondary representatives for individuals served. Committee members represent the needs of all individuals, local communities, and populations served. The CS Committee is

responsible for the oversight of Customer Services standards, including the regional Guide to Services and other informational materials for individuals 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 CS Committee develops and implements an annual survey and report of individuals' direct experiences with services/supports and develops PI projects from survey trends. The CS Committee ensures quarterly reporting of the QAPIP measures is provided to the Regional Consumer Advisory Committee, which serves as the primary source of consumer input to the CMHPSM.

This committee is supported by the PIHP Compliance Manager and Quality Manager, and the CMHPSM Chief Operating Officer serves as the PIHP Customer Service contact. The CS Committee reports to the Regional CPT Committee, including annual reports and recommendations based on the experiences of individuals served and satisfaction with services and supports.

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

Culturally and Linguistically Relevant Services
Customer Services
Notice of Privacy Practices

Regional Electronic Information Management Operations (EOC) Committee

The EOC Committee ensures, maintains, and develops core electronic medical record (EMR) software functions; optimizes and standardizes EMR processes whenever possible; and supports 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 CMHSP partners. Annually, the EOC Committee develops and implements a regional EOC Satisfaction Survey to obtain feedback from CMHSP partners. The CMHPSM Chief Information Officer (CIO) serves as chair of the committee, and each respective CMHSP CEO appoints CMHSP information technology staff to serve as representatives. CMHSP members ensure local implementation and local data integrity of EOC Committee oversight functions.

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

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

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

The UM/UR Committee ensures effective implementation of the CMHPSM's utilization functions and compliance with requirements related to service and eligibility decisions, conflict-free access and planning decisions, parity program oversight, and the appeals process. These functions are governed by CMHPSM policy, the MDHHS PIHP Contract, and related federal and state laws and regulations. CMHSP CEOs appoint UM/UR staff, internal appeals coordinators, and fair hearings officers of each CMHSP to serve on the committee. The CMHPSM Chief Operating Officer (COO) serves as chair, and PIHP staff who serve in UM/UR and Quality Improvement roles also serve as members.

Regional Policies: The committee is responsible for the implementation of 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 and Review

Regional Compliance Committee (RCC)

The RCC ensures compliance with requirements identified within CMHPSM policy development, procedures and compliance plan; the MDHHS PIHP Contract; and all related federal and state laws and regulations, including the Office of Inspector General guidelines and 42 CFR 438.608. The RCC contributes aspects of the QAPIP related to compliance with state and federal reporting, member rights, and corrective actions. CMHSP CEOs appoint local and regional rights officers and compliance managers to serve on the committee. The CMHPSM COO and Compliance Manager also serve on the committee.

Regional Policies: The committee is responsible for the implementation of 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
Conflict Free Case Management
Corporate Compliance Policy
Crisis/Safety Planning
Critical Incident, Sentinel Event, & Risk Event
Peer Review
Training

Regional Network Management Committee (NMC)

The NMC provides counsel and input to ROC with respect to regional policy development and strategic direction. Areas of input include:

- network development and procurement
- provider contract management (including oversight and monitoring)
- provider qualifications, credentialing, privileging and primary source verification of professional staff
- regular assessment of network capacity
- development of inter- and intra-regional reciprocity systems
- development of regional minimum training requirements for administrative, direct-operated, and contracted provider staff.

The NMC contributes to aspects of the QAPIP related to network adequacy and capacity; provider qualification, monitoring, and credentialing; training; and reciprocity standards. CMHSP CEOs appoint regional contracting, billing, procurement, and network management staff to serve on the committee. The CMHPSM CEO serves as coach to the committee, and the COO and Quality Manager also serve on the committee.

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

County of Financial Responsibility
Credentialing and Clinical Responsibilities for LIPs
Debarment, Suspension, and Exclusion
Employee Competency and Credentialing
Organizational Credentialing and Monitoring

Regional Consumer Advisory Council (RCAC)
The RCAC serves as the primary source of input by individuals served to the CMHPSM for the development and implementation of Medicaid specialty services and supports requirements in the region. QAPIP Plan documents, evaluations, and updates are shared with the RCAC for input on a regular basis. The RCAC is made up of and chaired by volunteer members who are primary or secondary individuals served from the region. Locally, each CMHSP has a local Consumer Advisory Committee that provides input and guidance to the CMHSP on various areas of the behavioral health system of care and individuals' experience with it.

D. Communication of Process and Outcomes

The CMHPSM staff and Regional Clinical Performance Team, in coordination with the CMHSPs and SUS Providers via regional committees and councils, is responsible for monitoring and reviewing performance measurement activities. This process includes identification and monitoring of opportunities for process and outcome improvements. After committee/council meetings, the status of key performance indicators, consumer/individual served satisfaction survey results, and PI projects are reported to individuals served and stakeholders through websites, newsletters, provider meetings, regional and local Consumer Advisory Councils, and town halls and focus groups.

Final performance and quality reports are available to the stakeholders and the general public on the CMHPSM website, and also by request. The Board of Directors receives quarterly updates 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 mandated and desired performance levels on performance indicators and analyze the causes of any statistical outliers. CMHPSM utilizes performance measurement to monitor system performance, identify opportunities for improvement and best practices, promote improved performance, and ensure compliance with PIHP contract requirements and state and federal processes and requirements.

Where state or federal regulations do not require specific performance measures, CMHPSM leadership chooses measures for improvement 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.
2) The previous year's performance on existing standards, audits, and community assessments.
3) The prevalence of a condition among, or need for a specific service by, the organization's individuals.
4) Demographic characteristics and health risks among the service area's individuals.
5) The interest of individuals in the aspect of service to be addressed.
6) The effect on a significant portion of individuals served with potentially significant effect on quality of care, services, or satisfaction.
7) The needs of the community, stakeholder feedback, efficient use of resources, and provision of person-centered and effective services.

In choosing performance measures, CMHPSM also incorporates the use of specific clinical and non-clinical performance measures (indicators). Indicators are indirect measures used to assess and improve quality and can reveal certain areas that require more attention. These are based on compliance with regulations, contract requirements, chosen projects, and external audits. These indicators are prioritized based on:

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

Indicator types that may be used to assess performance include:

- Process measures: What a provider does to maintain or improve quality of services, health, or outcomes for individuals served. These indicators reflect steps/activities in carrying out a service.

    - The percentage of persons served with a mental illness who receive a LOCUS assessment at least annually.
- Outcome measures: A reflection of the impact of behavioral health care services or intervention on the health status of individuals served.
    - The rate of Hospital Acquired Conditions.
- Balancing measures: Making sure problems do not result from improvement steps implemented in another part of the system.
    - The movement of the satisfaction score as systems are modified to increase access to care and reduce disparities with access: Does satisfaction also increase? Stay the same? Decrease? Are other issues inadvertently created?
- Structural measures: Fixed characteristics of an organization.
    - Whether an organization uses electronic health records; or
    - an organization's calculation of co-pays.

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.

B. Prioritizing Measures

Where state or federal regulations do not require specific performance measures, measures are assigned priority 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, including the previous year's performance on existing standards, audits, and community assessments.
2) The needs of the community, stakeholder feedback, efficient use of resources, and providing person-centered and effective services. This may include community assessments, and the prevalence of a condition among/ 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 individuals served with potentially significant effect on quality of care, services, or satisfaction.
4) Specific clinical and non-clinical performance indicators, based on compliance with regulations, contract requirements, chosen projects, and external audits. CMHPSM also chooses indicators based on Relevance, Measurability, Accuracy, and Feasibility, as above.

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 each 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
- consistent data collection techniques
- strategies to minimize interrater reliability concerns and maximize data validity.
- measure steward, or the person responsible for the measure

If a sampling method is used, the project/study description includes the population from which a sample is pulled and appropriate sampling techniques to achieve a statistically reliable confidence level. 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, which 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**)
4) Determine what modifications, if any, to make for the next cycle (**Act**).

** 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. Identify deficiencies (i.e., through audits, complaints, over-/under-utilization, clinical quality processes, administrative quality processes).
   - If the project is a CMHPSM choice (not determined by regulation), select an issue for a PI project based on criteria listed in Section A above.
   - 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 the identified deficiency. (**Plan**)
   - Conduct root cause analyses.
     - *Tools: Fishbone Diagram, 5 Whys, Key Driver Diagram*
   - Narrow down possible causes.
     - *Tools: Pareto chart and table*
   - Define the indicator and a data collection plan.
     - *Tool: Defining Indicator*
       - Includes numerator and denominator, exclusion criteria, standard and goal (if using a pre-existing standard, otherwise add in step 4).
     - *Tool: Indicator Collection and Monitoring Plan*
       - Data source, sample size, frequency of measurement, duration, display, person responsible.

3. Collect data on the quality indicator to establish a baseline. (**Plan**)
   - A baseline is a snapshot of performance that is typical over a period of time.
   - Use a historical baseline (preexisting indicator); or use a new baseline averaged over one year.

4. Set targets for improvement (aim/goal/standard). (**Plan**)
   - Use pre-existing targets set by regulation or contract (see step 2).
   - Use the **SMART** format to specify the targets: **S**pecific, **M**easurable, **A**cceptable, **R**ealistic to Achieve, **T**ime-bound with a deadline.

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

- *Tool: Project Planning Form*
    - Detail tasks to be performed, person(s) responsible for the tasks, timeline.

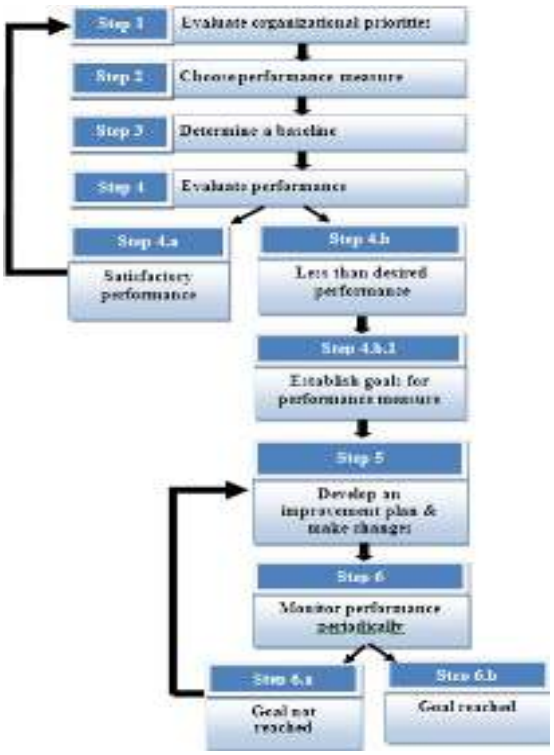
6. Implement change and gather new data at regular intervals to assess the success of intervention (**Do**)
    - Carry out the test.
    - Collect data and monitor performance periodically.
        - *Tool: Monitoring Interventions*

7. Analyze the results and compare them to baseline. (**Study**)
    - Complete appropriate statistical analyses.
        - *Tool: Run chart*
    - Interpret results and lessons learned.

8. Decide upon an action based on analyses. (**Act**)
    - Adopt: continue the process as it is with the same indicators/data monitoring OR test on a larger scale.
    - Adapt: modify the 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, 5 Whys, 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)
    - Abandon: do not do another test on the change idea/intervention.

9. Create a workplan for sustainability of the solution. **(Act)**
    - *Tool: Sustainability Planning*

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



VI. CMHPSM Measures of Performance

Please reference *CMHPSM QAPIP Figure 2. FY2024 Performance Measures* for specific FY2024 goals and measures discussed in this section (page 79).

A. Performance Measures

Michigan Mission Based Performance Indicators

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 PI Projects. Review and analysis of this data falls under Step 1 in the PIP guide/framework above (Section V of this plan). The requirements of this data are defined in the MDHHS-PIHP contract.

MDHHS, in compliance with federal mandates, has selected indicators to measure dimensions of quality, including access/timeliness for services, efficiency, and outcomes. MDHHS delegates the collection and reporting of performance indicators to the PIHP as defined in the Michigan Mission Based Performance Indicator System (MMBPIS).

Michigan Mission Based Performance Indicators
1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within 3 hours
2a: The percentage of new persons during the quarter receiving a completed bio-psycho-social assessment within 14 calendar days of a non-emergency request for service.

2b: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders.
3: Percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment.
4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days (child and adult).
4b: The percentage of discharges from an SUS detox unit during the quarter that were seen for follow-up care within 7 days.
10: The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.

Performance Measures

Project Description	**Indicator/Performance Measure**	**Goal/ Benchmark**	**FY2024 Outcomes (FY Averages)**	**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%	Child: **99.66%** Adult: **99.5%**	Goal met for all four quarters. Outcome met for FY2024.
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.	62%	Child SED: 51.18% Adult MI: 47.88% Child IDD: 53.22% Adult IDD: 51.71%	Not met for any quarter. Met for Q4 only. Outcome not met for FY2024.
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.	68.2%	SUD: 60.55%	Met for Q1 and Q3. Outcome not met for FY2024.
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.	74.5%	Child SED: 67.78% Adult MI: 62.25% Child IDD: **75.12%** Adult IDD: **76.82%**	Not met for any quarter. Met for Q2 and Q4; overall % met. Met for Q1 and Q4; overall % met.

				Outcome partially met for FY2024.
Hospital Discharges Follow-up-Psychiatric Inpatient	**4a.** The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days (child and adult).	95%	Child: 92.82% Adult: 92.08%	Met for Q3 only. Not met for any quarter. Outcome not met for FY2024.
Hospital Discharges Follow-up – SUD Detox	**4b.** The percentage of discharges from an SUD detox unit during the quarter that were seen for follow-up care within 7 days.	95%	SUD: **98.35%**	Goal met for all four quarters. Outcome met for FY2024.
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	Child: **12.14%** Adult: **10.82%** All (Ind. 5): **7.72%**	Met for Q2 and Q4; overall % met. Met for all four quarters. Outcome met for FY2024.

Indicator (num/pop)	Type	2024 Q1	2024 Q2	2024 Q3	2024 Q4	FY2024 Average
1Child	CMHSP	(144/145) 99.31%	(150/151) 99.34%	(145/145) 100.00%	(136/136) 100.00%	99.66%
1Adult	CMHSP	(642/643) 99.84%	(815/821) 99.03%	(696/699) 99.86%	(677/682) 99.27%	99.50%
2MIC	CMHSP	(134/307) 43.65%	(182/320) 56.88%	(123/285) 46.42%	(182/315) 57.78%	51.18%
2MIA	CMHSP	(402/810) 49.63%	(462/879) 51.42%	(430/985) 49.71%	(368/903) 40.75%	47.88%
2DDC	CMHSP	(60/123) 48.78%	(80/140) 57.14%	(57/124) 45.97%	(61/100) 61.00%	53.22%
2DDA	CMHSP	(24/53) 45.28%	(30/51) 58.82%	(19/47) 40.43%	(38/61) 62.30%	51.71%
2SUD	PIHP	(637/1037) 61.43%	(647/1106) 58.50%	(726/1143) 63.52%	(667/1135) 58.77%	60.55%
3MIC	CMHSP	(145/220) 65.91%	(156/234) 84.10%	(144/202) 71.29%	(155/222) 69.82%	67.78%
3MIA	CMHSP	(284/603) 52.49%	(316/498) 84.11%	(368/553) 66.55%	(355/536) 66.88%	62.25%
3DDC	CMHSP	(85/99) 85.86%	(86/109) 78.90%	(93/115) 72.17%	(87/90) 83.75%	75.12%
3DDA	CMHSP	(42/45) 93.33%	(14/25) 56.00%	(30/41) 73.17%	(39/46) 84.78%	78.82%
4Child	CMHSP	(37/42) 88.10%	(36/39) 92.31%	(34/35) 97.14%	(30/32) 93.75%	92.82%
4Adult	CMHSP	(180/193) 93.26%	(157/171) 91.81%	(188/202) 92.08%	(195/213) 91.55%	92.18%
4SUD	PIHP	(107/110) 97.27%	(95/97) 97.94%	(116/117) 99.15%	(105/108) 99.08%	98.35%
10Child	CMHSP	(9/50) 18.00%	(5/49) 10.20%	(7/46) 15.22%	(2/39) 5.13%	12.14%
10Adult	CMHSP	(25/276) 9.06%	(29/249) 11.65%	(27/302) 8.94%	(41/301) 13.62%	10.82%
5All	CMHSP	(65/808) 8.04%	(51/720) 7.08%	(54/686) 7.79%	(56/701) 7.99%	7.72%

Analysis of MMBPIS Outcomes

- Annual averages display indicators 1, 4b, 10, and 5 as **met** overall for FY2024. Indicator 3 was **partially met**, with both child and adult IDD populations meeting the threshold, and remaining groups falling below the benchmark for all quarters.
- Following the baseline measurements of FY2023, in FY2024 benchmarks were set for indicators 2 and 3, in addition to the standards previously set for indicator 4. For those

quarters in which these indicators were not met, in-depth review and a corrective action plan were initiated and reviewed by the CPT committee.
- Additional in-depth analysis of indicator 2a was conducted as this indicator is incorporated in the CMHPSM FY22-25 Performance Improvement Project (PIP) per state and federal requirements.

Trends (in order of significance/occurrence) related to Not Met/Partially Met indicators (2a, 2b, 4a; 3):

- Individual/guardian cancelling initial scheduled appointment or requesting a different appointment outside the timeframe.
- Individual not showing for scheduled appointment.
- Limited availability for appointments within the required timeframes due to staffing shortages/scheduling.
- Staff error in ensuring timeframe or in documenting reasons for not meeting the indicator.
- Ongoing challenges with billing changes related to telehealth screenings and meeting the needs of individuals served.

Primary interventions for improvements included:

- Increase in open/available appointment slots.
- Increase in staffing and employee retention efforts.
- Staff training and group supervision.
- Increase in more frequent internal audits.
- Offering same day appointments at intake.
- Transportation assistance
- Access to real-time data for more accurate internal auditing.

General outcomes of these interventions were mixed throughout the year, resulting in some quarters with improved percentages. Additional performance improvement efforts are ongoing and have been incorporated into the upcoming year's QAPIP plan.

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

MDHHS establishes specific performance indicators for PIHPs to improve specific behavioral health outcomes for people served across both mental health and substance use systems for each fiscal year. Meeting these measures includes a financial incentive benefit for the region. The PIHP's performance with these measures determines if a pay-for-performance incentive will be provided to the PIHP and the amount of that incentive. CMHPSM participated in the following PIHP performance measures for FY2024 per the MDHHS-PIHP contract:

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

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

Performance Measures

- Analyze and monitor BHTEDS records to improve housing and employment outcomes for persons served.
    - Measurement period will look back on FY2023 (prior) BHTEDS update/admissions record in comparison with the most recent (FY2024) record.
- Maintain overall BHTEDS completion rates to state 95% standard during FY2024.
    - Improve crisis encounter BHTEDs completion to 95% during FY2024.
- Complete and submit a narrative report to MDHHS detailing the BHTEDS process and analysis to improve housing and employment incomes for FY2023 and FY2024 data, including action steps.

Outcomes

- CMHSP completed monitoring and analysis of BHTEDS records throughout the fiscal year.
    - Data from the housing and employment narrative report has been reviewed with Regional EOC members and will be brought to the regional CPT meeting in January.
- In FY2024, CMHPSM maintained BHTEDS completion rates over 95% compliance for crisis and non-crisis encounters. All data fields also demonstrated a slight increase over FY2023's data, as noted in the most recent state-verified data:

MDHHS Report Data	Crisis BHTEDS	MH Encounters Non-Crisis BHTEDS	SUD Encounters with BHTEDS records
	98.80%	99.31%	99.93%

  Efforts over the course of FY24 to close open BHTEDS records have been successful. Starting in 02/06/2024 the CMHPSM had 4,351 records that needed a discharge record submitted. As of 1/08/2025 the state reported the region only had 61 records that still needed to be addressed.
- CMHPSM's CIO completed the narrative report and submitted it to MDHHS by the due date, receiving a passing grade.

Measure P.2. Adherence to antipsychotic medications for individuals with schizophrenia (SAA-AD): *Percentage of adults aged 18 and older with Schizophrenia or Schizoaffective Disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.*

CMHPSM will participate in state-planned and state-provided data validation activities and meetings and will submit data validation documentation as required by MDHHS. PIHPs will be provided SAA-AD data and validation template by January 31, and within 120 calendar days, return the data validation templated, completed, to DHHS.

Performance Measures

- Participate in state-planned/state-provided data validation activities and monitoring.

Outcomes

- CMHPSM Data Analyst and CIO participated in all data validation activities and monitoring during 2024.

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

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

Performance Measures

- Monitor data to decrease the disparity between the index population (White/Caucasian) and at least one other minority group in initiation of AOD Treatment (14 days).
- Monitor data to decrease the disparity between the index population (White/Caucasian) and at least one other minority group in engagement of AOD Treatment (34 days).

Outcomes

Based on the state CC360 database which has a significant lag time, with the most recent state data for FY2024 ending 6/30/2024:

- Initiation (IET14-TOT): 41.31%. There is no state threshold currently set for this metric.
    - All MHPs maintained percentages about 35% all quarters thus far.
- Engagement (IET34-TOT): 13.16%. There is no state threshold currently set for this metric.
    - All but one MHP in the region maintained percentages above 10% for all quarters thus far.

By Health Plan		IET14-TOT			IET34-TOT		
End date	Organization	denom	num	rate	denom	num	rate
6/30/24	CMHPSM Total	2583	1068	0.4135	2583	340	0.1316
3/31/24	CMHPSM Total	2738	1113	0.4065	2738	348	0.1271
12/31/23	CMHPSM Total	2903	1160	0.3996	2903	371	0.1278

- Disparities were noted between the index population (White/Caucasian) and Black/African American population in the most recent available state data (ending 6/30/2024). Disparity data did not change significantly over the comparison quarters. Quarter 4 data is still pending from the state.

Measure P.4. Increased participation in patient-centered medical homes *(PA 107 of 2013 §105(d)(18))*.

CMHPSM's goal was to increase participation in patient-centered medical homes. CMHPSM conducted an analysis of the prior fiscal year efforts, activities, and achievements of the CMHPSM regional contractors/regional partners towards this goal, including:

1) Comprehensive care
2) Patient-centered practices
3) Coordinated care
4) Accessible services
5) Quality and safety.

Performance Measures

- Participate in efforts and activities to increase participation in patient-centered medical homes, as noted above.
- Submit a narrative report to MDHHS regarding prior fiscal year efforts to increase participation in patient-centered medical homes.

Outcomes

- CMHPSM's COO completed the analysis and submitted the narrative report to MDHHS by the due date.

C. Shared Metrics Projects Between the CMHPSM, CMHSPs, and MHPs

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

Care Coordination for High Risk/High Utilization: *Implementation of Joint Care Management Processes Collaboration between entities for the ongoing coordination and integration of services.*

CMHPSM, the Mental Health Plans (MHP), and the CMHSPs met monthly to review consumers with high risk or high utilization of services to discuss interventions and supports to stabilize and better serve them in ways that reduce their risks. For FY2024 the CMHPSM and our partner MHPs goal was to include a process for identifying minors with appropriate severity/risk and providing care coordination of the population.

Performance Measures

- Monthly collaboration meeting completed between entities for the ongoing coordination and integration of services. (Goal:100%)

Outcomes

- CMHPSM continued to meet this metric at 100% through the monitoring of data reports in CC360 and attendance at monthly collaboration meetings.

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

1. FUH-AD: *The percentage of discharges for adults (18 years or older) who were hospitalized for treatment of selected mental illness and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days. The minimum performance standard for adults is 58%.*
2. FUH-C: *The percentage of discharges for children (ages 6-17 years) who were hospitalized for treatment of selected mental illness and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days. The minimum performance standard for children is 70%.*
3. Reduction of Racial Disparity: *CMHPSM will reduce the racial/ethnic disparity between the index population and at least one minority group for beneficiaries 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days.*

Performance Measures

- Maintain FUH-AD at or above the state benchmark of 58%.
- Maintain FUH-C at or above the state benchmark of 70%.
- Obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following a psychiatric hospitalization (adults and children). Disparities were calculated using the scoring methodology developed by MDHHS to detect statistically significant differences. The measurement period was calendar year 2023.

Outcomes

Based on the state CC360 database which has a significant lag time, with the most recent state data for FY2024 ending 6/30/2024:

- Adults (FUH-30AD): 64.65% - Exceeded benchmark of 58%.
    - All MHPs met the benchmark for adults for all quarters thus far.
- Children (FUH-30CH): 78.80% - Exceeded benchmark of 70%.
    - All but one MHP in the region met the benchmark for children for all quarters thus far.

The table below shows the data for the first three quarters (by end date) of FY2024. Cell colors in the *rate* column 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.

By Health Plan		FUH-30AD			FUH-30CH		
End date	Organization	denom	num	rate	denom	num	rate
6/30/24	**CMHPSM Total**	**1123**	**726**	**0.6465**	**217**	**171**	**0.7880**
3/31/24	**CMHPSM Total**	**1146**	**739**	**0.6449**	**225**	**187**	**0.8311**
12/31/23	**CMHPSM Total**	**1143**	**782**	**0.6842**	**233**	**195**	**0.8369**

- Disparities were noted between the index population (White/Caucasian) and Hispanic and African American/Black populations in the most recent state available data (ending

6/30/2024). Disparity data did not change significantly over the comparison quarters. Quarter 4 data from the state is still pending.

Follow up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence:

The percentage of beneficiaries aged 13 years and older with an Emergency Department (ED) visit for alcohol and other drug dependence that had a follow-up visit within 30 days.

Performance Measures

- Maintain FUA at or above the state benchmark of 27%.
- CMHPSM's goal was to reduce the racial/ethnic disparity between the index population and at least one minority group. The measurement period for addressing racial/ethnic disparities was a performance comparison of calendar year 2022 with calendar year 2023. Data was stratified by MDHHS by race/ethnicity and provided to PIHPs and MHPs.

Outcomes

Based on the state CC360 database which has a significant lag time, with the most recent state available data for FY2024 ending 6/30/2024:

- FUA: 37.86% - Exceeded benchmark of 27%.
    - All but 2 MHPs in the region met the benchmark for all quarters reported thus far.

By Health Plan		FUA-30		
End date	Organization	denom	num	rate
6/30/24	**CMHPSM Total**	**943**	**357**	**0.3786**
3/31/24	**CMHPSM Total**	**1024**	**367**	**0.3584**
12/31/23	**CMHPSM Total**	**1127**	**427**	**0.3789**

- Disparities were noted between the index population (White/Caucasian) and Black/African American population in the most recent state available data (ending 6/30/2024). Disparity data did not change significantly over the comparison quarters. Quarter 4 data is still pending.

D. Performance Improvement Projects (PIPs)

MDHHS requires CMHPSM to implement at least two PIPs each year. MDHHS chooses one project based on Michigan's Quality Improvement Council (QIC) recommendations. MDHHS contracts with an external quality review (EQR) organization to monitor and review this PIP. CMHPSM chooses the second PIP based on population needs and analyses of the previous year's performance indicators.

In FY22, MDHHS transitioned to two new PIP requirements for a FY22-25 PI cycle. Project 1 describes the project required by the state that includes oversight and auditing by the external quality review entity HSAG. For Project 2 the state description is less prescribed and not federally audited, and the PIHP was able to choose a project that addressed local needs. In reviewing PIP topics for the FY22-25 cycle, MDHHS and HSAG recommended that Project 2 focus on the reduction of racial and ethnic disparities in healthcare and health outcomes, and that

the PIHPs conduct a PIP identifying a measure or performance area where there is a disparity and focusing on efforts to eliminate those disparities. Where racial and ethnic disparities occurred, the PIP focus would need to include these disparities; where racial and ethnic disparities did not occur, PIHPs were 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, it was found that 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 individuals 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 populations of individuals identifying as White/Caucasian and Black/African American. Therefore, CMHPSM's goal was to 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 continues to be measured by HSAG.

2. ***Overall increase in performance in new individuals receiving a completed initial Biopsychosocial Assessment within 14 calendar days of a non-emergency request for service***

   This project aims to increase the percentage of new individuals during the quarter who receive a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service, for all populations. CMHPSM also focuses on MMBPIS Indicator 2 and the goal was to implement interventions to improve this overall rate while supporting PIP 1, above.

   <u>Performance Measures</u>
   - The racial disparities of no-shows for the initial Biopsychosocial Assessment (BPS) in individuals accessing CMH services will be reduced or eliminated.
   - 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.
   - Completion of PIP submission to HSAG by due date.
   - Passing score of HSAG PIP submission.
   - Implementation of interventions during FY2024, and measurement of outcomes.

   <u>Outcomes</u>
   - Overall, there was no statistically significant decrease in disparity in no-shows for the initial BPS. One county that had prior disparity no longer had statistically significant

disparity, yet the overall disparity in the region was not reduced significantly to meet this measure.

- PI Indicator 2 did not show statistically significant change overall:
  - Overall change from 54.3% to 49.3% (slight decrease)
  - Change in White/Caucasian (numerator) rate from 17.8% to 21.3% (increase)
  - Change in Black/African American (denominator) rate from 30.3% to 31.5% (slight increase)
  - Significant disparity between numerator and denominator was still noted.

		PI Indicator 2A			No Show Preventing 2A Compliance, White			No Show Preventing 2A Compliance, African Am.			disparity
Year ending	affiliate	denom	num	rate	denom	num	rate	denom	num	rate	
9/30/24	**All**	**5363**	**2642**	**49.3%**	**3407**	**727**	**21.3%**	**1217**	**383**	**31.5%**	*
9/30/23	**All**	**4921**	**2672**	**54.3%**	**3111**	**555**	**17.8%**	**1157**	**351**	**30.3%**	*

- The Performance Improvement Plan (PIP) submission was completed as required and submitted to HSAG by the due date.
- Due to the lack of increase in Indicator 2 (the metric for the second PI project), the region did not receive a passing score on the HSAG PIP submission. All other elements of the PIP submission were met.
- Interventions were implemented with mixed results. Barriers were noted to both implementation and effectiveness. The region's CPT committee is revising interventions for implementation in the following year's PIP projects.

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

Structure

The CPT Committee reviews and analyzes data related to critical events, sentinel events, and risk events reported by CMHSPs and SUS providers, including that which qualifies as "reportable events" according to the MDHHS Critical Event Reporting System. Critical and sentinel event reporting is required per the MDHHS-CMHPSM contract. CPT analyzes the event data for current trends and trends over time and appropriate use of root cause analyses – sentinel events and identified trends may require a root cause analysis and a CAP to prevent future occurrences. The Committee also monitors action plans and corrective action plans (CAP) related to events data, determines educational needs, and verifies compliance with policies and procedures. CMHPSM ensures that each CMHSP/SUS 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: https://www.cmhpsm.org/regional-policies

Regional Critical Incident, Sentinel Event, and Risk Event Policy
Regional Performance Improvement Policy

Reporting

Critical incidents. sentinel events, risk events, and unexpected deaths that occur in the region are reported to the state by CMHPSM within MDHHS required timeframes via the regional EHR incident and critical event reporting systems, with a direct feed to the state CRM. Reporting

includes those receiving mental health or substance use services who are in residential settings in CRCT. CMHPSM also reports SUD Sentinel Event data to MDHHS in accordance with Schedule E Reporting Requirements of the MDHHS-PIHP contract. Data on critical incidents is reported to MDHHS monthly. Residential treatment providers (both SUD and MH) prepare and file CIs reports.

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

CMHPSM delegates the responsibility of the review and follow-up of sentinel events, critical incidents, and other risk events that put people at risk of harm to the CMHSPs and SUD providers.

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

CMHSPs report suicide deaths, non-suicide deaths, arrests, emergency medical treatment and/or hospitalization for injuries and medication errors for required populations as defined by MDHHS. Additionally, subcategories reported for deaths include accidental/unexpected and homicide. Subcategories for emergency medical treatment and hospitalizations include those injuries from the use of physical management.

SUD Providers, including but not limited to residential providers, review and report deaths, injuries requiring emergency medical treatment and/or hospitalization, physical illness requiring hospitalization, serious behavioral issues, medication errors, and arrests and/or convictions as defined by MDHHS. Reporting includes analysis is used to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents.

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

and/or program/committee responsible for implementation and oversight, timelines, and strategies for measuring the effectiveness of the action.

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

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

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

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

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

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

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

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

Performance Measures

- The rate of critical incidents per 1000 persons served (excluding deaths) will demonstrate a decrease from previous year.
- The rate, per 1000 persons served, of Non-Suicide Death (Natural Cause, Accidental, Homicidal) will demonstrate a decrease from previous year.
- Ensure compliance with timely and accurate reporting of critical and sentinel events (100%).
    - 100% CEs reporting.
    - 100% timely reporting.
- Quarterly report and analysis of:
    - type,
    - trends over time (including mortality),
    - events per 1,000 members served,
    - regional trends over time for the fiscal year,
    - analysis of trends by service, engagement in treatment, precipitating events.
    - Analysis of CE trends for potential PI projects.
- The rate, per 1000 persons served, of Sentinel Events will demonstrate a decrease from the previous year.
- Individuals involved in the review of sentinel events must have the appropriate credentials to review the scope of care.
    - 100% reported to PIHP and state,
    - 100% timeframes met,
    - 3-day review of critical events (CEs) that are sentinel events (SEs),
    - 100% RCA completion.

Outcomes

- Critical Incidents per 1000 served increased from 4.7 in FY2023 to 4.9 in FY2024.
- The rate of Non-Suicide Deaths per 1000 served decreased from 2.8 in FY2023 to 2.4 in FY2024.
- The region's timeliness and accuracy reporting fell just under the 100% goal.
    - 96% of Critical Incidents were reported timely.
        - One county had essential staff turnover that resulted in incidents being reported untimely.
    - 94% of Critical Incidents were reported successfully from the region's EHR to the MDHHS Customer Relations Management (CRM) database.
        - 100% of Critical Incidents were reported successfully into the region's EHR. Intermittent issues with data transfer into MDHHS's updated CRM/MiCAL system resulted in some timely submissions being returned for re-submission.

- Quarterly data reports were made to CPT involving the numbers, types, trends over time, reporting and documentation completion, demographics, possible precipitating events/factors, LTSS, and population information.
- Sentinel Events per 1000 served increased slightly from 0.03 in FY2023 to 0.04 in FY2024.
- Sentinel Events were reviewed at the CMHSP level and results reported to the PIHP in compliance with state and federal guidelines and CMHPSM policies and procedures.

Recommendations

Based on performance measured in FY2024, there are no additional recommendations for the following year. CMHPSM will continue to comply with state regulations and updates to policies and procedures regarding critical incident reporting.

F. Behavioral Treatment Review

Structure

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

Regional Policy: https://www.cmhpsm.org/regional-policies

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 (with no medical diagnosis 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 to 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 or others

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.

Performance Measures
- Consistent quarterly reporting of BTC data (100%)
- Consistent data analysis of BTC data (100%)
- The percentage of individuals who have an approved Behavior Treatment Plan which includes restrictive and intrusive techniques.

Outcomes
- Data was aggregated and reported to the CPT committee for all quarters (100%). As there is currently no way to report this data automatically or via the EHR, a workgroup made up of the BTRPC Chairs for each county and CMHPSM Operations staff created a uniform procedure and updated template/process for manually reporting the required data to the PIHP.
- Data analysis was conducted each quarter, assessing trends in numbers, types of interventions, documentation, progress towards goals, demographics, population types, and incorporation of LTSS (100%).
- Due to the new data reporting procedure and influx of data, FY2024 served as a baseline year for establishing the percentage of individuals with restrictive or intrusive interventions with an approved Behavior Treatment plan. Over the course of FY2024, this included 245 individuals, averaging around 21 cases per 1000 members served.

Recommendations

- The current process for reporting is manual and therefore has limitations to efficacy, accuracy, and aggregation. In the following year, CMHPSM will work to develop methods for more automated data collection for this dataset.

G. Clinical Practice Guidelines

Structure

The CPT Committee ensures the review and updates of clinical practice guidelines (CPGs). The CMHPSM monitors adherence to the CPGs via annual review of CMHSP and SUS providers and delegates monitoring to the CMHSPs for any relevant sub-contractual provider service provision.

Regional Policy: https://www.cmhpsm.org/regional-policies

Clinical Practice Guidelines Policy

Reporting

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

Monitoring/Review

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

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

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

Performance Measures

- CPGs reviewed at least bi-annually.
- CPGs published to both provider network and members.

Outcomes

- CPGs were reviewed and approved by the Regional CPT Committee and by ROC by the required timeframes throughout the year.
- CPGs were published on the websites of CMHPSM and the ability to access them was communicated and distributed to providers and persons served.

H. Utilization Management

Structure

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

All CMHSPs and applicable regional providers are required to follow federal and state mental health parity requirements, which include use of the following assessments to determine level of care needs for persons served:

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

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

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

The committee continuously monitors and improves the utilization review process, identifies, and corrects over- and under- utilization and ensures appropriate and cost-efficient utilization of

services. The committee reviews and analyzes aggregated case record data to ensure medical necessity and appropriateness of care, including persons served with special health care needs and those with long-term supports and services.

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

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

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

The UM/UR Committee's FY24 review of the region's compliance with the parity program included the use of the LOCUS assessment, therefore monitoring of fidelity to the LOCUS was incorporated into the parity program analysis and the previous LOCUS project was discontinued for FY2024.

The CMHPSM includes CMHPSM UM/service decisions in its annual monitoring of CMHSPs and reports these findings to relevant regional committees and the CMHPSM Board as part of the QAPIP Evaluation.

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

For FY24 the committee reviewed both an overutilization and underutilization project.

- The overutilization project reviewed inpatient recidivism as potential overutilization of a higher level of care.
- The underutilization project assessed HSW members not receiving monthly services that qualify them for HSW enrollment as potential underutilization, including potential risks of maintaining HSW enrollment with the ending of public health emergency and subsequent enrollment exceptions.

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

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

The committee included 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 recommended and developed training needs for staff making or reviewing service decisions.

Performance Measures

- Accuracy and timeliness of service decisions and Adverse Benefit Determinations (ABDs):
    - Correct timeframes used for advance action notice. (Target 100%)
    - Accurate use of reduction, suspension, or termination decisions. (Target 100%)
    - ABDs provide service denial reasons in language understandable to person served.
    - Analyze type of denial, accuracy of service and denial decision explanation, and compliance with timeframes.
- Assess overutilization of services: Review of inpatient recidivism as potential overutilization of higher level of care, using following factors:
    - Persons receiving LTSS, and/or on c waiver,
    - Services/status, type, and service utilization before first admission,
    - Type or change in the services/IPOS after the first and/or second admission,
    - Engagement obstacles,
    - If hospitalization known or managed by CMH,
    - Compliance with MMBPIS Indicator 4a.
- Underutilization project: Assess HSW members not receiving monthly services that qualify them for HSW enrollment as potential underutilization, including potential risks of maintaining HSW enrollment with the ending of public health emergency and subsequent enrollment exceptions. Including following factors:
    - Utilization of monthly habilitative services,
    - Authorized services vs utilized services,
    - Service delays and proper ABD notice where applicable,
    - Person given choice of provider and HSW services.
- Evidence of use of parity program for those with established LOC in CMHPSM reviews of CMHSPs clinical records for all populations (Standard 90%).
    - A parity LOC is completed for each person served, including the accurate population.

- The relevant and appropriate level of care assessment is completed for each person served prior to authorizations being completed.
    - If the exception process is used, the reason for the exception is documented and reviewed at the supervisory level.
- Consistent regional service benefit is achieved as demonstrated by the percent of outliers (exceptions) to level of care benefit packages (Standard <=5%).
    - Measurement period is FY23.
- Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines. (Target 100%).
    - Implement an inner rater reliability with the MCG Indicia parity system for psychiatric inpatient, crisis residential, and partial hospitalization service decisions.
    - Baseline measurement period is Q1 of FY24.

Outcomes:

- Accuracy and timeliness of service decisions and Adverse Benefit Determinations (ABDs) (100%)
    - Met for advance action notices meeting timeframes
    - Not Met for accurate use of reduction, suspension, or termination decisions
    - Not Met for ABDs provide service denial reasons in language understandable to person served
- Assess overutilization of services: Review of inpatient recidivism as potential overutilization of higher level of care
    - Met for ensuring data included LTSS and waiver populations, whole of FY24
    - Not Met in meeting Indicator 4a of MMBPIS, and in conducting all aspects of analysis; those cases known to/admitted to CMH before the admission or after the admission had rates of compliance closer to the target. Data was affected by low denominator values.
- Underutilization project: Assess HSW members not receiving monthly services that qualify them for HSW enrollment as potential underutilization.
    - Partially Met for data that identified Utilization of monthly habilitative services and Authorized services vs utilized services
    - Not Met for assessing service delays, proper use of ABD decisions, and person given choice of providers. The data reports used did not fully support the analysis, and data was inconclusive. While data showed a consistent average of those not receiving authorized services at 3% or less, the causes were not evident.
- Evidence of use of parity program for those with established LOC in CMHPSM reviews of CMHSPs clinical records for all populations (Standard 90%).
    - Met for SED population; not met for I/DD Adult, I/DD Youth, MI/SMI Adult. Three of the four CMHs met their goal; the fourth CMH shows continued improvement.
- If the exception process is used, the reason for the exception is documented and reviewed at the supervisory level.
- Consistent regional service benefit is achieved as demonstrated by the percent of outliers (exceptions) to level of care benefit packages (Standard <=5%).

    - Met, exceptions remained at 5% or less and reasons for exceptions were documented
- Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines. (Target 100%).
    - Partially Met: Three of the four CMHs were able to complete the first round of MCG Inner Rater Reliability project.

Recommendations

- Accuracy and timeliness of service decisions and Adverse Benefit Determinations (ABDs): For FY25 auditing of ABDs will occur more frequently, with more reviews including the content of narrative. CMHSPs will provide actions plans for correcting ongoing errors. The regional training will be revised to support the needed changes in ABD practices.
- Assess overutilization of services: Review of inpatient recidivism as potential overutilization of higher level of care. For FY25 the committee will more closely assess potential causes, and review ways to collaborate this data analysis with regional CPT Committee. FY25 will also include a review of whether this project will continue or need to be revised with the state quality transformation plan in FY26.
- Underutilization project: Assess HSW members not receiving monthly services that qualify them for HSW enrollment as potential underutilization. For FY25 a sample size of cases will be reviewed for each CMH to establish any further trends, and the committee will pursue if additional reports can be used to further clarify reasons. A PowerBI reported was drafted in FY24 for potential analysis improvements in FY25, and the PIHP Waiver Coordinator will be consulted to improve collaborative analysis and identification of trends.
- Evidence of use of parity program for those with established LOC in CMHPSM reviews of CMHSPs clinical records for all populations (Standard 90%).
- Develop action plan with the CMH needing to complete MCG IRRs in FY25. For LOC analysis sample size of cases for each CMH will be reviewed monthly to establish any further trends and ways to improve performance.

I. Vulnerable Individuals

CMHPSM assures the health and welfare of the region's person served by establishing standards of care for individuals served. CMHPSM defines vulnerable people as individuals who have functional limitations and/or chronic illnesses. Each CMHSP/SUD Provider shall have processes for addressing and monitoring the health, safety and welfare of all individuals served.

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

CMHPSM assesses the quality and appropriateness of care furnished by monitoring of population health through data analytics software to identify adverse utilization patterns and to reduce health disparities, and by conducting individual clinical chart reviews during program specific reviews to ensure assessed needs are addressed and in the individual's plan of service

using practices that adhere to person centered and self-determination principles, and during transitions between care settings.

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

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

Performance Measures

- Conduct data analysis of completion and accuracy of HCBS and 1915i assessment and documentation in the clinical record.
- Reach 90% compliance with clinical documentation of those persons qualified for HCBS/1915i identified in the EHR.
- Ensure 100% of 1915i recipients are enrolled in MDHHS Waiver Services Application (WSA).

Outcomes

- Throughout FY2024, data analysis on 1915i and HCBS documentation within the clinical record was conducted by the CMHPSM Waiver Coordinator and Data Analyst, and reported monthly to CMHSPs to improve accuracy within the clinical record.
- This data analysis and reporting was used to create improvements to the clinical documentation process for 1915i recipients in the region's EHR. Improvement was steadily noted throughout the year and culminated in 93.5% compliance by the end of FY2024, exceeding the set benchmark.
- The data analysis and reporting was also used to create improvements to the MDHHS WSA enrollment process. As with the EHR documentation, improvement was steadily noted throughout the year. By the end of FY2024, 88.4% of eligible recipients were enrolled in the WSA, which did not meet the benchmark.

Recommendations

- CMHPSM Waiver Coordinator will meet quarterly with regional leads to reach 100% compliance with enrollment during FY2025.
- Additional monthly data monitoring is recommended to ensure ongoing compliance with documentation requirements. Suggested methods include random sample monitoring monthly and continual use of monthly data reports.

J. Long-Term Services and Supports (LTSS)

LTSS is defined as individuals with functional limitations and/or chronic illnesses that affect their goals of being a participant in their community in ways meaningful to them, and the

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

LTSS is defined by CMHPSM as persons receiving the following services:

LONG TERM SERVICES & SUPPORTS 1115 Pathway to Integration Waiver (michigan.gov)	**CPT/HCPCS** FY25 MDHHS Behavioral Health Code Charts and Provider Qualifications
Respite	H0045 (Out-of-Home Setting) S5150 (Unskilled caregiver, "family friend") S5151 (In-Home Setting) T1005 (15 minutes)
Community Living Supports	H2015 (Unlicensed Setting) H2016 (Licensed Residential Setting)
Private Duty Nursing	S9123 (Registered Nurse, Hour) S9124 (Licensed Practical Nurse, Hour) T1000 (RN or LPN, 15 minutes)
Supported Integrated Employment	H2023
Out of Home Non Vocational Rehab	H2014
Goods & Services	T5999
Environmental Modification	S5165
Supports & Service Coordination	T1017
Enhanced Pharmacy	T1999
Personal Emergency Response (PERS)	S5160 (Installation and testing) S5161 (Service fee, per month, excludes installation and testing)
Community Transition Services	T2038
Enhanced Medical Equipment & Supplies (including vehicle modification)	E1399 (Durable Medical Equipment) S5199 (Personal Care Items) T2028 T2029 T2039 (Vehicle Mod)
Family Training	G0177 (Family Education Groups) S5110 (Family Psycho-Education Skills Workshop) S5111 (Home care training; family) T1015 (Family Psycho-Education, Joining)
Non-Family Training	S5116
Specialty Therapies (Music, Art, Massage, etc)	G0176 (Music, Art, Recreation Therapy) 97124 (Massage) 97530 (Therapeutic Activities)
Children Therapeutic Foster Care	S5140 (age 11 and older) S5145
Therapeutic Overnight Camping	T2036
Transitional Services	T2038

Fiscal Intermediary	T2025
Prevocational Services	T2015

CMHPSM LTSS Defined in Data Reporting

LTSS	whether consumer is identified to be in Long Term Services is satisfied if in the last three months, either: * They were authorized for one of the listed CPT codes below * They had a service with at least one of the listed CPT codes below * The were on the HAB CHILD, 1915i or SEDW waiver, according to the MEF or CRCT insurance tables. CPT CODES: 'S5150', 'S5150', 'S5151', 'T1005', 'H2015', 'H2016', 'S9123', 'S9124', 'T1000', 'H2023', 'H2014 ', 'T5999', 'S5165 ', 'T1999', 'S5160', 'S5161', 'T2038 ', 'E1399', 'S5199', 'T2028', 'T2029', 'T2039', 'G0177', 'S5110', 'S5111' (Adults only), 'T1015', 'S5116', 'G0176', '97124', '97530', 'S5140', 'S5145', 'T2036', 'T2038', 'T2025'

CMHPSM ensures that LTSS are consistently provided in a manner that considers the health, safety, and welfare of individuals served, 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 by monitoring 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. This monitoring ensures assessed needs are addressed and documented in the individual's plan of service and during transitions between care settings. CMHPSM monitors compliance with federal and state regulations annually through site review verification activities and/or other appropriate oversight and compliance enforcement strategies as necessary. CMHSP organizations and SUS Providers that are unable to demonstrate acceptable performance may be subject to additional PIHP oversight and intervention.

Performance Measures

- CMHPSM incorporates the identification of persons using LTSS in data analysis, including QAPIP projects where applicable and possible, such as critical incidents, sentinel events, risk events, behavior treatment monitoring, 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.

Outcomes

- FY2024 established baseline data in many of these categories for comparison to future data. CMHPSM will continue to monitor and aggregate this data for analysis of quality of care for individuals in the LTSS population.

K. Member Experience with Services

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

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

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

Regional Customer Services: Consumer Satisfaction Survey

CMHPSM conducts periodic quantitative (surveys) and qualitative (focus groups) assessments of consumer experiences (including those receiving long-term supports). These assessments are representative of the individuals served and services and supports offered. A random sample of individuals 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.

For FY2024, the Regional Customer Service Committee (CS) collected and analyzed the data to address issues of quality, availability, and accessibility of care. Analysis included:

- All activities to assess member experience with services, such as all member satisfaction surveys, focus groups, member interviews, feedback from the Consumer Advisory Councils, 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, revisions will be made to the mechanisms for assessing member experience, such as identifying new member satisfaction surveys or developing new satisfaction questions; revise sampling methodology; and initiate new activities to assess satisfaction.
- Activities and findings specific to members receiving LTSS or home- and community-based services (HCBS).
- National Core Indicators (NCI) survey results. While not specific to PIHPs, the committee will assess the results to identify and investigate regional/local areas of dissatisfaction and implement interventions for improvement.

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

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

For FY2024 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 85% 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 Customer Services staff to call you?*

Performance Measures

- Percentage of children and/or families indicating satisfaction with mental health services. (Standard 85%/)
- Percentage of adults indicating satisfaction with mental health services. (Standard 85%)
- Percentage of individuals indicating satisfaction with long-term supports and services. (Standard 85%)
- Create a plan for improvement in areas that fell below the 85% threshold:
    - *My phone calls are returned by the next day*: 83.4
    - *If I have a concern or a problem I know how to contact Customer Services to file a complaint*: 76.5

Outcomes

- Overall, the survey received 389 responses, with an overall satisfaction rate calculated at 96.8%, above the 85% threshold.
- Areas that previously fell below the 85% threshold both showed improvement over FY2023 survey data and met the 85% threshold in FY2024:
    - *My phone calls are returned by the next day* increased to 94.3%.
    - *If I have a concern or a problem, I know how to contact Customer Services to file a complaint* increased to 88.9%.
- All survey questions received a score of 88% or higher.

Recommendations

- 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.
- Continue to seek feedback from the RCAC on the development of the revised survey for FY2024 and potential ways to provide education to individuals served.
- Include a specific question at the beginning of the survey to allow complete aggregation of data by age.

Recovery Self-Assessment (RSA)

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

For this fiscal year CMHPSM continued to distribute the Recovery Self-Assessment-Revised survey (RSA-R) (O'Conell, Tondora, Croog, Evans, & Davidson, 2005) to the contracted providers in its four-county region that use the Recovery Oriented System of Care (ROSC) model. "A ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with a risk of alcohol and drug problems" (SAMHSA, 2010). The survey was distributed to Lenawee, Livingston, Monroe, and Washtenaw counties. The CMHPSM seeks to accurately assess and measure the effectiveness of Substance Use Disorder (SUD) and Community Mental Health

(CMH) providers in the implementation of recovery focused services from the perspective of clients, provider staff, and administrative staff. FY2024 data was analyzed to include year-to-year comparisons and long-term trends from at least the last five years. Survey questions were updated by the SUD Team and CMHPSM Data Analyst for increased accuracy, using a 3-point Likert Scale instead of the previous 5-point scale (1 = Disagree; 2 = I am neutral; 3 = Agree; N/A = Not Applicable; D/K = Don't Know) and include a comment box.

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

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

Performance Measures

- Percentage of consumers indicating satisfaction with substance use services. (Standard 85% OR 2.5 Likert score)

Outcomes

A total of 238 individuals participated in this analysis. Some individuals skipped answering some questions which accounts for the lower total amounts represented below:

Participant	Total	Lenawee	Livingston	Monroe	Washtenaw	Out of Region
Clients	112	17	38	20	37	
Provider Staff	126	8	55	16	44	3

Responses were aggregated by clients/staff, county, and domain area.

The survey noted that there were no responses from individuals provided SUD services through one county due to possible survey fatigue. CMHPSM staff also noted that the number of participants dropped significantly from FY2023 to FY2024 (from over 500 to just over 200 respondents).

- All survey areas averaged above the 2.5 Likert score threshold. The lowest average score was 2.59 (Diversity of Treatment Options – one county); the highest were 3.00 (Goals – two counties).

Recommendations

- Each county will develop a county-specific plan to address their local report responses. This may include additional analysis into decreased response rates to develop interventions to increase response rates for future surveys.
- As MDHHS no longer requires use of the RSA, the CMHPSM will continue to look for an updated validated survey tool for use in future survey years.

Grievance Process

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.

Performance 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%)
- An improvement from FY2023 in the percentage of grievance cases that meet documentation requirements in the EHR.

Outcomes

- All grievances were completed and documented within compliance of state and federal timelines, surpassing the 90-day standard (100%).
- An internal audit process was created to review grievances quarterly for compliance with EHR documentation standards, and additional training was completed on the documentation process. Grievance documentation has increased in compliance with documentation standards. This will be evaluated further in FY2025 HSAG monitoring.

Recommendations

- Based on FY2024 baseline data, the region will establish documentation compliance standards for improvement over FY2025. This will be evaluated further in the FY2025 HSAG Monitoring and reported quarterly throughout the year.

Appeals Process

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.

Performance 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%)
- An improvement from FY2023 in the percentage of appeals cases that meet documentation requirements in the EHR.

Outcomes

- All local appeals were completed and documented within compliance of state and federal timelines (100%).
- An internal audit process was created to review appeals cases quarterly for compliance with EHR documentation standards, and additional training was completed on the documentation process. Appeals documentation has increased in compliance with documentation standards. This will be evaluated further in FY2025 HSAG monitoring.

Recommendations

- Based on FY2024 baseline data, the region will establish documentation compliance standards for improvement over FY2025. This will be evaluated further in the FY2025 HSAG Monitoring and reported quarterly throughout the year.

VII. Provider Standards

A. Provider Qualifications

Structure

CMHPSM has established written policies and procedures, in accordance with MDHHS's Credentialing and Recredentialing Processes, for ensuring appropriate credentialing and recredentialing of the provider network. Whether directly implemented, delegated, or contracted, CMHPSM ensures that credentialing activities occur upon employment/contract initiation and minimally every two years thereafter. CMHPSM also ensures via written policies and procedures 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.

The tasks of credentialing/recredentialing, privileging, primary source verification, and qualification of organizational providers are largely delegated to CMHSPs/SUS Provider staff and their contractors. CMHPSM monitors CMHSP and SUS 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. Any 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, education, and cultural competence. The CMHSPs/SUS Providers are responsible for the selection, orientation, training and evaluation of the performance and competence 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 (NMC)

The NMC 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. NMC is involved in the development of an annual Network Adequacy Plan and oversees capacity and performance

Regional Licensed Independent Professional (LIP) Committee
The CMHPSM conducts credentialing and recredentialing reviews of LIPs for the region through review by the CMHPSM Regional LIP Committee.

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

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

conducts a network adequacy plan in conjunction with the regional Network Management Committee that assesses at minimum:

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

Performance Measures

- Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements.
- Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements.
- Complete assessment of FY24 CMHPSM audits of CMHSP delegated functions and SUD services, and development performance improvement projects where indicated based on findings and resultant CAPs.
- CMHPSM will demonstrate an increase in applicable providers within the network that are "in compliance" with the HCBS rule (MDHHS HCBS CAP Guidance form).

Outcomes

- Licensed provider compliance review was conducted through auditing of providers via the following:
  - Medicaid Services Verification: 100% of cases reviewed showed evidence of licensed providers in compliance with staff qualifications.
  - Monitoring of CMHSPs: A FY2024 Q1 review was conducted for comparison of the FY2023 baseline to identify improvements and/or further corrective action.
  - Auditing of Providers: Credentialing/recredentialing resulted in no findings that prevented approval of credentialing/recredentialing applications.
  - State Reporting: Credentialing and recredentialing data is reviewed and reported to the state twice a year. FY2024 findings did not result in any substantial changes or provider corrections.
- Non-licensed provider compliance review conducted through auditing of providers via the following:

- Medicaid Services Verification: 100% of cases reviewed showed evidence of licensed providers in compliance with staff qualifications.
- Monitoring of CMHSPs: A FY2024 Q1 review was conducted for comparison of the FY2023 baseline to identify improvements and/or further corrective action.
- Auditing of Providers: Credentialing/recredentialing resulted in no findings that prevented approval of credentialing/recredentialing applications.
- State Reporting: Credentialing and recredentialing data is reviewed and reported to the state twice a year. FY2024 findings did not result in any substantial changes or provider corrections; see Provider Credentialing section below.

- The Network Adequacy plan and additional reporting requested by MDHHS was completed and submitted by the state due date.
- There continues to be a trend of HCBS providers having insufficient staffing capacity related to the COVID pandemic and prior provider stability challenges reported to MDHHS. Provider capacity issues are most prominent in services related to community living supports (CLS), specialized residential homes, and skill-building/vocational services. However, 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.

Recommendations

- Continue to work towards provider stability in HCBS-related services through policy.
- Complete ongoing auditing and monitoring of CMHSPs and SUD providers.
- CMHPSM will incorporate any relevant MDHHS Site review findings in data analysis and process improvements.

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 FY23 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.

Performance Measures

- Credentialing and re-credentialing of organizational providers meet all state/federal requirements and timelines.
- Credentialing and re-credentialing of LIP providers meet all state/federal requirements and timelines.

Outcomes

In FY2024, the region conducted credentialing activities for 627 individuals and 65 organizations.

Individual Credentialing		
Reporting Period	**Number Initially Credentialed**	**Number Recredentialed**

Q1-Q2	40	249
Q3-Q4	44	294
Total	84	543

Organizational Credentialing		
Reporting Period	**Number Initially Credentialed**	**Number Recredentialed**
Q1-Q2	5	25
Q3-Q4	9	26
Total	14	51

98.6% of individual and organizational providers were recredentialed within required timeframes. All credentialing activities were reported to MDHHS within the required timelines.

- For organizations:
  - 97% of organizations were credentialed or recredentialed within 90 days.
  - 88% of organizations were recredentialed within 2 years. Several organizations requested additional time to obtain the documents required in the credentialing process and were granted extensions by the PIHP.
- For individuals:
  - 99.8% of individuals were credentialed or recredentialed within 90 days.
  - 99.6% of individuals were recredentialed within 2 years.

Recommendations

- Increase random sample monitoring of credentialing and recredentialing records to assess for improvements based on FY2024 baseline data.
- Conduct more frequent outcome reporting of CMHSP auditing sub-contractual providers based on these measures.

C. Incorporate any related findings from the FY2024 MDHHS Site Review into monitoring and oversight of measures in FY2025. Verification of Services

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

Medicaid Services Event Verification for Medicaid and Healthy Michigan Plan includes testing of data elements from the individual claims/encounters to ensure:

- the proper code is used for billing;
- the code is approved under the contract;
- the eligibility of the beneficiary on the date of service;

- that the service provided is part of the beneficiaries individualized plan of service (and provided in the authorized amount, scope and duration);
- the service date and time;
- services were provided by a qualified individual and fall 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 Healthcare Common Procedure Coding System (HCPCS) guidelines.

Data collected through the Medicaid Services Event Verification process is aggregated, analyzed, and reported for review at 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: https://www.cmhpsm.org/regional-policies

Service Verification Policy Services Suited to Condition Policy

Performance Measures

- CMHPSM will complete Medicaid Event verification reviews and submit the required annual report in accordance with CMHPSM and MDHHS policy and procedure.

Outcomes

- CMHPSM completed all required Medicaid Event/Service verification activities and submitted the required annual report in accordance with state and CMHPSM policy and procedure.

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, and 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: https://www.cmhpsm.org/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 full and meaningful access and participation in services for individuals served.
- Ensuring that cultural and language needs are discussed with individuals served initially and as needed, at least annually.
- Authorizing or making recommendations for specialty services for speech, language, hearing, and cultural service needs.
- Evaluating effectiveness of a referral and the individual's satisfaction with the services.
- Incorporating cultural competence in the 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 individuals served to identify and request the need for interpretive services and/or 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.

Performance Measures and Outcomes

- No specific performance measures were set for this area in the FY2024 QAPIP. The CMHPSM regional training platform maintains data on trainings completed annually. Cultural competence training is included in the monitoring tools related to provider performance and credentialing/recredentialing. There were no findings in provider auditing during FY2024 that resulted in provider performance issues or contractual sanctions related to cultural competence.

E. Provider Monitoring

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

SUD Providers must first obtain written authorization from CMHPSM in order to subcontract any portion of their agreement with CMHPSM. These subcontracts shall require compliance with all standards contained in the BBA, the Medicaid Provider Manual, and the Master Contract between the PIHP and the MDHHS. Each CMHSP/SUD Provider is required to document annual monitoring of each provider subcontractor as required by the BBA and MDHHS. The monitoring structure shall include provisions for requiring corrective action or imposing sanctions, up to and including contract termination if the contractor's performance is inadequate. CMHPSM continually works to assure that the CMHSPs support reciprocity by developing regionally standardized contracts, provider performance protocols, maintain common policies, and evaluate common outcomes to avoid duplication of efforts and reduce the burden on shared contractors.

CMHPSM monitors compliance with federal and state regulations annually through a process that includes any combination of desk review, site review verification activities, and/or other appropriate oversight and compliance enforcement strategies. CMHSPs/SUD Providers that are unable to demonstrate acceptable performance may be required to provide corrective action, may be subject to additional PIHP oversight and interventions, and may be subject to sanctions imposed by CMHPSM, up to and including contract termination.

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

The CMHPSM monitoring CMHSP Access systems for both CMH and SUD access services for FY24 incorporated any barriers related to the findings of the previous years monitoring and the FY22-25 PIP.

Performance Measures

- CMHPSM SUD providers will meet ASAM continuum completion rates (Target 75%)
- CMHPSM SUD providers will improve meeting priority population timelines (Target 75%)
    - FY2023 comparison: Screening requirement met 85.1%; Admission requirement not met 45.8%
- CMHPSM SUD providers will show a decrease in open SUD wrapper admissions without service and an increase in closed cases. (30%)
- Monthly data reviews and quarterly data analysis reporting. (Target 95%)

Outcomes

- ASAM continuum completion rates fell just shy of the threshold at 72%.
- Priority population timelines include both a target for screening and for admission, both set at 75%.
    - Screening: 85.5% (threshold met; overall slight increase over the previous FY)
    - Admission: 48.6% (threshold not met; overall slight increase over the previous FY)
- Expired SUD wrappers remained below 30% for all four quarters of FY2024, with a maximum of 26% noted in quarters 2 and 4.
- The CMHPSM SUD Treatment team performed monthly data reviews via a new dashboard set up for FY2024. Quarterly data analysis was reported to the CPT committee.

Recommendations

- The CMHPSM SUS Treatment Team will continue to monitor priority population timelines and create interventions or CAPS as needed to increase compliance.
- Following data analysis, additional metrics will be added to measure expired service wrappers and case closure outcomes.

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.

Performance Measures

- Score of Met for all applicable EQR Medicaid Managed Care standards reviewed by HSAG for FY2023.

Outcomes

- CMHPSM received an overall compliance score of 85%, for the FY2024 EQR Review, successfully completing 72 out of 85 applicable elements.
- A total of 13 elements were marked Not Met, necessitating creation of a CAP for the FY2025 QAPIP:
    - Standard I – Member Rights/Member information: 3
        - Content updates to the Member Handbook to match the state template
        - Updating member-facing materials to be in 12-point font
        - Use of taglines in the provider directory printout
    - Standard III – Availability of Services: 3
        - Ensuring non-urgent callbacks occur within one business day
        - Monitoring timeframe compliance for walk-in requests for service
        - Monitoring of Access telephone answering rates
    - Standard IV – Assurances of Adequate Capacity and Services: 0
    - Standard V – Coordination and Continuity of Care: 1
        - Person-centered plans must reflect the individual's strengths and preferences
    - Standard VI – Coverage and Authorization of Services: 6
        - Ensuring that Adverse Benefit Determinations (ABDs) meet content requirements and are written at or below 6.9 grade level
        - Ensuring timely provision of authorization decisions (14 days for standard requests for service)
        - Ensuring timely and appropriate provision of expedited authorization decisions (72 hours)
        - Ensuring timely and appropriate use of authorization decision extensions (up to 14 days)

- Ensuring timely and accurate giving of oral and written notice for service authorization decisions
- Ensuring denial notices are issued timely when service decisions are not reached within the designated time frames

Recommendations

- CMHPSM will submit a CAP for all Not Met items by the required deadline (1/29/2025), detailing the plans for improvement in each area.

CMHPSM will implement the approved CAP to make relevant corrections regarding the Not Met standards listed above.

VIII. Resources

CENTERS FOR MEDICARE AND MEDICAID SERVICES, Quality Measurement and Quality Improvement.
https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/mms/quality-measure-and-quality-improvement-

CENTERS FOR MEDICARE AND MEDICAID SERVICES, QAPI Process Tool Framework.
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapitools.

HEALTH SERVICES ADVISORY GROUP, Quality Assurance and Performance Improvement
https://www.hsag.com/QAPI

MDHHS PIHP CONTRACT, SCHEDULE A- STATEMENT OF WORK CONTRACT ACTIVITIES, Quality Improvement and Program Development (current FY25).

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

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

MDHHS REPORTING REQUIREMENTS.
https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting

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

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

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

The QAPIP priorities guided quality efforts for FY24. Figure 1 provides the QAPIP Priorities and Quality Work Plan for FY24. The FY24 QAPIP Workplan includes completion of required elements of the QAPIP, growth areas based on external site reviews, and the review of effectiveness. QAPIP activities are aligned with the MDHHS 2023-2026 Continuous Quality Strategy Goals (https://www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/reports) and CMHPSM Strategic Plan Metrics and Milestones that support CMHPSM Mission, Vision, and Values contributing to for the individuals we serve. Figure 2 provides the FY24 QAPIP Performance Measures.

FY2024 Workplan Priority Outcomes:	Green- Met Outcome	White – Partially Met Outcome.	Orange – Outcome Not Met.	Grey – No benchmark or establishing baseline.

A. Figure 1. FY2024 QAPIP Priorities and Work Plan

Governance	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**FY2024 Outcomes**
CMHPSM Board of Directors will approve the QAPIP Plan and Report	Submit the annual QAPIP Plan to the Board. Submit the annual QAPIP Evaluation to the Board	CMHPSM COO	12/14/23 02/08/24	Met
Board of Directors review QAPIP Progress Reports	Submit QAPIP progress reports to the Board.	CMHPSM COO	Quarterly	Met
CMHPSM QAPIP will be submitted to Michigan Department of Health and Human Services	Submit the Board approved QAPIP Plan, Report (Evaluation), and Governing Body Form to MDHHS (via MDHHS FTP Site)	CMHPSM Compliance/Quality Manager	2/28/24	Met
Communication of Process and Outcome Improvements	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**FY2024 Outcomes**
The QAPIP Plan and Report will be provided annually to network providers and to members upon request.	Post to the CMHPSM website. Ensure CMHSP contractors receive the QAPIP. Provide QAPIP Plan and Evaluation reporting at CMHPSM provider meetings. Communications to providers on the availability of QAPIP reports on the CMHPSM website. Communications to regional committees. Ensure Regional Customer Services Committee includes members' ability to request QAPIP documents in informational materials	CMHPSM Compliance/Quality Manager CMHPSM Network Management Committee Regional Customer Services Committee	03/03/2024	Met

Consumers & Stakeholders receive reports on key performance indicators, consumer satisfaction survey results and performance improvement projects	Present reports on QAPIP activities and performance measures to RCAC on Consumer Services reports on persons experience, satisfaction survey results, grievances, appeals, PIPs, MMBPIS, event data, quality policies/procedures and Customer Service Reports to RCAC. Incorporate RCAC feedback in interventions and recommendations related to survey data and QAPIP activities.	CMHPSM Compliance/Quality Manager Regional Customer Services Committee	Quarterly Annually Annually	Met Met
Performance Measurement and Quality reports are made available to stakeholders and general public.	Post to the CMHPSM website. Ensure CMHSP contractors receive the QAPIP and inform communities of its availability on the website.	CMHPSM COO Regional NMC Committee	Annually	Met
MDHHS Performance Indicators	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**FY2024 Outcomes**
CMHPSM will meet or exceed the MMBPIS standards for Indicators 1, 4, 10 as required by MDHHS.	Complete quality checks on data prior to submission to ensure validity and reliability of data.	CMHSPs CPT leads	Quarterly	Met
	Verify Medicaid eligibility prior to MMBPIS submission. Submit MMBPIS data to MDHHS quarterly by due date.	CMHPSM Regional Data Coordinator CMHPSM CIO	Quarterly	Met Met
	Conduct quarterly analysis of CMHSP and CMHPSM provider MMBPIS performance. Require and review corrective action plans where standards were not met. Oversee effectiveness of corrective action plans through monthly review of subsequent data.	Regional CPT Committee CMHPSM Compliance/Quality Manager	Monthly QAPIP data review Quarterly CAP review Q1 Feb Q2 May Q3 August Q4 November	Met
CMHPSM will demonstrate an increase in compliance with access standards.	Monitor access requirements for priority populations, delineated by each priority population type. Establish a mechanism to monitor access requirements for persons enrolled in health homes (OHH, BHH, CCBHC).	Regional CPT Committee CMHPSM Compliance/Quality Manager CMHPSM SUD Services Director	Monthly QAPIP data review Quarterly CAP review Q1 Feb Q2 May Q3 August Q4 November	Met Met

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

CMHPSM will engage in two performance improvement projects for the FY22-25 PIP cycle: 1. Reducing Racial Disparities Specific to No-Shows for the Initial Biopsychosocial Assessment (BPS) in Individuals Accessing CMH services. 2. Overall increase in performance in new persons receiving a completed bio-psycho-social initial assessment within 14 calendar days of a non-emergency request for service.	Implement CMHPS specific interventions identified in causal barrier analysis in FY24. Conduct monthly trends and quarterly analysis of performance with PIP indicators. Determine casual barriers and factors where disparity was not reduced. Require and review corrective action plans and interventions where standards were not met. Oversee effectiveness of corrective action plans through monthly review of subsequent data.	Regional CPT Committee Regional EOC Committee CMHPSM Compliance/Quality Manager CMHPSM CIO CMHPSM Health Data Analyst	Monthly Quarterly	Met Met
	Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations). Review with relevant committees/councils.	Regional CPT Committee CMHPSM Compliance/Quality Manager	Monthly data review Quarterly reporting to Regional CPT RCAC, and CMHPSM Board	Met
	Complete and submit PIP 1 to HSAG as required for validation.	CMHPSM Compliance/Quality Manager	June/July 2024	Met
	Complete and submit PIP 1 to MDHHS as required.	CMHPSM Compliance/Quality Manager	2/28/2024	Met
Quantitative and Qualitative Assessment of Member Experiences	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**FY2024 Outcomes**
CMHPSM will obtain a qualitative and quantitative assessment of member experiences for all representative populations, including members receiving LTSS, and take specific action as needed, identifying sources of dissatisfaction, outlining systematic action steps and interventions, evaluating for	Develop surveys for all populations. Incorporate identification of persons receiving LTSS in survey data	Regional Customer Services Committee CMHPSM SUD Services Director	03/31/2024	Met
	Incorporate the analysis of Michigan specific National Core Indicator Data to identify trends and areas for improvement.	Regional Customer Services Committee CMHPSM Compliance/Quality Manager	09/30/2024	Met

effectiveness to improve satisfaction, communicating results.	Complete annual assessment of the member experience report to include the trends, causal sources of dissatisfaction, and interventions in collaboration with relevant committees/councils. Report the results of the member satisfaction survey to RCAC and CMHPSM Board for input and feedback on planned interventions.	Regional Customer Services Committee CMHPSM SUD Services Director	09/30/2024	Partially met Partially met
	Conduct analysis of a potential new SUD community survey tool to replace the RSA. Continue RSA for FY24 if new survey undetermined.	CMHPSM SUD Services Director	04/30/2024	Met
CMHPSM will meet or exceed the standard for Grievance resolution in accordance with federal and state standards.	CMHPSM will conduct quarterly monitoring of compliance with data collection/documentation that meets state and federal grievance standards, providing retraining and interventions, as needed.	CMHPSM COO CMHPSM Compliance/Quality Manager Regional Customer Services Committee	12/31/2024 Monthly Quarterly Q1 February Q2 May Q3 August Q4 November	Met
Event Monitoring and Reporting	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**FY2024 Outcomes**
CMHPSM will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths) are collected, monitored, reported, and followed up on as specified in the PIHP Contract.	Submit Critical Events monthly timely and accurately. Conduct analysis of Behavior Treatment Committee data quarterly.	CMHSPs CMHPSM Compliance /Quality Manager CMHPSM COO	Monthly Quarterly Q1 February Q2 May Q3 August Q4 November	Partially met Met
	Submit CMH Sentinel Events (MDHHS CRM) immediate notification) to CMHPSM based on notification requirements of the event. (24 hour, 48 hours, 5 days)	CMHSPs SUD Providers	As Needed	Met
	Submit SUD Sentinel events bi-annually as required	CMHPSM SUD Providers (Residential, Recovery Housing)	April 2023 October 2023	Met
	Conduct oversight through SE data review and provider monitoring to ensure appropriate follow up is occurring for all events dependent on the type and	CMHPSM Compliance/Quality Manager	Quarterly Q1 February Q2 May	Met

	severity of the event, including a root cause analysis, mortality review, immediate notification to MDHHS as applicable, and meeting required timeframes. Conduct primary source verification of critical incidents and sentinel events.	CMHPSM COO Regional CPT Committee	Q3 August Q4 November	
CMHPSM will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths) are monitored and followed up on as specified in the PIHP Contract.	Conduct analysis on critical events to monitor compliance with reporting, trends, and opportunities for performance improvements.	CMHPSM Compliance/Quality Manager CMHPSM COO Regional CPT Committee	Quarterly Q1 February Q2 May Q3 August Q4 November	Met
Medicaid Services Verification	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**FY2024 Outcomes**
CMHPSM will meet or exceed a 95% rate of compliance of Medicaid delivered services in accordance with MDHHS requirements.	Complete Medicaid Event verification reviews in accordance with CMHPSM policy and procedure.	CMHPSM COO CMHPSM CFO	12/31/2024	Met
	Complete the MEV Annual Methodology Report identifying trends, patterns, strengths and opportunities for improvement.	CMHPSM COO	12/31/2024	Met
	Submit the Annual MEV Methodology Report to MDHHS as required	CMHPSM COO	12/31/2024	Met
Utilization Management Plan	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**FY2024 Outcomes**
CMHPSM will establish a Utilization Management Plan in accordance with the MDHHS requirements	Complete performance summary quarterly reviewing trends, patterns of under / over utilization, medical necessity criteria, and the process used to review and approve provision of medical services. Identify CMHSPs/SUDPs requiring improvement and present/provide to relevant committees/ councils.	Regional UM/UR Committee	Quarterly Q1 February Q2 May Q3 August Q4 November	Partially met
	Ensure utilization of parity screening tools and admission criteria. LOCUS, CAFAS, PECFAS DECA, MCG, ASAM.	Regional UM/UR Committee Regional CPT Committee	Quarterly (parity)	Met

	Complete analysis of parity program compliance with LOC and LOC exceptions.	Regional UM/UR Committee		Met
CMHPSM will demonstrate full compliance with timeframes of service authorization decisions in accordance with the MDHHS requirements.	Oversight of compliance with policy through primary source verification during CMHPSM reviews of ABD state data reports and reviews of delegated functions of CMHSPs.	Regional UM/UR Committee	Quarterly Q1 February Q2 May Q3 August Q4 November	Met
	Analysis of ABD data reports in meeting service decision timeframes.			Met
CMHPSM will meet or exceed the standard for compliance with the adverse benefit determination notices completed in accordance with the 42 CFR 438.404 Includes assurance that ABDs accurately provide service denial reasons in language understandable to person served, type of denial, accuracy of service and denial decision explanation, and compliance with timeframes	Revise ABD training for staff based on outcomes of state data reporting. Staff to complete training.	Regional UM/UR Committee	03/30/2024	Met
	Oversight of compliance with policy through primary source verification during CMHPSM reviews of ABD state data reports and reviews of delegated functions of CMHSPs.	Regional UM/UR Committee	Quarterly Q1 February Q2 May Q3 August Q4 November	Met
CMHPSM will meet or exceed the standard for Appeal resolution in accordance with federal and state standards.	CMHPSM will conduct quarterly monitoring of compliance with data collection/documentation that meets state and federal appeals standards, providing retraining and interventions, as needed.	CMHPSM COO CMHPSM Compliance/Quality Manager Regional UM/UR Committee	Quarterly	Met
Practice Guidelines	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**FY2024 Outcomes**
CMHPSM will adopt, develop, implement nationally accepted or mutually agreed upon (CMHPSM/ MDHHS) clinical practice guidelines/ standards, evidenced based practices,	Review of CPGs for any updates or revisions to CPGs being utilized in the region.	Regional CPT Committee	Bi-annually or as needed if new CPGs are adopted	Met
	Update CPG list, including providers that implement/offer CPGs.	CMHPSM COO	Bi-annually	Met

best practice, and promising practices relevant to the individual served.	Communicate available CPGs to provider networks	Regional NMC Committee	March 2024 December 2024	Met
CMHPSM will demonstrate full compliance with MDHHS required practice guidelines.	Oversight during CMHPSM reviews of managed care delegated functions to ensure providers adhere to practice guidelines as required.	CMHPSM COO CMHPSM Compliance/Quality Manager	Annually	Met
Oversight of Vulnerable Individuals and Long Term Supports and Services	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**FY2024 Outcomes**
CMHPSM will evaluate health, safety and welfare of persons served considered vulnerable and receiving LTSS order to determine opportunities for improving oversight of their care and their outcomes.	Ensure the identification of LTSS remains in all regional quality/health and safety data reporting including events data, behavior treatment data, survey data of persons experience, performance measures. Ensure LTSS populations served are incorporated in measures of provider monitoring, service authorization, and reviews of outcomes data.	CMHPSM COO CMHPSM Health Data Analyst Regional CPT Committee	Quarterly data review Q1 February Q2 May Q3 August Q4 November	Met
Assure accurate identification of persons served within HCBS, 1915i services, and LTSS.	Conduct data analysis of completion and accuracy of HCBS and 1915i assessment and documentation in the clinical record. 90% compliance with clinical documentation of those persons qualified for HCBS/1915i identified in the EHR. 100% of 1915i recipients enrolled in MDHHS WSA Maintain identification of LTSS in data analysis.	CMHPSM COO CMHPSM Health Data Analyst Regional CPT Committee	Report analysis Quarterly Q1 February Q2 May Q3 August Q4 November	Met Met Not Met
CMHPSM will assess the quality and appropriateness of care furnished to members (vulnerable people) receiving LTSS including an assessment of care between care settings, a comparison of services and supports received	Include analysis of regional committee performance reports (including barriers, improvement efforts, recommendations, and status of recommendations) for efforts to support community integration. Critical incidents, sentinel events, risk events, behavior treatment plans, member satisfaction results, practice guidelines, credentialing and recredentialing, verification of Medicaid services, over and underutilization, provider network monitoring	CMHPSM COO CMHPSM Compliance/Quality Manager Regional CPT Committee Regional CS Committee Regional NMC Committee	Quarterly Q1 February Q2 May Q3 August Q4 November	Met

Behavior Treatment	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	FY2024 Outcomes
CMHPSM will demonstrate an increase in compliance with Behavior Treatment data collection and analysis.	Submit data on Behavior Treatment Plans where intrusive and/or restrictive techniques have been approved by the behavior treatment committee and where emergency interventions have been used	CMHPSM BTC Chairs CMHPSM Compliance/Quality Manager	FY24 Quarterly February May August, November	Met
	Complete Behavior Treatment performance reports that analyze the use of emergency interventions, plans approved with restrictive and/or intrusive interventions, and adherence to the BTPR Standards (including barriers, improvement efforts, recommendations, and status of recommendations).	CMHPSM Compliance/Quality Manager Regional CPT Committee	FY24 Annual QAPIP Plan 2/28/24 FY24 QAPIP Evaluation 2/28/25 FY24 Quarterly February May August, November	Met
	CMHPSM will explore system abilities to report BTC data electronically more efficiently while maintaining security/privacy and reporting standards.	CMHPSM Compliance/Quality Manager Regional CPT Committee	FY24 Annual Report 2/28/23 FY24 quarterly February May August, November	Met
	CMHPSM will conduct quarterly analysis and reporting of BTC data to Regional CPT Committee for any corrective action measures to be taken, and incorporated into the CMHPSM QAPIP documents and reports	CMHSM COO CMHPSM Compliance/Quality Manager	FY24 Quarterly March May August, November	Met
Provider Monitoring	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**FY2024 Outcomes**
CMHPSM will be in compliance with PIHP Contract Requirements.	Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP. Coordinate quality improvement plan development,	Regional NMC Committee CMHPSM COO	Annual	Met

	incorporating goals and objectives for specific growth areas based on the site reviews, and submission of evidence for the follow up reviews.	CMHPSM SUD Services Director		
CMHPSM will demonstrate an increase in compliance with the External Quality Review (EQR) - Compliance Review	Implement corrective action plans for areas that were not in full compliance, and quality improvement plans for recommendations. See CAP for specific action steps. Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	CMHPSM COO CMHPSM Compliance/Quality Manager Regional Compliance Committee	Monthly Quarterly	Met
CMHPSM will demonstrate full compliance with the EQR - Performance Measure Validation Review	Implement quality improvement plans for recommendations provided by the external quality review team. Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	CMHPSM CIO CMHPSM COO CMHPSM Compliance/Quality Manager Regional CPT Committee Regional EOC Committee	9/30/2024	Met
CMHPSM will receive a score of "Met" for the EQR Performance Improvement Project Validation	Implement and comply with all PIP Validation submission requirements	CMHPSM CIO CMHPSM COO CMHPSM Compliance/Quality Manager Regional CPT Committee Regional EOC Committee	9/30/2024	Met
CMHPSM will demonstrate an increase in compliance with the MDHHS c waiver/1915 Reviews.	Monitor systematic remediation for effectiveness through delegated managed care reviews and performance monitoring through data.	CMHPSM COO CMHPSM Compliance/Quality Manager	09/30/24	Partially met
CMHPSM will demonstrate full compliance with the MDHHS Substance Use Disorder Protocols	Provide evidence to support SUD requirements	CMHPSM COO CMHPSM SUD Services Director	09/30/24	Met
CMHPSM will demonstrate assurances of adequate capacity and	Submit Network Adequacy Report to MDHHS	CMHPSM COO	02/28/24	Met

services for the region, in accordance with the MDHHS Network Adequacy standards.	Complete Network Adequacy Assessment including all required elements.	Regional NMC Committee	09/30/24	
Provider Qualifications	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**FY2024 Outcomes**
CMHPSM will ensure physicians, other healthcare providers, and non-licensed individuals are qualified to perform their jobs. CMHPSM will have credentialing policies/ procedures, in accordance with MDHHS Credentialing and Re-Credentialing Process, for ensuring that all providers rendering services to individuals are appropriately credentialed within the state and are qualified to perform their services. CMHPSM ensures all delegates performing credentialing functions comply with all initial (including provisional/temporary) credentialing requirements according to initial credentialing and re-credentialing monitoring tools for organizations and LIPs	CMHPSM will conduct quarterly monitoring of compliance with Organizational credentialing and re-credentialing requirements, providing retraining and procedures revisions as needed. Data reports of progress will be included in the QAPIP report to the Regional CPT Committee and the CMHPSM governance bodies. CMHPSM will conduct quarterly monitoring of compliance with LIP credentialing and re-credentialing requirements providing retraining and procedures revisions as needed. Data reports of progress will be included in the QAPIP report to the Regional CPT Committee and the CMHPSM governance bodies. Primary Source Verification and credentialing and recredentialing policy and procedure review will occur during CMHPSM reviews of CMHSP delegated functions and Medicaid Service Verification activities. CMHPSM will increase monitoring for providers scoring less than 90% on the file review and will be subject to additional review of credentialing and re-credentialing records. Review semi-annual credentialing and re-credentialing report to ensure credentialing within the appropriate timeframes.	CMHPSM COO Regional NMC Committee	Quarterly	Met
		CMHPSM COO Regional NMC Committee	Quarterly	Met
		CMHPSM COO Regional NMC Committee	Annually	Met
		CMHPSM COO Regional NMC Committee	Semi Annually May 2024 November 2024	Met

Clinical service providers are credentialed by the CMHSP prior to providing services and ongoing.	CMHPSM will conduct quarterly monthly monitoring of compliance with credentialing and re-credentialing requirements for directly hired CMHSP staff as delegated to the CMHSPs, providing retraining and procedures revisions as needed	CMHPSM COO Regional NMC Committee	Quarterly reporting	Partially met
Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements.	CMHPSM Oversight and monitoring during CMHSP and SUD Provider reviews of delegated functions.	CMHPSM COOCMHPSM SUD Services Director Regional NMC Committee	Annually	Met
Non-licensed providers will demonstrate an increase in compliance with staff qualifications and training requirements.	CMHPSM Oversight and monitoring during CMHSP and SUD Provider reviews of delegated functions.	CMHPSM COO CMHPSM SUD Services Director Regional NMC Committee	Annually	Met

B. Figure 2. FY24 Performance Measures

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

FY2024 Performance Measure Outcomes:	Green- Meeting or Exceeding State Benchmark	White – in-process or data is not yet available as of this status report.	Orange – Not currently meeting benchmark as of this status report.	Grey – No benchmark, or establishing baseline, or is a baseline year.

***Continuous Quality Strategy Goal(s)**	**Michigan Mission Based Performance Indicator System**	**Committee/ Council**	**FY2024 Performance**
1	CMHPSM will meet or exceed the standard for Indicator 1: Percentage of Children who receive a Prescreen within 3 hours of request (Standard is 95% or above)	Regional CPT Regional EOC	Met

1	CMHPSM will meet or exceed the standard for Indicator 1: Percentage of Adults who receive a Prescreen within 3 hours of request (Standard is 95% or above)	Regional CPT Regional EOC	Met
1	CMHPSM will meet or exceed the standard for Indicator 2.A: Percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (reported by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children.) Performance measured by total % of all populations (total numerator/denominator) **CMHPSM FY22 Baseline = 61.3% = 50TH – 75TH Percentile** **FY24 Performance Measure: reach or exceed the 75th Percentile (62%)** **MDHHS Indicator 2 Percentile %s** **50th = 57.0%** **75th = 62.0%**	Regional CPT Regional EOC	Not met
1	CMHPSM will meet or exceed the standard for Indicator 2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders. Performance measured by total % of all populations (total numerator/denominator) **CMHPSM FY22 Baseline = 60.8% = Below 50TH Percentile** **FY24 Performance Measure: reach or exceed the 50TH Percentile (68.2%)** **MDHHS Indicator 2e Percentile %s** **50th = 68.2%** **75th = 75.3%**	Regional CPT Regional EOC	Not met
1	CMHPSM will meet or exceed the standard for Indicator 3: Percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (reported by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children). Performance measured by total % of all populations (total numerator/denominator) **CMHPSM FY22 Baseline = 74.5% = 50TH – 75TH Percentile** **FY24 Performance Measure: reach or exceed the 75TH Percentile (83.8%)** **MDHHS Indicator 3 Percentiles %s** **50th = 72.9%** **75th = 83.8%**	Regional CPT Regional EOC	Partially met
1, 3	CMHPSM will meet or exceed the standard for Indicator 4a1: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (Standard is 95% or above) (Child)	Regional CPT Regional EOC	Not met
1, 3	CMHPSM will meet or exceed the standard for Indicator 4a2: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (Standard is 95% or above) (Adult)	Regional CPT Regional EOC	Not met

1, 3	CMHPSM will meet or exceed the standard for Indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (Standard is 95% or above)	Regional CPT Regional EOC	Met
1, 3	CMHPSM will meet or exceed the standard for Indicator 10: Re-admission to Psychiatric Unit within 30 Days (Standard is 15% or less) (Child)	Regional CPT Regional EOC	Met
1, 3	CMHPSM will meet or exceed the standard for Indicator 10: Re-admission to Psychiatric Unit within 30 Days (Standard is 15% or less) (Adult)	Regional CPT Regional EOC	Not met
1, 3	CMHPSM will demonstrate and increase in compliance with access standards for the SUD priority populations. (Compared to FY23 Data)	Regional CPT Regional EOC	Met
Continuous Quality Strategy Goal(s)	**BH TEDS Data**	**Committee**	**FY2024 Performance**
2, 3	Analyze and monitor BHTEDS records to improve housing and employment outcomes for persons served. Maintain overall BHTEDS completion rates to state 95% standard during FY2024. Improve crisis encounter BHTEDs completion to 95% during FY2024.	Regional EOC Regional CPT	Met Met
Continuous Quality Strategy Goal(s)	**Performance Improvement Projects**	**Committee**	**FY2024 Performance**
1, 2, 3, 4	PIP 1: The racial disparities of no-shows for the initial Biopsychosocial Assessment (BPS) in individuals accessing CMH services will be reduced or eliminated. (FY2022 Baseline)	Regional EOC Regional CPT	Not met
1, 2, 3, 4	PIP 2: Overall increase in performance in new persons receiving a completed bio-psycho-social initial assessment within 14 calendar days of a non-emergency request for service.	Regional EOC Regional CPT	Not met
Continuous Quality Strategy Goal(s)	**Assessment of Member Experiences**	**Committee**	**FY2024 Performance**
1, 2, 3	Percentage of children and/or families indicating satisfaction with mental health services. (Standard 85%/) Percentage of adults indicating satisfaction with mental health services. (Standard 85%) Percentage of individuals indicating satisfaction with long-term supports and services. (Standard 85%) Create plan for improvement in areas that fell below the 85% threshold: My phone calls are returned by the next day 83.4	Regional Customer Services Committee	Met Met Met Met

	If I have a concern or a problem I know how to contact Customer Services to file a compliant 76.5		
1, 2, 3	Percentage of consumers indicating satisfaction with substance use services. (Standard 85% OR 2.5 Likert score)	CMHPSM SUD Director Regional Co-Occurring Workgroup	Met
Continuous Quality Strategy Goal(s)	**Member Appeals and Grievance Performance Summary**	**Committee**	**FY2024 Performance**
1, 2, 3	The percentage (rate per 100) of Medicaid appeals which are resolved in compliance with state and federal timeliness and documentation standards including the written disposition letter (30 calendar days) of a standard request for appeal. (Standard 95%) An improvement from FY2023 in the percentage of appeals cases that meet documentation requirements in the EHR.	Regional UM/UR Committee Regional CPT Committee	Met Met
1, 2, 3	The percentage (rate per 100) of Medicaid grievances are resolved with a compliant written disposition sent to the consumer within 90 calendar days of the request for a grievance. (Standard 95%) An improvement from FY2023 in the percentage of grievance cases that meet documentation requirements in the EHR.	Regional CS Committee Regional CPT Committee	Met Met
Continuous Quality Strategy Goal(s)	**Adverse Event Monitoring and Reporting**	**Committee**	**FY2024 Performance**
	The rate of critical incidents per 1000 persons served will demonstrate a decrease from previous year. (CMHSP) (excluding deaths)	Regional CPT Committee Regional EOC Committee	Partially met
	The rate, per 1000 persons served, of Non-Suicide Death will demonstrate a decrease from previous year. (CMHSP)(Natural Cause, Accidental, Homicidal) Ensure compliance with timely and accurate reporting of critical and sentinel events (100%) 100% CEs reporting 100% timely reporting	Regional CPT Committee Regional EOC Committee	Met Partially met Met Partially met
	Quarterly report and analysis of type, trends over time (including mortality), events per 1,000, regional trends over time for the fiscal year, analysis of trends by service,	Regional CPT Committee	Met

	engagement in treatment, precipitating events. Analysis of CE trends for potential PI projects	Regional EOC Committee	
	The rate, per 1000 persons served, of Sentinel Events will demonstrate a decrease from the previous year.	Regional CPT Committee Regional EOC Committee	Not met
	Individuals involved in the review of sentinel events must have the appropriate credentials to review the scope of care. 100% reported to PIHP and state 100% timeframes met 3-day review of critical events (CEs) that are sentinel events (SEs) 100% RCA completion	Regional CPT Committee Regional EOC Committee	Met Met Met Met Met
Continuous Quality Strategy Goal(s)	**Joint Metrics**	**Committee**	**FY2024 Performance**
	Collaboration meeting completed between entities for the ongoing coordination and integration of services. (100%)	Regional EOC Committee Regional CPT Committee	Met
	The percentage of discharges for adults (18 years or older) who were hospitalized for treatment of selected mental illness and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days. FUH Report, Follow-Up After Hospitalization Mental Illness **Adult (Standard-58%)** Measurement period will be calendar year 2023.	Regional EOC Committee Regional CPT Committee	Met
	The percentage of discharges for children (ages 6-17 years) who were hospitalized for treatment of selected mental illness and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days. FUH Report, Follow-Up After Hospitalization Mental Illness **Child (Standard-70%)** Measurement period will be calendar year 2023.	Regional EOC Committee Regional CPT Committee	Met
	Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days Racial/ethnic group disparities will be reduced for beneficiaries six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an	Regional EOC Committee	Not met

	outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days. CMHPSM will reduce the racial/ethnic disparity between the index population and at least one minority group. (Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences) Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2022 with calendar year 2023.	Regional CPT Committee	
	Follow up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence: CMHPSM will reduce the disparity between the index population and at least one minority group. For beneficiaries 13 years and older with an Emergency Department (ED) visit for alcohol and other drug dependence that had a follow-up visit within 30 days. (Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences) Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2022 with calendar year 2023	Regional EOC Committee Regional CPT Committee	Not met
Continuous Quality Strategy Goal(s)	**PIHP Performance Based Incentive Payments**	**Committee**	**FY2024 Performance**
	Implement data driven outcomes measurement to address social determinants of health. Analyze and monitor BHTEDS records to improve housing and employment outcomes for persons served. Measurement period is prior fiscal year. Use most recent update or discharge BH-TEDS record during the measurement period, look back to most recent prior update or admission record. Submit completed report to state.	Regional EOC Committee Regional CPT Committee	Met
	Percentage of Adults Age 18 and Older with Schizophrenia or Schizoaffective Disorder who were Dispensed and Remained on an Antipsychotic Medication for at Least 80 Percent of their Treatment Period (SAA-AD): CMHPSM will participate in DHHS-planned and DHHS provided data validation activities and meetings and return completed data validation template to state 120 calendar days from January 31, 2024.	Regional EOC Committee Regional CPT Committee	Met
	CMHPSM will reduce the disparity between the index population and at least one minority group regarding the percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who initiate treatment within 14 calendar days of the diagnosis received: **(1. Initiation of AOD Treatment)**	Regional EOC Committee Regional CPT Committee	Not met

	Data will be stratified and provided by the State by race/ethnicity Measurement period will be a comparison of calendar year 2022 with Calendar year 2023.		
	CMHPSM reduce the disparity between the index population and at least one minority group regarding the percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment and who had two or more additional AOD services or Medication Assisted Treatment (MAT) within 34 calendar days of the initiation visit. **(2. Engagement of AOD Treatment)** Data will be stratified and provided by the State by race/ethnicity Measurement period will be a comparison of calendar year 2022 with Calendar year 2023.	Regional EOC Committee Regional CPT Committee	Not met
	CMHPSM will increase participation in patient-centered medical homes/health homes. (narrative report)	Regional CPT Committee	Met
Continuous Quality Strategy Goal(s)	**Priority Measures**	**Committee**	**FY2024 Performance**
	Clinical SUD		
	CMHPSM SUD providers will meet ASAM continuum completion rates (Target 75%) CMHPSM SUD providers will improve meeting priority population timelines (Target 75%) Screening requirement met 85.1% Admission requirement met 45.8% CMHPSM SUD provider will show a decrease in open SUD wrapper admissions without service and an increase in closed cases. (30%) Monthly data reviews and quarterly data analysis reporting. (Target 95%)	Regional CPT Committee	Met Met Met Met
Continuous Quality Strategy Goal(s)	**Utilization Management/LTSS**	**Committee**	**FY2024 Performance**
	Correct timeframes used for advance action notice (Target 100%) Accurate use of reduction, suspension, or termination decisions. (Target 100%) ABDs provide service denial reasons in language understandable to person served. Analyze type of denial, accuracy of service and denial decision explanation, and compliance with timeframes.	Regional UM/UR Committee	Q4 Pending, last Q3 review Met Not Met Met

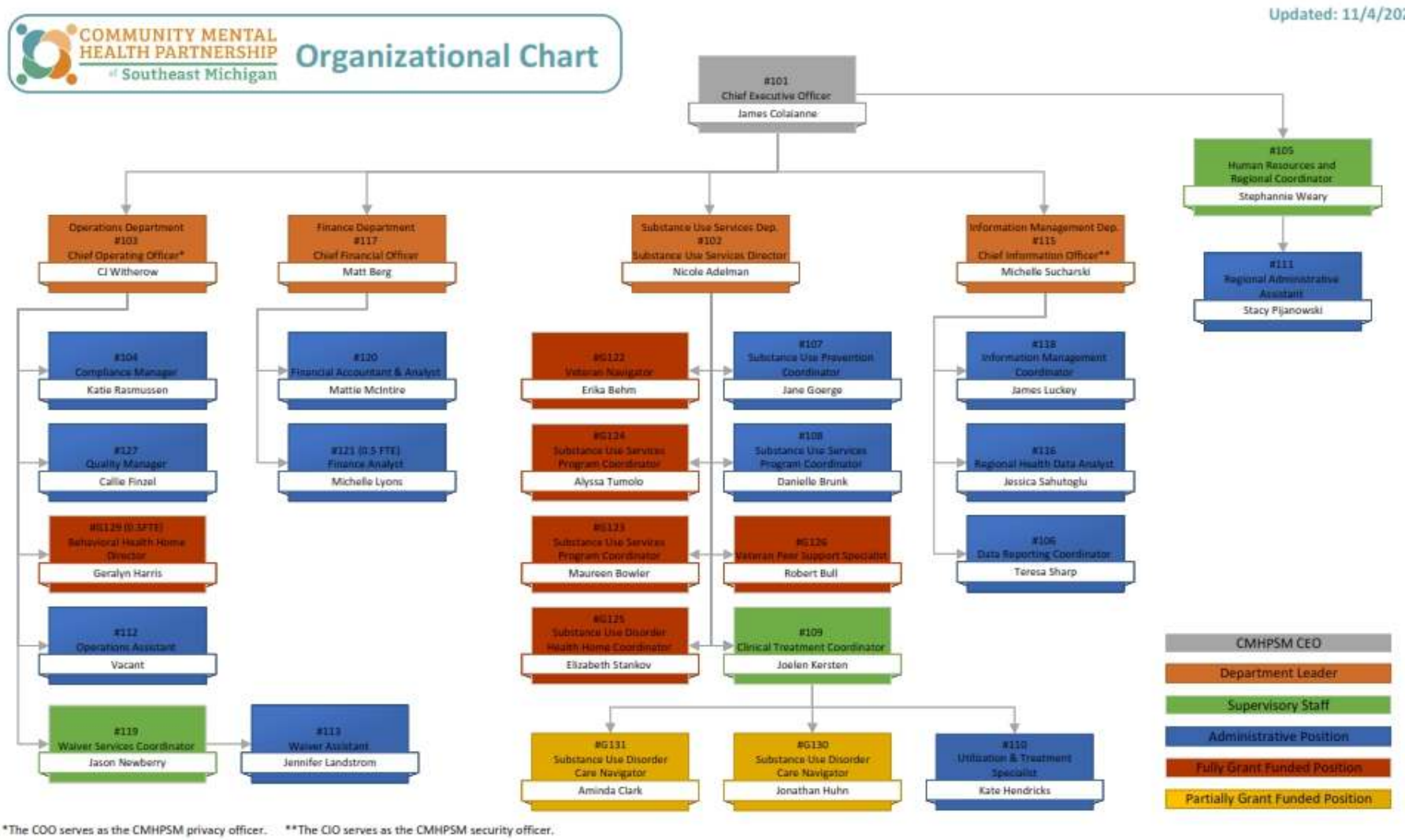
	Assess overutilization of services: Review of inpatient recidivism as potential overutilization of higher level of care, using following factors: • Persons receiving LTSS, and/or on c waiver • Services/status, type, and service utilization before first admission • Type or change in the services/IPOS after the first and/or second admission • Engagement obstacles • If hospitalization known or managed by CMH • Compliance with MMBPIS Indicator 4a	Regional UM/UR Committee	Q4 Pending, last Q1-Q2 review Met
	Underutilization project: Assess HSW members not receiving monthly services that qualify them for HSW enrollment as potential underutilization, including potential risks of maintaining HSW enrollment with the ending of public health emergency and subsequent enrollment exceptions. Including following factors: • Utilization of monthly habilitative services • Authorized services vs utilized services • Service delays and proper ABD notice where applicable • Person given choice of provider and HSW services	Regional UM/UR Committee	Q4 Pending, last Q1-Q2 review Met
	Evidence of use of parity program for those with established LOC in CMHPSM reviews of CMHSPs clinical records for all populations (Standard 90%). A parity LOC is completed for each person served, including the accurate population The relevant and appropriate level of care assessment is completed for each person served prior to authorizations being completed. If the exception process is used, the reason for the exception is documented and reviewed at the supervisory level.	Regional UM/UR Committee	Partially met Partially met
	Consistent regional service benefit is achieved as demonstrated by the percent of outliers (exceptions) to level of care benefit packages (Standard <=5%). Measurement period is FY23	Regional UM/UR Committee	Met
	Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines. (Target 100%). Implement an inner rater reliability with the MCG Indicia parity system for psychiatric inpatient, crisis residential, and partial hospitalization service decisions. Baseline measurement period is Q1 of FY24	Regional UM/UR Committee	Partially Met Met
Continuous Quality Strategy Goal(s)	**Behavior Treatment**	**Committee**	**FY2024 Performance**

	Consistent quarterly reporting of BTC data (100%) Consistent data analysis of BTC data (100%)	Regional CPT Committee	Met Met
	The percentage of individuals who have an approved Behavior Treatment Plan which includes restrictive and intrusive techniques.	Regional CPT Committee	Met - baseline
Continuous Quality Strategy Goal(s)	**Clinical Practice Guidelines**	**Committee**	**FY2024 Performance**
	CPGs reviewed at least bi-annually.	Regional CPT Committee	Met
	CPGs published to both provider network and members.	Regional CS Committee Regional NMC Committee	Met
Continuous Quality Strategy Goal(s)	**Provider Monitoring**	**Committee**	**FY2024 Performance**
	Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements.	Regional NMC Committee	Met
	Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements.	Regional NMC Committee	Met
	Credentialing and re-credentialing of organizational providers meet all state/federal requirements and timelines.	Regional NMC Committee	Partially met
	Credentialing and re-credentialing of LIP providers meet all state/federal requirements and timelines.	Regional LIP Committee	Met
	Complete assessment of FY24 CMHPSM audits of CMHSP delegated functions and SUD services and development performance improvement projects where indicated based on findings and resultant CAPs.	CMHPSM COO Regional CPT Committee Regional Compliance Committee	Met
	CMHPSM will demonstrate an increase in applicable providers within the network that are "in compliance" with the HCBS rule (MDHHS HCBS CAP Guidance form).	Regional NMC Committee	Met
Continuous Quality	**Health Home (OHH, BHH, CCBHC) Performance Measures**	**Committee**	**FY2024 Performance**

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

X. Attachments

A. Attachment A: CMHPSM Organizational Structure



B. Attachment B: Performance Improvement Framework