

**COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN
BOARD MEETING**

Patrick Barrie Room

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

Wednesday, December 11, 2024, 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

| | <u>Guide</u> |
|-------------------------------------------------------------------------------------------------------------------|--------------|
| I. Call to Order | 1 min |
| II. Roll Call | 2 min |
| III. Consideration to Adopt the Agenda as Presented | 2 min |
| IV. Consideration to Approve the Minutes of the 10-09-2024 Meeting and Waive the Reading Thereof {Att. #1} | 2 min |
| V. Consideration to Approve the Minutes of the 10-30-2024 Special Meeting and Waive the Reading Thereof {Att. #2} | 2 min |
| VI. Audience Participation (3 minutes per participant) | |
| VII. Old Business | 30 min |
| a. Information: FY2024 Finance Report September 2024 {Att. #3} | |
| b. Information: CEO Contract Committee Update | |
| VIII. New Business | 45 min |
| a. Board Action: FY2025 QAPIP Plan {Att. #4} | |
| b. Board Action: Proclamations for Joelen Kersten (10-yr) and James Colaianne (10-yr) {Att. #5} | |
| c. Board Action: Contracts {Att. #6} | |
| IX. Reports to the CMHPSM Board | 15 min |
| a. Information: CEO Report to the Board {Att. #7} | |
| X. Adjournment | |

CMHPSM Mission Statement

Through effective partnerships, the CMHPSM shall ensure and support the provision of quality integrated care that focuses on improving the health and wellness of people living in our region.

**COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN
REGULAR BOARD MEETING MINUTES
October 9, 2024**

Members Present for In-Person Quorum: Judy Ackley, Rebecca Curley, LaMar Frederick, Bob King, Molly Welch Marahar, Mary Serio, Holly Terrill,

Members Not Present For In-Person Quorum: Patrick Bridge, Mary Pizzimenti, Rebecca Pasko, Alfreda Rooks, 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:

- I. Call to Order
Meeting called to order at 6:01 p.m. by Board Chair Bob King.
- II. Roll Call
 - Quorum confirmed.
- III. Consideration to Adopt the Agenda as Presented
**Motion by M. Welch Marahar, supported by H. Terrill, to approve the agenda
Motion passed with no objections**
- IV. Consideration to Approve the Minutes of the September 11, 2024 Meeting and Waive the Reading Thereof
**Motion by M. Welch Marahar, supported by J. Ackley, to approve the minutes of the 09/11/2024 meeting and waive the reading thereof
Motion passed with no objections**
- V. Audience Participation
None
- VI. Old Business
 - a. Information: FY2024 Finance Report through August 31, 2024
 - M. Berg presented.
 - b. Information: FY2018-2019 Deficit Update
 - Withholds and payments have proven to be valid. There was a mistake in the state's CHAMPS system that caused an error which has been resolved. The region was made whole.
 - The FY18-19 deficit has been resolved. FY18-22 are now closed.
- VII. New Business
 - a. Board Action: FY2024 Q3-4 Provider Stabilization Funding
**Motion by M. Welch Marahar, supported by M. Serio, to approve the FY24 Q3 and Q4 provider stabilization funding as proposed
Motion passed with no objections**

CMHPSM Mission Statement

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b. Board Action: Anniversary Proclamations

Motion by M. Welch Marahar, supported by H. Terrill, to approve the CMHPSM Board to sign the formal proclamation acknowledging the 10 years of service by Jane Goerge to the PIHP region as a CMHPSM employee
Motion passed with no objections

Motion by J. Ackley, supported by L. Frederick, to approve the CMHPSM Board to sign the formal proclamation acknowledging the 10 years of service by Teresa Sharp to the PIHP region as a CMHPSM employee
Motion passed with no objections

Motion by M. Welch Marahar, supported by M. Serio, to approve the CMHPSM Board to sign the formal proclamation acknowledging the 5 years of service by Alyssa Tumolo to the PIHP region as a CMHPSM employee
Motion passed with no objections

c. Board Action: Contracts

Motion by L. Frederick, supported by M. Welch Marahar, to authorize the CEO to execute the contracts/amendments as presented
Motion passed with no objections

d. Board Information: FY2024 Strategic Plan Metrics Update

- J. Colaianne provided an update on the Strategic Plan. Discussion followed.

Meeting agenda addition:

Motion by J. Ackley, supported by M. Welch Marahar, to provide the 5% cost of living adjustment that was previously approved for all other staff to the CEO, effective Oct. 1, 2024
Motion passed with no objections

VIII. Reports to the CMHPSM Board

a. Information: SUD Oversight Policy Board

- At the most recent OPB meeting, officers were elected for FY25, 5 policies were approved and the OPB discussed the new fee-for-service model.

b. Information: CEO Report to the Board

- The 7 PIHPs that haven't signed the FY25 contract yet continue to work together in negotiations with the state.
- The CMHPSM has 3 open positions. Interviews and recruitment are in process.
- The PIHPs received notice that a special meeting will be held on Nov. 1, 2024, regarding Conflict Free Access and Planning proposal requirements.

IX. Adjournment

Motion by M. Welch Marahar, supported by J. Ackley, to adjourn the meeting
Motion passed with no objections

- The meeting was adjourned at 6:52 p.m.

Rebecca Pasko, CMHPSM Board Secretary

CMHPSM Mission Statement

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**COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN
SPECIAL BOARD MEETING MINUTES
October 30, 2024**

Members Present for In-Person Quorum: Judy Ackley, Rebecca Curley, LaMar Frederick, Bob King, Rebecca Pasko, Mary Pizzimenti, Mary Serio, Holly Terrill,

Members Not Present For In-Person Quorum: Patrick Bridge, Molly Welch Marahar, Alfreda Rooks, Annie Somerville, Ralph Tillotson

Staff Present: Stephannie Weary, James Colaianne, Matt Berg, Nicole Adelman, Lisa Graham, CJ Witherow, Connie Conklin, Kathryn Szewczuk, Trish Cortes

Guests Present: Attorneys Greg Moore (phone) and Chris Ryan from Taft Law

I. Call to Order
Meeting called to order at 4:02 p.m. by Board Chair Bob King.

II. Roll Call
• Quorum confirmed.

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

IV. Audience Participation
None

V. Old Business

a. Closed Session to Discuss Pending Litigation

Motion by M. Serio, supported by L. Frederick, to move that the CMHPSM Board meet in closed session under section 8(1)(e) of the Open Meetings Act, to consult with our attorney regarding trial or settlement strategy in connection with pending legal action related to our FY2025 MDHHS contract

Motion passed unanimously

- The meeting entered into closed session at 4:05 p.m.
- After returning to open session at 4:39 p.m.:

Motion by L. Frederick, supported by J. Ackley, to authorize the CEO to decline signing the proposed FY25 MDHHS/PIHP contract as currently written
Motion carried unanimously

Motion by M. Serio, supported by R. Pasko, to join the other PIHPs in any legal action enacted in relation to the proposed MDHHS/PIHP contract
Motion carried unanimously

VI. Old Business

a. FY2025 CEO Contract Clarification

CMHPSM Mission Statement

Through effective partnerships, the CMHPSM shall ensure and support the provision of quality integrated care that focuses on improving the health and wellness of people living in our region.

- J. Colaianne recommended to the board that they rescind the 5% cost of living adjustment (COLA) for the CEO that was approved at the 10/9/24 board meeting and reconsider the COLA percentage in conjunction with the CEO contractual annual increases.

Motion by L. Frederick, supported by M. Serio, to rescind the 5% COLA, which the board approved on 10/9/24, for further consideration
Motion carried unanimously

- The board agreed to convene a subcommittee to review the CEO contract for potential updates to incorporate the addition of a COLA.
- Subcommittee volunteers:
 - ❖ L. Frederick
 - ❖ M. Serio
 - ❖ B. King
 - ❖ H. Terrill

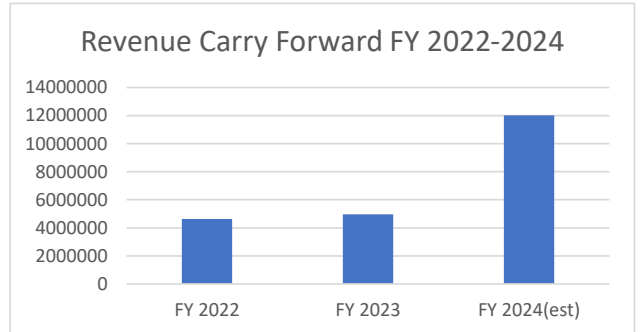
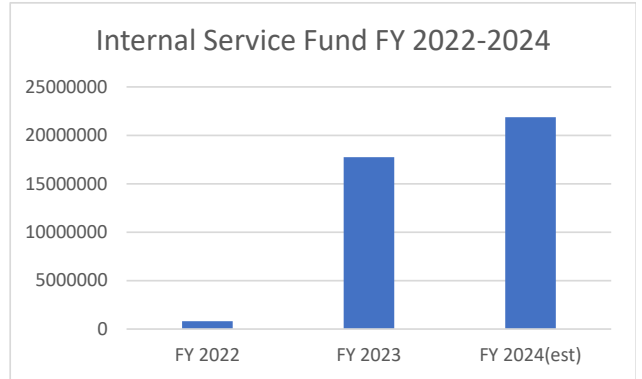
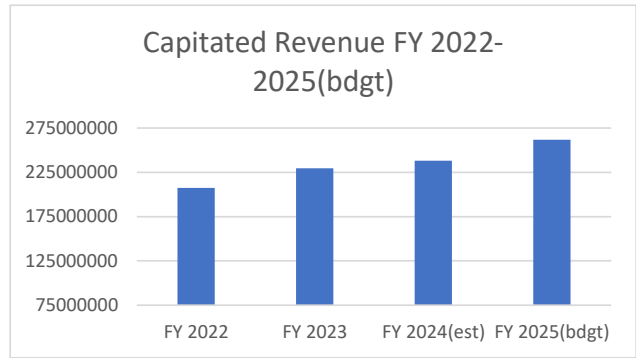
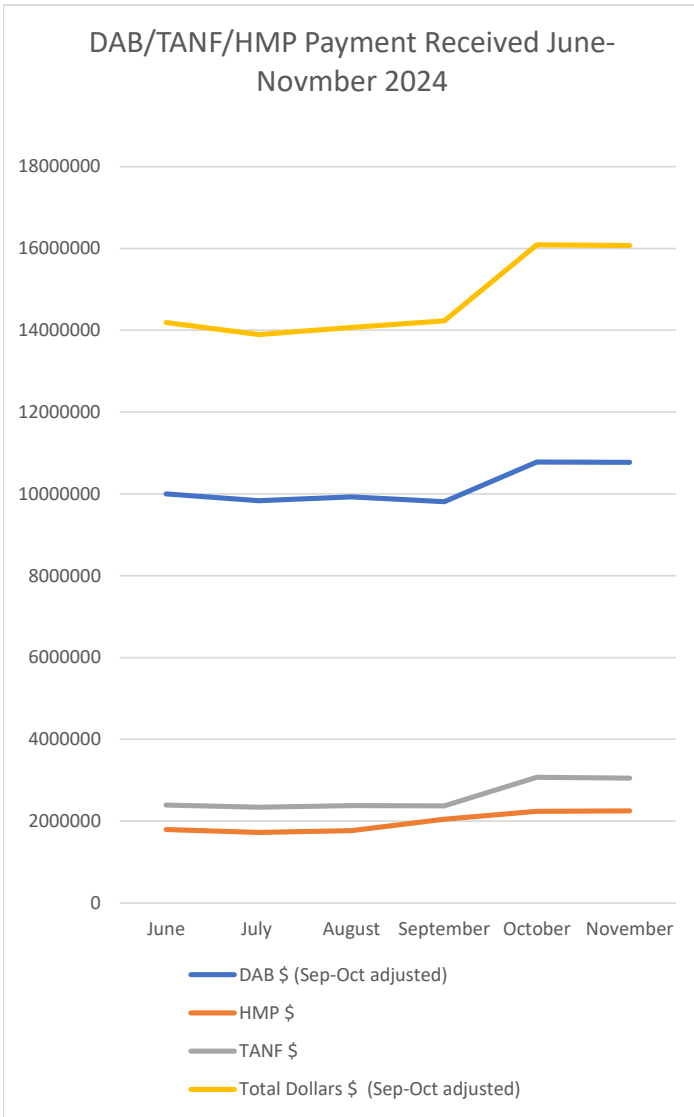
VII. Adjournment

Motion by L. Frederick, supported by R. Curley, to adjourn the meeting
Motion carried unanimously

- The meeting was adjourned at 4:46 p.m.

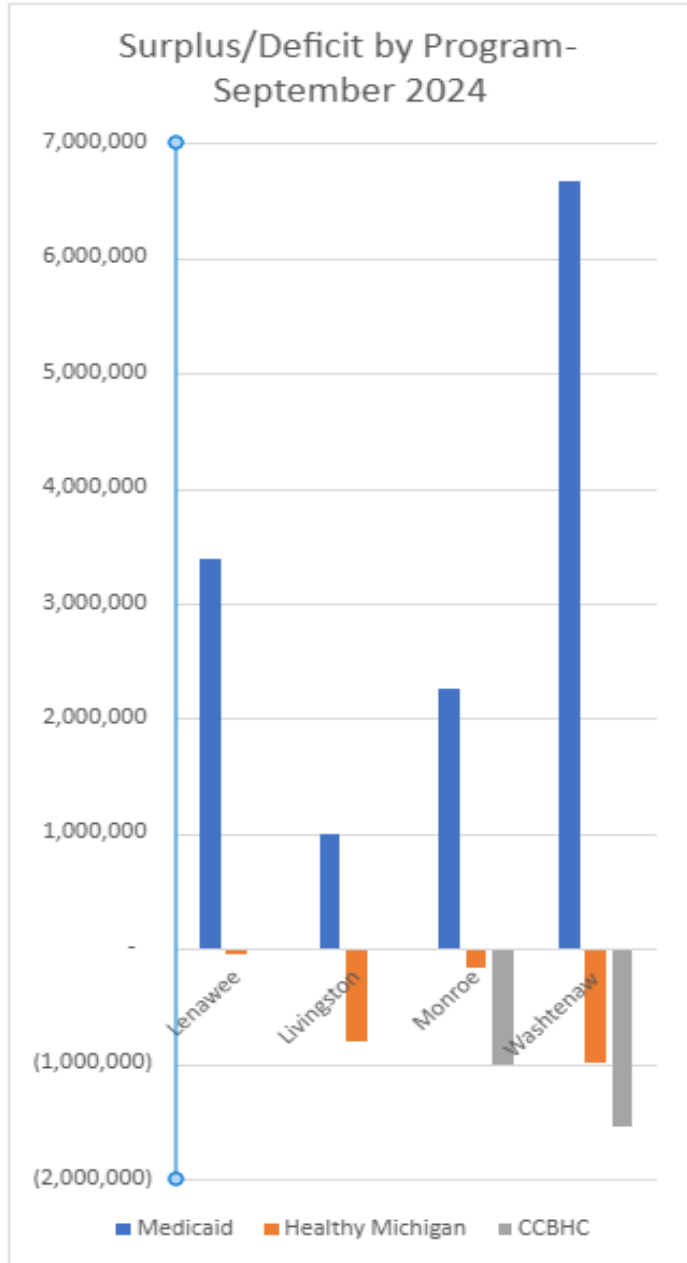
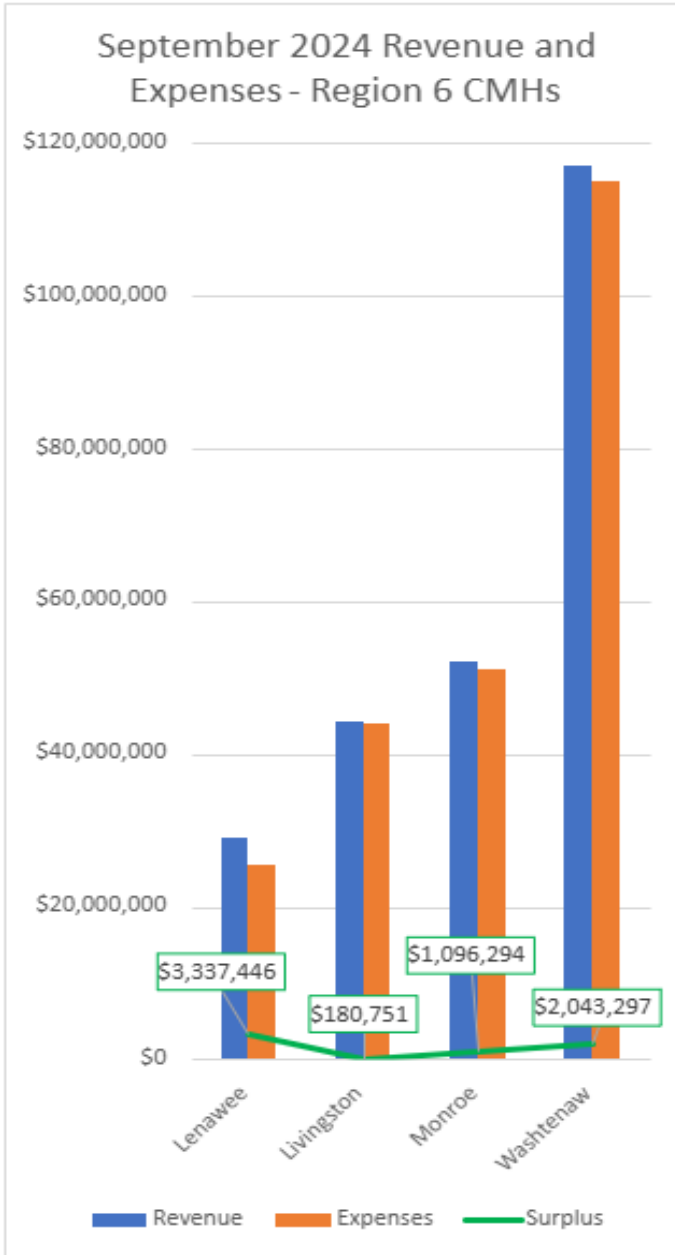
Rebecca Pasko, CMHPSM Board Secretary

Community Mental Health Partnership of Southeast Michigan
Financial Summary for September 30, 2024



| September 2024 Projected | Budget R1 FY 2024 | YTD Budget | YTD Actual | Actual to Budget | Percent Variance | Projected Year-End | Projected to Budget |
|-------------------------------------------|----------------------|--------------------|--------------------|---------------------|---------------------|-----------------------|------------------------|
| MH Medicaid Revenue | 253,779,643 | 253,779,643 | 251,977,904 | (1,801,739) | (0) | 251,977,904 | (1,801,739) |
| MH Medicaid Expenses | 250,021,112 | 250,021,112 | 247,499,190 | 2,521,922 | 1.0% | 247,499,190 | (14,453,534) |
| MH Medicaid Net | 3,758,531 | 3,758,531 | 4,478,714 | 720,183 | 19.2% | 4,478,714 | 12,651,795 |
| SUD/Grants Revenue | 23,570,266 | 23,570,266 | 25,840,244 | 2,269,978 | 9.6% | 25,840,244 | 2,269,978 |
| SUD/Grants Expenses | 22,005,574 | 22,005,574 | 24,562,308 | 2,556,734 | -11.6% | 24,562,308 | 2,556,734 |
| SUD/Grants Net | 1,564,692 | 1,564,692 | 1,277,936 | (286,756) | 18.3% | 1,277,936 | (286,756) |
| PIHP | | | | | | | |
| PIHP Revenue | 2,049,180 | 2,049,180 | 2,111,862 | 62,682 | 3.1% | 2,111,862 | 62,682 |
| PIHP Expenses | 3,185,842 | 3,185,842 | 2,712,662 | (473,180) | 14.9% | 2,712,662 | (473,180) |
| PIHP Total | (1,136,662) | (1,136,662) | (600,800) | 535,862 | 47.1% | (600,800) | 535,862 |
| Total Revenue | 279,399,089 | 279,399,089 | 279,930,010 | 530,921 | 0.2% | 279,930,010 | 530,921 |
| Total Expenses | 275,212,528 | 275,212,528 | 274,774,159 | 438,369 | 0.2% | 274,774,159 | 438,369 |
| Total Transfers Out/ISF & PBIP | | | 5,538,616 | | | 5,538,616 | |
| Total Net | 4,186,561 | 4,186,561 | (382,765) | 969,290 | 23.2% | (382,765) | (4,569,326) |

Regional CMH Revenue and Expenses
Regional Charts



| July 2024 | 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) |
| Total Medicaid/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% |

SUMMARY PAGE

- The following chart compares the liquid assets of CMHPSM at the start of FY 2025 to the end of the reporting period, October 31, 2024. Cash was down in October due to the PIHP paying out the CMHSP's Performance Bonus Incentive Payment award from FY 2022.

| Asset Type | Description | September 2024 | October 2024 |
|----------------------------|--------------------------|-------------------|-------------------|
| Cash | Operations | 3,857,082 | 3,957,739 |
| | Total Cash | 3,857,082 | 3,957,739 |
| Investments | Money Market | 2,804,901 | 319,652 |
| | US Treasuries | 10,622,728 | 10,649,295 |
| | Total Investments | 13,427,630 | 10,968,946 |
| Total Liquid Assets | | 17,284,711 | 14,926,685 |

- The first quarter is a transitional quarter for the PIHP and the CMHs. We are all closing out the prior year and trying to get projects started in the new year. The CMHs generally do not complete financial results until the end of the first quarter. The usual CMH results will not be available until then.

For the PIHP, many Substance Use providers have not submitted all of the October claims and many of the Grant programs have not submitted their first Financial Status Reports. The following October summary is the same summary usually included on the first page of the financial report. A preliminary FY 2025 (October 2024) financial summary report is included. The Regional Board reports in January 2025 will reflect FY 2025 for both PIHP and Partner CMHSPs..

| October 2024 | FY 2025 Budget | YTD Budget | October 2024 Actual | Actual to Budget | Percent Variance | Projected Year-End | Projected to Budget |
|-------------------------------------------|--------------------|-------------------|------------------------|---------------------|---------------------|-----------------------|------------------------|
| MH Medicaid Revenue | 287,130,663 | 22,427,555 | 22,658,833 | 231,277 | 1.0% | 287,130,663 | - |
| MH Medicaid Expenses | 276,792,340 | 21,791,028 | 22,382,754 | (591,726) | -2.7% | 276,792,341 | - |
| MH Medicaid Net | 10,338,323 | 636,527 | 276,079 | (360,448) | -56.6% | 10,338,322 | - |
| SUD/Grants Revenue | 29,680,656 | 2,473,388 | 1,931,759 | (541,629) | -21.9% | 29,680,656 | - |
| SUD/Grants Expenses | 25,724,924 | 2,174,698 | 1,743,255 | (431,443) | 19.8% | 25,724,925 | - |
| SUD/Grants Net | 3,955,732 | 298,690 | 188,504 | (110,186) | 36.9% | 3,955,731 | - |
| PIHP | | | | | | | |
| PIHP Revenue | 2,059,480 | 198,153 | 210,839 | 12,686 | 6.4% | 2,059,480 | - |
| PIHP Expenses | 3,648,683 | 290,792 | 240,577 | (50,215) | 17.3% | 3,648,683 | - |
| PIHP Total | (1,589,203) | (92,639) | (29,738) | 62,901 | 67.9% | (1,589,203) | - |
| Total Revenue | 318,870,799 | 25,099,097 | 24,801,430 | (297,666) | -1.2% | 318,870,799 | - |
| Total Expenses | 306,165,949 | 24,256,518 | 24,366,586 | (110,067) | -0.5% | 306,165,949 | - |
| Total Transfers Out/ISF & PBIP | | | | | | | |
| Total Net | 12,704,852 | 842,578 | 434,845 | (407,734) | -48.4% | 12,704,850 | (2) |

Fiscal Year 2024 Update

Medicaid Mental Health

1. The biggest item of note for Medicaid is that our current numbers show that we will have a \$12M carry forward of revenue from FY 2024 to FY 2025. This is more than \$4M carried forward from FY 2023 to FY 2024.
2. The total Medicaid revenue includes a recoupment of (\$1,186,513) of FY 2024 revenue in October of 2024 related to MDHHS payment system issues.
3. The HRA passthrough amount increased from a budget of \$5.4M to an actual of \$11.3M. HRA passthrough does not impact the PIHP's financial status as MDHHS pays the PIHPs exactly the amount to be passed through to hospitals.
4. The amount of CCBHC Supplemental passed through to Washtenaw and Monroe CCBHCs increased by almost \$2M over budgeted amount. The CCBHC Supplemental also does not impact the PIHP's bottom line.
5. The detailed amounts shown for each CMHSP reflect actual reported usage as of today. Both Monroe and Washtenaw show an amount due to CCBHC Supplemental revenue. The CMHs complete final cost allocation after the end of the fiscal year and these amounts may still change.

Medicaid and Grant SUS

1. Substance use revenue was up 9.6% due mostly to increased grant expenditure. The fourth quarter had increased grant expenditure in FY2024.
2. PA2 revenue exceeded budget projections. \$185,688 is shown going back to the PA2 reserve.
3. Opioid Health Homes showed an increase in annual usage which is reflected in both revenue and expenses.

PIHP Administration

1. PIHP revenue is within budgeted parameters.
2. PIHP expenditures are below budget due to open positions during FY 2024 and savings in contracts & other budget lines.

Transfers

1. The \$3,616,499 transfer to ISF comes from projected Medicaid/HMP surplus.
2. When the Performance Bonus Incentive Payment is earned and awarded to the PIHP it is transferred to unearned revenue to be distributed to the CMHSPs after funding is received, usually in spring. This funding can be used by CMHSP partners as local funding for programming.

FY 2025 Considerations

In FY 2025 the budget projects \$261.9M in capitated Medicaid revenue. The \$261.9M does not include HRA payment, Supplemental CCBHC, PA2 or grant revenue. With that level of capitated revenue, we could increase our Revenue Carry Forward to \$19.6M before lapsing funds back to the state.

**Community Mental Health Partnership of Southeast Michigan
Preliminary Statement of Revenues, Expenditures Transfers
From FY 2024 Interim FSR Filed with MDHHS**

| | Budget R1 FY 2024 | YTD Budget | YTD Actual | Actual to Budget | Percent Variance | Projected Year-End | Projected O(U) Budget |
|------------------------------|----------------------|--------------------|--------------------|---------------------|---------------------|-----------------------|--------------------------|
| MEDICAID | | | | | | | |
| MEDICAID REVENUE | | | | | | | |
| Medicaid/Medicaid CCBHC | 128,391,843 | 128,391,843 | 128,582,354 | 190,511 | 0.1% | 128,582,354 | 190,511 |
| Medicaid Waivers | 61,704,640 | 61,704,640 | 62,715,805 | 1,011,165 | 1.6% | 62,715,805 | 1,011,165 |
| HMP/HMP CCBHC | 14,272,296 | 14,272,296 | 14,264,501 | (7,795) | -0.1% | 14,264,501 | (7,795) |
| Medicaid Autism | 17,600,547 | 17,600,547 | 18,378,184 | 777,637 | 4.4% | 18,378,184 | 777,637 |
| Future Year Carryforward | | | (12,009,306) | | | (12,009,306) | (12,009,306) |
| Prior Year Carry Forward | 3,849,666 | 3,849,666 | 4,257,536 | 407,870 | 10.6% | 4,257,536 | 407,870 |
| Prior Year Recovery | (345,001) | (345,001) | (345,001) | 0 | 0.0% | (345,001) | 0 |
| Behavioral Health Home | 1,213,586 | 1,213,586 | 1,308,905 | 95,319 | 7.9% | 1,308,905 | 95,319 |
| CCBHC | 21,692,066 | 21,692,066 | 23,459,119 | 1,767,053 | 8.1% | 23,459,119 | 1,767,053 |
| HRA Revenue | 5,400,000 | 5,400,000 | 11,365,806 | 5,965,806 | 110.5% | 11,365,806 | 5,965,806 |
| Medicaid Revenue | 253,779,643 | 253,779,643 | 251,977,904 | (1,801,739) | -0.7% | 251,977,904 | (1,801,739) |
| MEDICAID EXPENDITURES | | | | | | | |
| IPATax | 2,481,014 | 2,481,014 | 2,204,554 | 276,460 | 11.1% | 2,204,554 | (276,460) |
| HRA Payments | 5,400,000 | 5,400,000 | 11,365,806 | (5,965,806) | -110.5% | 11,365,806 | (5,965,806) |
| Lenawee CMH | | | | | | | |
| Medicaid (b) & 1115i | 17,931,110 | 17,931,110 | 14,303,403 | 3,627,707 | 20.2% | 14,303,403 | (3,627,707) |
| Medicaid Waivers | 7,197,756 | 7,197,756 | 7,411,466 | (213,710) | -3.0% | 7,411,466 | 213,710 |
| Healthy Michigan Expense | 2,537,816 | 2,537,816 | 2,477,886 | 59,930 | 2.4% | 2,477,886 | (59,930) |
| Autism Medicaid | 1,096,819 | 1,096,819 | 1,207,516 | (110,697) | -10.1% | 1,207,516 | 110,697 |
| Behavioral Health Homes | 51,164 | 51,164 | 54,908 | (3,744) | -7.3% | 54,908 | 3,744 |
| DHIP | | - | 56,126 | (56,126) | | 56,126 | 56,126 |
| Lenawee CMH Total | 28,814,665 | 28,814,665 | 25,511,304 | 3,303,361 | 11.5% | 25,511,304 | (3,303,361) |
| Livingston CMH | | | | | | | |
| Medicaid (b) & 1115i | 26,133,028 | 26,133,028 | 24,502,798 | 1,630,230 | 6.2% | 24,502,798 | (1,630,230) |
| Medicaid Waivers | 9,929,468 | 9,929,468 | 9,981,667 | (52,199) | -0.5% | 9,981,667 | 52,199 |
| Healthy Michigan Expense | 2,467,711 | 2,467,711 | 3,613,082 | (1,145,371) | -46.4% | 3,613,082 | 1,145,371 |
| Autism Medicaid | 5,309,239 | 5,309,239 | 5,845,075 | (535,836) | -10.1% | 5,845,075 | 535,836 |
| Behavioral Health Homes | 76,122 | 76,122 | 71,442 | 4,680 | 6.1% | 71,442 | (4,680) |
| DHIP | | - | 111,723 | (111,723) | | 111,723 | 111,723 |
| Livingston CMH Total | 43,915,568 | 43,915,568 | 44,125,786 | (210,218) | -0.5% | 44,125,786 | 210,218 |
| Monroe CMH | | | | | | | |
| Medicaid | 22,189,214 | 22,189,214 | 21,005,126 | 1,184,088 | 5.3% | 21,005,126 | (1,184,088) |
| Medicaid Waivers | 11,799,227 | 11,799,227 | 11,418,326 | 380,901 | 3.2% | 11,418,326 | (380,901) |
| Healthy Michigan | 2,860,301 | 2,860,301 | 3,025,405 | (165,104) | -5.8% | 3,025,405 | 165,104 |
| Autism Medicaid | 2,066,470 | 2,066,470 | 2,275,029 | (208,559) | -10.1% | 2,275,029 | 208,559 |
| CCBHC Supplemental | 7,191,388 | 7,191,388 | 9,080,295 | (1,888,907) | -26.3% | 9,080,295 | 1,888,907 |
| CCBHC Base Capitation | 6,000,000 | 6,000,000 | 4,547,450 | 1,452,550 | 24.2% | 4,547,450 | (1,452,550) |
| Behavioral Health Homes | 335,062 | 335,062 | 304,177 | 30,885 | 9.2% | 304,177 | (30,885) |
| DHIP | | - | 49,243 | (49,243) | | 49,243 | 49,243 |
| Monroe CMH Total | 52,441,662 | 52,441,662 | 51,705,051 | 736,611 | 1.4% | 51,705,051 | (736,611) |
| Washtenaw CMH | | | | | | | |
| Medicaid | 49,969,192 | 49,969,192 | 42,941,616 | 7,027,576 | 14.1% | 42,941,616 | (7,027,576) |
| Medicaid Waivers | 32,610,867 | 32,610,867 | 32,919,707 | (308,840) | -0.9% | 32,919,707 | 308,840 |
| Healthy Michigan Expense | 6,155,256 | 6,155,256 | 8,281,857 | (2,126,601) | -34.5% | 8,281,857 | 2,126,601 |
| Autism Medicaid | 7,423,397 | 7,423,397 | 8,172,604 | (749,207) | -10.1% | 8,172,604 | 749,207 |
| CCBHC Supplemental | 11,800,970 | 11,800,970 | 12,959,035 | (1,158,065) | -9.8% | 12,959,035 | 1,158,065 |
| CCBHC Base Capitation | 8,500,000 | 8,500,000 | 5,731,658 | 2,768,342 | 32.6% | 5,731,658 | (2,768,342) |
| CCBHC Incentive | | - | 1,005,491 | | | 1,005,491 | 1,005,491 |
| Behavioral Health Homes | 508,521 | 508,521 | 554,069 | (45,548) | -9.0% | 554,069 | 45,548 |
| DHIP | | | 20,650 | (20,650) | | 20,650 | 20,650 |
| Washtenaw CMH Total | 116,968,203 | 116,968,203 | 112,586,688 | 4,381,515 | 3.7% | 112,586,688 | (4,381,515) |
| Medicaid Expenditures | 250,021,112 | 250,021,112 | 247,499,190 | 2,521,922 | 1.0% | 247,499,190 | (14,453,534) |
| Medicaid Total | 3,758,531 | 3,758,531 | 4,478,714 | 720,183 | 19.2% | 4,478,714 | 12,651,795 |

**Community Mental Health Partnership of Southeast Michigan
Preliminary Statement of Revenues, Expenditures Transfers
From FY 2024 Interim FSR Filed with MDHHS**

| | Budget R1 FY 2024 | YTD Budget | YTD Actual | Actual to Budget | Percent Variance | Projected Year-End | Projected O(U) Budget |
|------------------------------------|----------------------|--------------------|-------------------|---------------------|---------------------|-----------------------|--------------------------|
| SUD/GRANTS | | | | | | | |
| SUD/GRANTS REVENUE | | | | | | | |
| Healthy Michigan Plan SUD | 8,667,532 | 8,667,532 | 8,837,508 | 169,976 | 2.0% | 8,837,508 | 169,976 |
| Medicaid SUD | 4,172,534 | 4,172,534 | 4,073,212 | (99,322) | -2.4% | 4,073,212 | (99,322) |
| PA2 - Reserve Investment | 20,000 | 20,000 | 183,500 | 163,500 | | 183,500 | |
| PA2 - Tax Revenue (Est) | 1,397,444 | 1,397,444 | 2,183,483 | 786,039 | 56.2% | 2,183,483 | 786,039 |
| PA2 - Use of Reserve (Est) | 0 | - | (185,688) | (185,688) | 0.0% | (185,688) | - |
| Federal/State Grants | 8,702,756 | 8,702,756 | 10,010,020 | 1,307,264 | 15.0% | 10,010,020 | 1,307,264 |
| Opioid Health Homes | 610,000 | 610,000 | 738,211 | 128,211 | 17.4% | 738,211 | 128,211 |
| SUD/Grants REVENUE | 23,570,266 | 23,570,266 | 25,840,244 | 2,269,978 | 9.6% | 25,840,244 | 2,269,978 |
| | | | | 0 | | | |
| | | | | 0 | | | |
| SUD/GRANTS EXPENDITURES | | | | | | | |
| SUD Administration | | | | | | | |
| Salaries & Fringes | 1,227,918 | 1,227,918 | 1,098,342 | (129,576) | 10.6% | 1,098,342 | (129,576) |
| Other Expenses | | - | 31,375 | 31,375 | | 31,375 | 31,375 |
| Indirect Cost Recovery | (427,500) | (427,500) | (400,034) | 27,466 | 6.4% | (400,034) | 27,466 |
| SUD Administration | 800,418 | 800,418 | 729,683 | (70,735) | -8.8% | 729,683 | (70,735) |
| Lenawee SUD Services | 1,911,748 | 1,911,748 | 1,931,323 | 19,575 | -1.0% | 1,931,323 | 19,575 |
| Livingston SUD Services | 2,250,253 | 2,250,253 | 2,420,717 | 170,464 | -7.6% | 2,420,717 | 170,464 |
| Monroe SUD Services | 3,731,736 | 3,731,736 | 3,906,821 | 175,085 | -4.7% | 3,906,821 | 175,085 |
| Washtenaw SUD Services | 7,709,340 | 7,709,340 | 8,492,024 | 782,684 | -10.2% | 8,492,024 | 782,684 |
| Opioid Health Homes | 488,000 | 488,000 | 647,693 | 159,693 | -32.7% | 647,693 | 159,693 |
| Veteran Navigation | 205,383 | 205,383 | 207,000 | 1,617 | -0.8% | 207,000 | 1,617 |
| COVID Grants | 2,655,383 | 2,655,383 | 2,938,633 | 283,250 | -10.7% | 2,938,633 | 283,250 |
| SOR | 1,998,619 | 1,998,619 | 2,513,369 | 514,750 | -25.8% | 2,513,369 | 514,750 |
| Gambling Prevention Grant | 24,520 | 24,520 | 52,919 | 28,399 | -115.8% | 52,919 | 28,399 |
| Tobacco/Other | 90,880 | 90,880 | 424,895 | 334,015 | -367.5% | 424,895 | 334,015 |
| Women's Specialty Services | 139,294 | 139,294 | 297,230 | 157,936 | -113.4% | 297,230 | 157,936 |
| | | - | | | | | |
| SUD/Grants Expenditures | 22,005,574 | 22,005,574 | 24,562,308 | 2,556,734 | 11.6% | 24,562,308 | 2,556,734 |
| SUD/Grants Total | 1,564,692 | 1,564,692 | 1,277,936 | (286,756) | 18.3% | 1,277,936 | (286,756) |
| PIHP | | | | | | | |
| PIHP REVENUE | | | | | | | |
| Incentives (Est) | 1,890,000 | 1,890,000 | 1,922,117 | 32,117 | 1.7% | 1,922,117 | 32,117 |
| Local Match | 159,180 | 159,180 | 159,180 | - | 0.0% | 159,180 | - |
| Other Income | | | 30,565 | 30,565 | | 30,565 | 30,565 |
| PIHP Revenue | 2,049,180 | 2,049,180 | 2,111,862 | 62,682 | 3.1% | 2,111,862 | 62,682 |
| PIHP EXPENDITURES | | | | | | | |
| PIHP Admin | | | | | | | |
| Local Match | 159,180 | 159,180 | 159,180 | - | 0.0% | 159,180 | - |
| Salaries & Fringes | 1,801,909 | 1,801,909 | 1,541,158 | (260,751) | -14.5% | 1,541,158 | (260,751) |
| Contracts & Other | 1,221,753 | 1,221,753 | 1,011,138 | (210,615) | -17.2% | 1,011,138 | (210,615) |
| PIHP Admin | 3,182,842 | 3,182,842 | 2,711,476 | (471,366) | 14.8% | 2,711,476 | (471,366) |
| | | | | | | | - |
| Board Expense | 3,000 | 3,000 | 1,185 | (1,815) | -60.5% | 1,185 | (1,815) |
| PIHP Expenditures | 3,185,842 | 3,185,842 | 2,712,662 | (473,180) | 14.9% | 2,712,662 | (473,180) |
| PIHP Total | (1,136,662) | (1,136,662) | (600,800) | 535,862 | -47.1% | (600,800) | 535,862 |
| TRANSFERS OUT (Preliminary) | | | | | | | |
| Transfer to ISF | | | 3,616,499 | | | 3,616,499 | |
| Transfer to PBIP Reserve | | | 1,922,117 | | | 1,922,117 | |
| TRANSFERS OUT Total | | | 5,538,616 | | | 5,538,616 | |
| Organization Total | 4,186,561 | 4,186,561 | (382,765) | (4,569,326) | -109.1% | (382,765) | 12,900,902 |
| Totals | | | | | | | |
| Revenue | 279,399,089 | 279,399,089 | 279,930,010 | 530,921 | -0.2% | 279,930,010 | 530,921 |
| Expenses | 275,212,528 | 275,212,528 | 274,774,159 | 438,369 | -0.2% | 274,774,159 | (12,369,981) |
| Net Before Transfers | 4,186,561 | 4,186,561 | 5,155,851 | 969,290 | 23.2% | 5,155,851 | 12,900,902 |

**State of Michigan, Department of Health and Human Services
Risk Management Strategy Submission for State Fiscal Year 2025
Provider Attestation**

FY2025 RISK MANAGEMENT STRATEGY SUBMISSION ATTESTATION

| | |
|-------------------|------------------------------------------------------------------|
| | <u>Community Mental Health Partnership of Southeast Michigan</u> |
| | Name of Entity |
| Name of Preparer: | <u>Matt Berg / James Colaianne</u> |
| Title: | <u>CFO / CEO</u> |
| Phone Number: | <u>734-222-3865</u> |
| E-mail Address: | <u>bergm@cmhpsm.org / colaiannej@cmhpsm.org</u> |

I hereby attest that the information submitted in the report herein is current, complete, accurate, and in compliance with MDHHS/PIHP Contract Requirements to the best of my knowledge. I understand that failure to attest (as indicated by the completed section below) will result in non-acceptance by the Michigan Department of Health and Human Services.

| | |
|--------------|------------------------|
| Name: | <u>James Colaianne</u> |
| Title: | <u>CEO</u> |
| Signature: | <u>James Colaianne</u> |
| Date Signed: | <u>12/3/2024</u> |

The FY2025 risk management strategy must be submitted to MDHHS-BDHHA-Contracts-MGMT@michigan.gov no later than 11:59pm, December 3, 2024

Michigan Department of Health and Human Services

PIHP Risk Management Strategy Submission for State Fiscal Year 2025 as defined in MDHHS / PIHP Contract; Schedule A, Statement of Work; Section 6, Contractor Risk Management Strategy

PIHP Name: Community Mental Health Partnership of Southeast Michigan (Region 6)

#1 For Fiscal Year ended 9.30.2024, report the following:

| | | Amount |
|---------------|---------------------------------------------------------|----------------------|
| A. | Expected balance of the Medicaid ISF | \$ 3,213,188 |
| B. | Projected Medicaid Savings | \$ 12,009,306 |
| C. | Expected balance of the Healthy Michigan Plan ISF | \$ 17,474,598 |
| D. | Projected Healthy Michigan Plan savings | \$ - |
| E. | The PIHP's expected unrestricted fund balance | \$ 1,500,000 |
| F. | Public Act 2 (P.A.2) fund balance | \$ 6,130,749 |
| G. | Performance Bonus Incentive Program (PBIP) fund balance | \$ 3,871,061 |
| Total: | | \$ 44,198,902 |

#2 For Standalone PIHPs only, Fiscal Year ended 9.30.2024:

| | | |
|----|-----------------------------------------------------|------|
| A. | Projected GF redirected for Unfunded Medicaid Costs | \$ - |
| B. | Projected GF carryforward Earned | \$ - |

#3 For Fiscal Year ending 9.30.2025, report the following:

| | | |
|------------------------------------|---------------------------------------------------------------------------------|---------------------|
| A. | Projection of Medicaid/HMP capitation payments for PIHP and affiliates in total | \$ 261,867,311 |
| B. | Projection of Medicaid/HMP waiver expenditures for PIHP and affiliates in total | \$ (253,289,726) |
| Surplus or (Deficit) Total: | | \$ 8,577,585 |

#4 Is FY24 Medicaid Revenue expected to be below projected expenditures?

No

NO GO TO NEXT QUESTION (#5)

YES ANSWER LETTERS A - D BELOW

| | |
|----|------------------------------------------------------------------------------------------------------------------|
| A. | Provide a brief summary of the expected change in Medicaid revenue and costs from FY24 to FY25: |
| B. | Provide the amount of projected local and state risk obligations the plan covers: |
| C. | Provide a detailed description of the funds (ISF, local, etc.) that will be used to satisfy the risk obligation: |
| D. | Provide a description of any related actions such as plans to increase efficiency or reduce costs: |

#5 Is FY25 Medicaid Revenue expected to exceed projected expenditures?

| | | |
|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------|
| A. | Provide how much will be allocated to Medicaid savings, ISF deposit, or lapse. | |
| NOTE: The planned utilization of this difference must be specified below. | | |
| | Amount | |
| | Projected Earned Medicaid Savings ending balance | \$ 5,000,000 |
| | Projected Medicaid ISF ending balance | \$ 20,687,786 |
| | Projected Medicaid Lapse | \$ - |

| | | |
|----|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|
| B. | Standalone PIHPs only: Provide any general fund allocations that are expected to exceed expenditures for FY25, for the PIHP in total, whether they will be included in carry-forward or lapsed and the expected amounts of each. | |
| | Amount | |
| | General Fund Carry-Forward Earned | \$ - |
| | General Fund Lapse to MDHHS | \$ - |

#6 Multi-county PIHPs: Briefly describe PIHP/CMHSP affiliate risk management relationships, including the PIHP responsible CMHSP arrangements with affiliate CMHSPs in sharing financing responsibility for the projected Medicaid risk exposure. This item does not apply to single-county PIHPs.

The Community Mental Health Partnership of Southeast Michigan (CMHPSM), in its role as the Pre-Paid Inpatient Health Plan (PIHP) for our four-county region, retains the Medicaid and Healthy Michigan Savings and the Medicaid and Healthy Michigan Internal Service Funds (ISF) on behalf of our Community Mental Health Service Programs (CMHSPs). The CMHPSM plans to cover annual Medicaid expenditures first with Medicaid Savings as identified in 1B and 1D above followed by current year Medicaid revenue. As of FYE2024 interim calculations, ISF funding for the CMHPSM is on hand for risk as noted in items 1A and 1C above. The CMHPSM estimates FY2025 revenue and FY2024 Medicaid/HMP savings will be sufficient to cover projected FY2025 PIHP and CMHSP expenses. The ISF is our tool to cover timing variation in the sufficiency of prospective capitation revenue when measured against the total cost of service expenditures needed to provide medically necessary services to eligible beneficiaries during the term of the contract. If current year ISF funding is insufficient, in accordance with GASB Statement No. 10, the internal service fund will continue to be used to account for cost overruns and, in accordance with GASB Statement No. 54, we would report a fund deficit at the end of that fiscal year. The CMHPSM and our CMHSP partners operate with a shared governance understanding of current and future budget planning, as well as shared regional revenue and expense reports to manage our region's financial health.



Community Mental Health Partnership of Southeast Michigan

2025 Quality Assessment and Performance Improvement Program Plan

Fiscal Year 2025

Final Version Approved:

CMHPSM Clinical Performance Team: 11/21/2024

Reviewed by Regional Operations Committee: 12/2/2024

Approved by CMHPSM Board:

Submitted to MDHHS for Review: 2/28/2025

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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 themselves 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 | Incident Reporting Medication Administration, Storage, and Other Treatment Performance Improvement |
|----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|

| | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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 | 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**ceptable, **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.

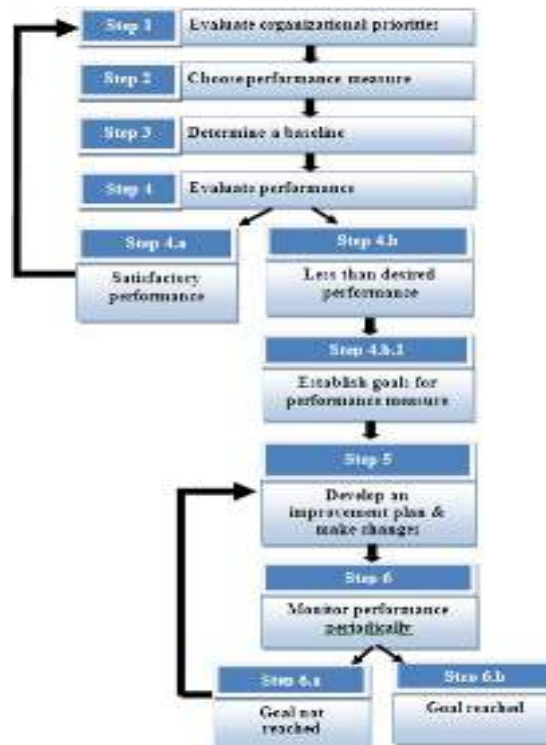
8. Decide upon an action based on analyses. (**Act**)

- 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. FY25 Performance Measures* for specific FY2025 goals for the measures discussed in this section (page 61).

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. |

Pursuant to its contract with MDHHS, CMHPSM is responsible for ensuring that its CMHSPs and Substance Use Services Providers are measuring performance using the standardized performance indicators in the MMBPIS. Data is reviewed within the region on a quarterly basis at the CPT Committee, and regional trends are identified and discussed at the CPT meetings and relevant committees/councils as applicable for regional planning efforts and coordination. MMBPIS indicators are also analyzed for trends in service delivery and health outcomes over time, including whether there have been improvements or barriers impacting the quality of health care and services for members as a result of the activities. If minimum performance targets or requirements are not met, CMHSPs/SUS providers develop a quality improvement or corrective action plan (CAP) that documents causal factors, interventions, implementation timelines, and any other actions taken to

correct undesirable variation. The CPT Committee reviews the quality improvement plan and monitors the fidelity of its implementation and its effectiveness over the re-measurement period identified.

MDHHS Behavioral Health Quality Transformation Plan: FY2026-2029

The current MDHHS behavioral health quality strategic plan on which MMBPIS is based will conclude in 2025. As part of the state's FY 2026-2029 Behavioral Health Quality Transformation Plan, MMBPIS indicators above will be sunset and replaced with an additional system of indicators based on national standards set by the National Committee for Quality Assurance (NCQA) and CMS's Healthcare Effectiveness Data and Information Set (HEDIS) measures. The performance indicator measurement year will be changing from a fiscal year (October 1st to September 30th) to a calendar year (January 1st to December 31st) reporting cycle, with the new metrics beginning January 1st of 2025. At this time, MDHHS indicates that the PIHPs will continue to report the MMBPIS indicators through December 31st of 2025 while the state will be collecting Year 1 metrics (below) based on encounter data.

The updated measures will focus on the following domain areas:

- mental health,
- substance use disorders,
- patient experience,
- comorbid conditions,
- Home and Community Based Services,
- access to care, and
- social needs.

The data will also be stratified according to demographic factors, including age, race and ethnicity, biologic sex, and geography.

MDHHS and the PIHP system are in the process of developing, validating, and preparing the measures and systems required for this rollout. MDHHS will largely be collecting data for these metrics automatically using claims and encounters; the data will be available for PIHP access via the CareConnect 360 (CC360) system, MDHHS's database of claim information for care coordination across Medicaid providers. The focus of CMHPSM's FY25 QAPIP in relationship to the state transformation plan will include working with the state on application and implementation and validation of measures.

CMHPSM will be working to identify areas that contribute to accurate and timely data submission and developing a PI project beginning FY25 to improve timeliness and accuracy of Service Activity Log (SAL) completion.

MDHHS will begin reporting analysis of the following measures relevant to the FY25 QAPIP starting January 1st, 2025:

| Metric Code | Metric Description |
|--------------------|---------------------------------------------------------------------------------------------------|
| ADD | Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication |
| CDF | Screening for Depression and Follow-up Plan |
| FUH | Follow-up After Hospitalization for Mental Illness |
| APM | Metabolic Monitoring for Children and Adolescents on Antipsychotics |
| APP | Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics |
| FUA | Follow-up After Emergency Department Visit for Substance Use |
| FUM | Follow-up After Emergency Department Visit for Mental Illness |
| IET | Initiation and Engagement into Substance Use Disorder Treatment |
| MSC | Medical Assistance with Smoking and Tobacco Use Cessation |
| AMM | Antidepressant Medication Management |

As MDHHS implements additional aspects of its BH Quality Transformation Plan each fiscal year, subsequent QAPIs will incorporate these measures.

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 will participate in the following PIHP performance measures for FY2025 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.

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 be measured against a minimum standard of 62%, covering the measurement period of calendar year 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 will be measured against a minimum standard of 40% at initiation and 14% at engagement for the measurement period of calendar year 2024.

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

CMHPSM will submit a narrative report to the state summarizing prior fiscal year efforts, activities, and achievements of the CMHPSM regional contractors/regional partners to increase participation in patient-centered medical homes. The narrative report will include information regarding:

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

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 FY2025, these metrics include:

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

CMHPSM, the Mental Health Plans (MHP), and the CMHSPs meet monthly to review consumers with high risk or high utilization of services to discuss interventions and supports to stabilize and better serve them in ways that reduce their risks. CMHPSM will ensure that at least 25% of adult enrollees have a completed Care Coordination plan documented.

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 79%.*

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.*

CMHPSM will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following a psychiatric hospitalization (adults and children). Disparities are calculated using the scoring methodology developed by MDHHS to detect statistically significant differences. The measurement period will be calendar year 2024.

Initiation and Engagement (IET) of Alcohol and Other Drug Dependence Treatment:

The percentage of adolescents and adults with a new substance use disorder (SUD) episodes that result in treatment initiation and engagement:

1. Initiation of AOD Treatment: *The percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis. The minimum performance standard is 40%.*

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. The minimum performance standard is 14%.*

CMHPSM will be measured against a minimum standard of 40% at initiation and 14% at engagement for the measurement period of calendar year 2024. CMHPSM will reduce the racial/ethnic disparity between the index population and at least one minority group. Data will be stratified by MDHHS by race/ethnicity and provided to PIHPs and MHPs.

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.*

CMHPSM will reduce the racial/ethnic disparity between the index population and at least one minority group. The measurement period for addressing racial/ethnic disparities will be a performance comparison of calendar year 2023 with calendar year 2024. Data will be stratified by MDHHS by race/ethnicity and provided to PIHPs and MHPs.

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 will implement interventions to reduce these disparities between the two populations in the percentage of no-shows to a biopsychosocial assessment within 14 days of a non-emergency request for services. This Performance Improvement Project will be measured by HSAG.

2. Overall increase in performance in new 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 will implement interventions to improve this overall rate while supporting PIP 1, above.

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>

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|--------------------------------------------------------------------------------------------------------------|
| 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/MiCAL system. 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. In addition, reporting includes analysis 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.

High-risk events that have a critical impact are reported to the state directly and more immediately and categorized as Immediately Reportable Events (IRE). These include specific types of death, community crises, and specific types of provider network changes.

CMHPSM delegates to the CMHSPs and SUS providers the responsibility of review and follow-up for sentinel events, critical incidents, and other risk events that put people at risk of harm. These events are monitored by the providers as defined (below) by MDHHS:

Risk events include actions taken by individuals receiving services, including:

- 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.

Critical events are reported for required populations as defined by MDHHS, and include:

- Deaths, including suicide deaths, non-suicide deaths, and deaths of unknown causes.
 - Subcategories include accidental/unexpected and homicide deaths.
- Arrests.
- Emergency medical treatment and/or hospitalization for injuries and medication.
 - Subcategories include injuries from the use of physical management and falls.
- Critical Events that are also Risk Events are documented and reported by residential providers.

SUS Residential Providers are required to review and report specific Sentinel Events:

- Deaths.
- Injuries requiring emergency medical treatment and/or hospitalization.

- Physical illness requiring hospitalization.
- Serious behavioral issues.
- Medication errors.
- Arrests and/or convictions.

Addressing Quality of Care

CMHPSM and CMHSPs report critical events through the state CRM/MiCAL 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/SUS 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.

CMHPSM immediately notifies MDHHS in the event of a death of an individual who received services within one year of discharge from a state-operated service. Following immediate event notification to 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.

Monitoring/Review

CMHPSM and CMHSPs use both qualitative (descriptive) and quantitative (measurement-based) methods to review Critical Incidents, Sentinel Events, and Risk Events for both mental health and substance use services, including individuals in CMHSP SUS contractual residential settings and those identified as receiving Long-term Supports and Services (LTSS).

CMHPSM completes quarterly monitoring and review of these events to assess 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 individuals served by SUS providers. Upon request, CMHPSM provides MDHHS with 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 SUS providers and members receiving SUS services.
- A review of data per event type per 1,000 members, in order to conduct a comparative analysis between CMHSPs and providers.
- An in-depth review of CMHSPs and providers who consistently report minimal or no critical incidents, sentinel events, and risk events.

In addition, the CMHPSM ensures standardization of reporting requirements between CMHSPs and providers to allow the PIHP to easily aggregate the data.

During FY25, CMHPSM will continue to implement the data enhancements created by a CMHPSM regional workgroup in FY23 to improve the quality of the data, create guidance materials for staff completing data entry, and review opportunities for technical supports with data reporting that has been a manual process.

F. Behavioral Treatment Review

Structure

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

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

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| Behavior Treatment Committee Policy |
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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 their guardian may be used with members. Following CMHSP review, this data is submitted to the PIHP for aggregation and oversight and reported to the CPT Committee. 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 |

Each CMHSP monitors whether the intrusive or restrictive techniques were approved in accordance with the MDHHS Technical Requirement for Behavior Treatment Plans. To be implemented, the CMHSP ensures that written informed consent has been given by the person served or their guardian in the Person-Centered Planning process.

CMHSPs also report whether 3 or more emergency physical management techniques or emergency use of law enforcement interventions were used within a 30-day period. In these cases, the BTC reviews the individual’s case within 30 days for any potential modifications to the IPOS 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 Quality Manager. The CMHPSM Quality Manager works collaboratively with BTC Chairpersons to ensure analysis of this data and provide reports and recommendations for potential PI projects to the Regional CPT Committee.

Monitoring/Review

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

G. Clinical Practice Guidelines

Structure

The 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>

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|-------------------------------------|
| Clinical Practice Guidelines Policy |
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Reporting

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

Monitoring/Review

CMHPSM ensures the creation and application 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 CPT Committee maintains and reviews a list of 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 individuals served by our region.

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

H. St Utilization Management

Structure

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

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

- American Society of Addiction Medicine (ASAM) – for adults and adolescents with a substance use disorder.
- Child, Adolescent Functional Assessment Scale (CAFAS) – for the assessment of children 7 to 18 years of age with suspected serious emotional disturbance. MDHHS has indicated it will continue application of this assessment in FY25 until the MichiCANS has been fully implemented. Use of this assessment will remain in place pending further MDHHS guidance.
- 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. MDHHS has indicated it will continue application of this assessment in FY25 until the MichiCANS has been fully implemented. Use of this assessment will remain in place pending further MDHHS guidance.
- 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. MDHHS has indicated it will continue application of this assessment in FY25 until the MichiCANS has been fully implemented. Use of this assessment will remain in place pending further MDHHS guidance.

- Michigan Child and Adolescent Needs and Strengths Tool (MichiCANS) – for the assessment of mental health services for children birth to 20 years of age with suspected serious emotional disturbance. This assessment will be replacing the CAFAS, PECFAS, and DECA assessments when those assessments are sunset.
- 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 in the region 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.

CMHPSM conducts oversight and monitoring of the process used to review and approve the provision of medical services via the Regional Utilization Management (UM)/Utilization Review (UR) Committee. The purpose of the Regional UM/UR Committee is to ensure the most efficient and effective use of clinical care resources, to support the utilization management process, and to review specific service delivery patterns, including underutilization, overutilization, 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 for those individuals served with special health care needs and those with long-term supports and services.

Reporting

UM/UR-related data is entered into 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 Consumer Advisory Council for feedback and suggestions for interventions or improvements.

Monitoring/Review

The 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 FY25 review of the region's compliance with the parity program will include the use of the LOCUS and MichiCANS assessments as required by the state; therefore, monitoring of fidelity to these assessments will be incorporated into the parity program analysis. The CMHPSM includes CMHPSM utilization management and 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.

For FY25 CMHPSM will develop and implement utilization management procedures to comply with the CCBHC requirements of PIHP retrospective review of approved/rendered services to confirm that the care was medically necessary. This project will be completed in conjunction with Regional UM/UR Committee, and collaboration with the Statewide PIHP UM/UR Workgroup.

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 individuals 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 FY25, the UM/UR Committee will review both an overutilization and underutilization project. The overutilization project reviews inpatient recidivism as potential overutilization of a higher level of care.

The underutilization project consists of assessing HSW members not receiving monthly services that qualify them for HSW enrollment as potential underutilization, including potential risks of maintaining HSW enrollment with the ending of public health emergency and subsequent enrollment exceptions.

The UM/UR Committee will be available in FY25 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 will continue to conduct analysis on compliance with the program for all populations relevant to state parity requirements, as well as patterns and percentages of parity exceptions that may require modifications to the system.

The committee will include review of consumer/individual served and provider satisfaction in this analysis through grievances and appeals submitted by individuals served and provider appeals of claims denials to assist in evaluating the effectiveness of utilization management decisions.

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

I. Vulnerable Individuals

CMHPSM ensures the health and welfare of the region’s individuals served by establishing standards of care. CMHPSM defines vulnerable people as individuals who have functional limitations and/or chronic illnesses. Each CMHSP/SUS 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 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 software to identify adverse utilization patterns and to reduce health disparities, as well as 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 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 SUS 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 individuals served within the Home and Community Based Services Waiver and/or enrolled in (c) waivers to ensure health, safety, and welfare concerns are prevented or addressed in assessing and providing for their needs.

J. Long-Term Services and Supports (LTSS)

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

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|------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| LTSS | <p>whether consumer is identified to be in Long Term Services is satisfied if in the last three months, either:</p> <ul style="list-style-type: none"> * 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 * They were on the HAB CHILD, 1915i or SEDW waiver, according to the MEF or CRCT insurance tables. <p>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'</p> |
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|--|---------------------------------------------------------------------------------------------------------|
| | (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.

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.

K. Member Experience with Services

Annually at minimum, CMHPSM surveys individuals receiving services funded by CMHPSM and organizations providing services to individuals served using a standardized survey or assessment tool. The tools vary in accordance with service population needs and address quality, availability, and accessibility of care. CMHPSM conducts focus groups as needed to obtain input on specific issues. CMHSPs and/or SUS Providers may also query consumers regarding the degree of satisfaction with services 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, and appeals data.

The Regional Customer Service committee collects, analyzes, and reports on the aggregated results of the surveys and/or assessments to the CPT Committee, Regional Consumer Advisory Council, and other relevant committees/councils, who identify strengths and 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 CPT Committee, RCAC, and CMHPSM Board determine appropriate action for improvements. The findings are incorporated into program improvement action plans as appropriate. The CMHSPs/SUS providers act 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 SUS 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.

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

- All activities to assess member experience with services, such as all member satisfaction surveys, focus groups, member interviews, feedback from the Consumer Advisory 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 FY25, the CMHPSM will explore the use of surveys and other opportunities for the voice of individuals 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, PI projects, and corrective actions implemented, CMHPSM and CMHSP Boards, Consumer Advisory Councils, individuals served, and providers are informed of assessment results and any subsequent recommendations and interventions. The Board and

Regional Consumer Advisory Council are also requested to provide feedback and recommendations relevant to the assessment or future surveys.

Recovery Self-Assessment (RSA)

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

For this fiscal year CMHPSM will continue to distribute a revised version of 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)

During the previous year, the SUS Team held discussions with the Regional Data Analyst on ways to increase the usefulness of the data obtained by the survey. The revised version for FY25 includes use of a three-point Likert scale (instead of the five-point Likert scale used previously) to provide more variation in responses, and continuing to use “Not Applicable” and “Don’t Know” with comments as options.

The survey is distributed to Lenawee, Livingston, Monroe, and Washtenaw counties. The CMHPSM seeks to accurately assess and measure the effectiveness of Substance Use Service (SUS) and Community Mental Health (CMH) providers in the implementation of recovery-focused services from the perspective of clients, provider staff, and administrative staff. Current fiscal year data is analyzed to include year-to-year comparisons and long-term trends from at least the last five years.

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

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

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>

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| Organizational Credentialing/Rec credentialing and Monitoring Policy Credentialing for Licensed Independent Providers Policy |
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Employee Competency and Credentialing Policy

Reporting

NMC reports to ROC, including factors of procurement, performance, and capacity of the provider network, and provides performance improvement reporting to relevant committees such as the 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 the 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 are qualified to perform their jobs. This includes methodologies for monitoring both licensed healthcare professionals (who are licensed by the State and are employees of/under contract to CMHPSM) and non-licensed and external providers of care and support. CMHPSM reviews the CMHSPs documentation of internal/directly employed staff qualifications as well as evidence submitted through sub-contractual organizational provider monitoring to ensure compliance with provider qualifications.

Network Adequacy Plan

In accordance with the MDHHS PIHP contract and federal regulations 42 CFR §438.207, §438.68, and §438.206(c)(1), CMHPSM must provide documentation on which the State bases its certification that CMHPSM has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network as referenced in 42 CFR §438.604(a)(5); §438.606; §438.207(b) and §438.206(d). CMHPSM 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 the region for the provision of all covered services.
- Assurance that the provider network meets Home and Community Based Service Waiver requirements around choice and access for individuals 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.

- Consideration of anticipated enrollment and expected utilization of services.
- Timeliness of appointments, including MMBPIS and appointment standards for its SUS 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 makeup of its membership and the capability of its provider network to meet the needs of its members.
- Physical accessibility, including an analysis of provider types who can or cannot provide physical accessibility to members with disabilities.

B. Credentialing and Recredentialing

CMHPSM has established written policies and procedures, in accordance with the MDHHS 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 (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.

CMHPSM is responsible for credentialing, privileging, primary source verification, and qualification of staff who are employees of CMHPSM or under contract with the PIHP. CMHPSM delegates the tasks of credentialing, privileging, primary source verification, assessment of provider quality indicators, and assuring qualification of CMHSP/SUS Provider staff and their contractors to the CMHSP Participants/SUS Providers for Lenawee and Livingston Counties. CMHPSM maintains these tasks for Washtenaw and Monroe counties at this time.

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/SUS Provider verifies identity, applicable licensure, training, and other evidence of the ability to perform the assigned responsibilities.

CMHPSM monitors the CMHSPs and SUS 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 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/SUS 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. This analysis also includes collaboration with Regional CS and CPT Committees on whether there have been improvements and/or 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. These tools are used collaboratively within the 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 FY25, credentialing and recredentialing performance improvement projects will be conducted and reported to the Network Management Committee. The PIHP will continue to review samples of credentialing and recredentialing cases to ensure compliance with policy and state/federal requirements for organizational licensed/non-licensed staff, LIPs, and CMHSP licensed and non-licensed staff.

C. Verification of Services

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

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

- the proper code is used for billing;
- the code is approved under the contract;
- the eligibility of the beneficiary on the date of service;
- that the service provided is part of the beneficiaries individualized plan of service (and provided in the authorized amount, scope and duration);
- the service date and time;
- services were provided by a qualified individual and 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>

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| Service Verification Policy Services Suited to Condition Policy |
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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>

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| Culturally and Linguistically Relevant Services Policy Customer Services Policy |
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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.

E. Provider Monitoring

CMHPSM uses a standard written contract to define its relationship with CMHSPs/SUS 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/SUS 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, through either direct service provision or the management of a qualified and competent provider panel. Each CMHSP/SUS Provider is also contractually required to maintain written subcontracts with all organizations or practitioners on its provider panel.

SUS Providers must first obtain written authorization from CMHPSM to subcontract any portion of their agreement with CMHPSM. These subcontracts 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/SUS Provider is required to document annual monitoring of each provider subcontractor as required by the BBA and MDHHS. The monitoring structure includes 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 and provider performance protocols, maintaining common policies, and evaluating 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/SUS Providers that are unable to demonstrate acceptable performance may be required to provide corrective action plans, 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 the 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 SUS access services for FY25 will incorporate any barriers related to the findings of the previous year's monitoring and the FY22-25 PIP. Analysis of findings, corrective action plans (CAPs), and performance improvement projects to be developed based on findings and trends of monitoring data will continue into FY25.

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

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

VIII. Resources

CENTERS FOR MEDICARE AND MEDICAID 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.ihc.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx>

IX. CMHPSM Quality Assessment and Performance Improvement Program QAPIP Priorities and Workplan Priorities FY2025

The QAPIP priorities shall guide quality efforts for FY25. Figure 1 provides the QAPIP Priorities and Quality Work Plan for FY25. The 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 the individuals we serve. Figure 2 provides the FY25 QAPIP Performance Measures.

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

A. Figure 1. FY2025 QAPIP Priorities and Work Plan

| Governance | Objectives/Activities | Assigned Person or Committee/Council | Frequency/ Due Date |
|---------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|----------------------|
| CMHPSM Board of Directors will approve the QAPIP Plan and Report | Submit the annual QAPIP Plan to the Board. Submit the annual QAPIP Evaluation to the Board. | CMHPSM COO | 12/14/24 02/08/24 |
| Board of Directors reviews QAPIP Progress Reports | Submit QAPIP progress reports to the Board. | CMHPSM COO | Quarterly |
| CMHPSM QAPIP will be submitted to Michigan Department of Health and Human Services | Submit the Board approved QAPIP Plan, Report (Evaluation), and Governing Body Form to MDHHS (via MDHHS FTP Site). | CMHPSM Quality Manager | 2/28/25 |
| Communication of Process and Outcome Improvements | Objectives/Activities | Assigned Person or Committee/Council | Frequency/ Due Date |
| The QAPIP Plan and Report will be provided annually to network providers and to members upon request. | Post to the CMHPSM website. Ensure CMHSP contractors receive the QAPIP. Provide QAPIP Plan and Evaluation reporting at CMHPSM provider meetings. Communications to providers on the availability of QAPIP reports on the CMHPSM website. Communications to regional committees. Ensure Regional Customer Services Committee includes members ability to request QAPIP documents in informational materials | CMHPSM Quality Manager CMHPSM Network Management Committee Regional Customer Services Committee | 03/03/2025 |
| Consumers & Stakeholders receive reports on key performance indicators, consumer satisfaction survey results and performance improvement projects | To present reports on QAPIP activities and performance measures to RCAC on Consumer Services reports on persons experience, satisfaction survey results, grievances, appeals, PIPs, MMBPIS, event data, quality policies/procedures and Customer Service Reports to RCAC. | CMHPSM Quality Manager Regional Customer Services Committee | Quarterly |

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| | Incorporate RCAC feedback in interventions and recommendations related to survey data and QAPIP activities. Postings to the CMHPSM website. Ability to request information is in informational materials for consumers and stakeholders. | | Twice annually Twice annually |
| Performance Measurement and Quality reports are made available to stakeholders and general public. | Post to the CMHPSM website. Ensure CMHSP contractors receive the QAPIP and inform communities of its availability on the website. | CMHPSM COO Regional NMC Committee | Annually |
| MDHHS Performance Indicators | Objectives/Activities | Assigned Person or Committee/Council | Frequency/ Due Date |
| CMHPSM will meet or exceed the MMBPIS standards for Indicators 1, 2a, 2e, 3, 4, 10 as required by MDHHS. | Complete quality checks on data prior to submission to ensure validity and reliability of data | CMHSPs CPT leads | Quarterly |
| | Verify Medicaid eligibility prior to MMBPIS submission. Submit MMBPIS data to MDHHS quarterly by due date. | CMHPSM Regional Data Coordinator CMHPSM CIO | Quarterly |
| | Conduct quarterly analysis of CMHSP and CMHPSM provider MMBPIS performance. Require and review corrective action plans where standards were not met. Oversee effectiveness of corrective action plans through monthly review of subsequent data. | Regional CPT Committee CMHPSM Quality Manager | Monthly QAPIP data review Quarterly CAP review Q1 Feb Q2 May Q3 August Q4 November |
| CMHPSM will demonstrate an increase in compliance with access standards. | Monitor access requirements for priority populations, delineated by each priority population type. Establish a mechanism to monitor access requirements for persons enrolled in health homes (SUDHH, BHH, CCBHC). | Regional CPT Committee CMHPSM Quality Manager CMHPSM SUS Director | Monthly QAPIP data review Quarterly CAP review Q1 Feb Q2 May Q3 August Q4 November |

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| <p>CMHPSM will show an increase in compliance with access standards for SUS priority populations</p> | <p>Conduct quarterly analysis of CMHSP and SUS provider performance of access standards for priority populations. Data analysis to delineate performance by each priority population. Develop baseline measures and performance expectations specific to each priority population as well as overall access.</p> <p>Require and review corrective action plans where standards were not met. Oversee effectiveness of corrective action plans through monthly review of subsequent data.</p> <p>Incorporate SUS care navigator position to meet access timeliness standards for SUS priority populations.</p> | <p>Regional CPT Committee CMHPSM Quality Manager CMHPSM SUS Director</p> | <p>Monthly QAPIP data review Quarterly CAP review Q1 Feb Q2 May Q3 August Q4 November</p> |
| <p>CMHPSM will comply with the state FY25 activities and requirements in preparing for implementation of the MDHHS FY26-29 BH Quality Transformation</p> | <p>CMHPSM will have policies/procedures for ensuring internal data collection and monitoring that meets Behavioral Health Quality Transition standards.</p> <p>CMHPSM will participate in any collaboration activities or data validation as required by MDHHS.</p> <p>CMHPSM will develop a performance measure to improve accuracy and timeliness of encounter (SAL) submissions to that impact state measures of the FY26-29 MDDHS BH Quality Transformation Plan</p> | <p>Regional EOC Committee Regional CPT Committee</p> <p>Regional CPT Committee CMHPSM CIO CMHPSM Health Data Analyst CMHPSM Quality Manager</p> | <p>9/30/2025</p> |
| <p>BH-TEDS</p> | <p>Objectives/Activities</p> | <p>Assigned Person or Committee/Council</p> | <p>Frequency/ Due Date</p> |
| <p>CMHPSM will demonstrate an improvement or maintain data quality for the BH-TEDS Implement data driven outcomes measurement to address social determinants of health</p> | <p>Measurement period is prior fiscal year (FY2023) look back to most recent (FY2024) prior BH-TEDS update or admission record.</p> | <p>CMHPSM CIO Regional EOC Committee Regional CPT Committee</p> | <p>Narrative report to MDHHS by 7/31/2025</p> |
| | <p>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.</p> | <p>CMHPSM CIO</p> | <p>7/31/2025</p> |

| Performance Improvement Projects | Objectives/Activities | Assigned Person or Committee/Council | Frequency/ Due Date |
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| <p>CMHPSM will engage in two performance improvement projects for the FY22-25 PIP cycle:</p> <p>1. Reducing Racial Disparities Specific to No-Shows for the Initial Biopsychosocial Assessment (BPS) in Individuals Accessing CMH services.</p> <p>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.</p> | <p>Implement CMHPS specific interventions identified in causal barrier analysis in FY24.</p> | <p>Regional CPT Committee Regional EOC Committee CMHPSM Quality Manager CMHPSM CIO CMHPSM Health Data Analyst</p> | <p>Monthly</p> <p>Quarterly</p> |
| | <p>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.</p> | | <p>Regional CPT Committee CMHPSM Quality Manager</p> |
| | <p>Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations). Review with relevant committees/councils.</p> | <p>CMHPSM Quality Manager</p> | |
| | <p>Complete and submit PIP 1 to MDHHS as required.</p> | <p>CMHPSM Quality Manager</p> | <p>2/28/2025</p> |
| Quantitative and Qualitative Assessment of Member Experiences | Objectives/Activities | Assigned Person or Committee/Council | Frequency/ Due Date |
| <p>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</p> | <p>Develop surveys for all populations. Continue identification of persons receiving LTSS in survey data</p> | <p>Regional Customer Services Committee CMHPSM SUS Director</p> | <p>03/31/2025</p> |
| | <p>Continue to incorporate the analysis of Michigan specific National Core Indicator Data to identify trends and areas for improvement.</p> | <p>Regional Customer Services Committee CMHPSM Quality Manager</p> | <p>09/30/2025</p> |

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| systematic action steps and interventions, evaluating for 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 SUS Director | 09/30/2025 |
| | Conduct analysis of a potential new SUS community survey tool to replace the RSA. Continue RSA for FY25 if new survey undetermined. | CMHPSM SUS Director | 04/30/2025 |
| 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 Manager CMHPSM Quality Manager Regional Customer Services Committee | 12/31/2025 Monthly Quarterly Q1 February Q2 May Q3 August Q4 November |
| Event Monitoring and Reporting | Objectives/Activities | Assigned Person or Committee/Council | Frequency/ Due Date |
| CMHPSM will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths) are collected, monitored, reported, and followed up on as specified in the PIHP Contract. | Submit Critical Events monthly timely and accurately. | CMHSPs | Monthly |
| | Submit required events to the state CRM CIR system timely and accurately. Complete any required remediation/CIR risk analysis timely and accurately. | CMHPSM Quality Manager CMHPSM COO | Quarterly Q1 February Q2 May Q3 August Q4 November |
| | Conduct analysis of Behavior Treatment Committee data. | CMHPSM Quality Manager | Quarterly |
| | Ensure changes to Adverse Event Reporting requirements (i.e. incorporation of falls, 1915i data, etc.) are reflected in policy and reporting as required, timely and accurately. | CMHPSM COO CMHPSM Quality Manager | As needed |

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| | Submit CMH Sentinel Events (MDHHS MiCAL/CRM) (immediate notification) to CMHPSM based on notification requirements of the event. (24 hours, 48 hours, 5 days) | CMHSPs SUS Providers | As Needed |
| | Submit SUD Sentinel events (MDHHS MiCAL/CRM) (immediate notification) based on notification requirements of the event (24 hours) | CMHPSM SUS Providers (Residential, Recovery Housing) | As Needed |
| | Conduct oversight through Sentinel Event (SE) data review and provider monitoring to ensure appropriate follow up is occurring for all events dependent on the type and severity of the event, 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 Compliance Manager CMHPSM Quality Manager CMHPSM COO Regional CPT Committee | Quarterly Q1 February Q2 May 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 and sentinel events to monitor compliance with reporting, trends, and opportunities for performance improvements. | CMHPSM Compliance Manager CMHPSM Quality Manager CMHPSM COO Regional CPT Committee | Quarterly Q1 February Q2 May Q3 August Q4 November |
| Medicaid Services Verification | Objectives/Activities | Assigned Person or Committee/Council | Frequency/ Due Date |
| CMHPSM will meet or exceed a 95% rate of compliance for Medicaid delivered services in accordance with MDHHS requirements. | Complete Medicaid Event verification reviews in accordance with CMHPSM policy and procedure. | CMHPSM COO CMHPSM CFO | 12/31/2025 |
| | Complete the MEV Annual Methodology Report identifying trends, patterns, strengths and opportunities for improvement. | CMHPSM COO | 12/31/2025 |
| | Submit the Annual MEV Methodology Report to MDHHS as required | CMHPSM COO | 12/31/2025 |
| Utilization Management Plan | Objectives/Activities | Assigned Person or Committee/Council | Frequency/ Due Date |
| CMHPSM will establish a Utilization Management Plan in accordance with the MDHHS requirements | Complete performance summary quarterly reviewing trends, patterns of under-/over-utilization, medical necessity criteria, and the process used to review and approve provision of medical services. Identify CMHSPs/SUSPs requiring improvement and present/provide to relevant committees/ councils. | Regional UM/UR Committee | Quarterly Q1 February Q2 May Q3 August Q4 November |

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| | Ensure utilization of parity screening tools and admission criteria. LOCUS, CAFAS, PECFAS, DECA, MichiCANS, MCG, ASAM. | Regional UM/UR Committee Regional CPT Committee | Quarterly (parity) |
| | Complete analysis of parity program compliance with LOC and LOC exceptions. | Regional UM/UR Committee | Quarterly |
| 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 |
| | Analysis of ABD data reports in meeting service decision timeframes. | | |
| 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 | 03/30/2025 |
| | 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 |
| 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 Manager CMHPSM Quality Manager Regional UM/UR Committee | Quarterly |
| Practice Guidelines | Objectives/Activities | Assigned Person or Committee/Council | Frequency/ Due Date |
| CMHPSM will adopt, develop, implement nationally accepted or | 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 |

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| mutually agreed upon (CMHPSM/MDHHS) clinical practice guidelines/standards (CPGs), evidenced based practices, best practice, and promising practices relevant to the individual served. | | | CPGs are adopted |
| | Update CPG list, including providers that implement/offer CPGs. | CMHPSM COO | Bi-annually |
| | Communicate available CPGs to provider networks | Regional NMC Committee | March 2025 December 2025 |
| 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 Manager | Annually |
| Oversight of Vulnerable Individuals and Long Term Supports and Services | Objectives/Activities | Assigned Person or Committee/Council | Frequency/ Due Date |
| CMHPSM will evaluate health, safety and welfare of persons served considered vulnerable and receiving LTSS order to determine opportunities for improving oversight of their care and their outcomes. | Ensure the identification of LTSS remains in all regional quality/health and safety data reporting including events data, behavior treatment data, survey data of persons experience, performance measures. Ensure LTSS populations served are incorporated in measures of provider monitoring, service authorization, and reviews of outcomes data. | CMHPSM COO CMHPSM Health Data Analyst Regional CPT Committee | Quarterly data review Q1 February Q2 May Q3 August Q4 November |
| CMHPSM will 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. Measure: 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. Conduct data analysis of completion and accuracy in incorporating state requirements relevant to HCBS documentation standards in the use of limitations/restrictive means in Person-Centered Planning and IPOS development, including developing a baseline measure during FY25 by which future improvement standards will be measured. | CMHPSM COO CMHPSM Health Data Analyst Regional CPT Committee CMHPSM Quality Manager | Report analysis Quarterly Q1 February Q2 May Q3 August Q4 November |

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| | 90% compliance with clinical documentation of those persons qualified for HCBS/1915i identified in the EHR. | | |
| 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 | Continue 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. Continue to incorporate PIHP monitoring of LTSS for CMHs. | CMHPSM COO CMHPSM Compliance Manager CMHPSM Quality Manager Regional CPT Committee Regional CS Committee Regional NMC Committee | Quarterly Q1 February Q2 May Q3 August Q4 November |
| Behavior Treatment | Objectives/Activities | Assigned Person or Committee/Council | Frequency/ Due Date |
| 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 Quality Manager | Quarterly February May August November |
| | Complete Behavior Treatment performance reports that analyze the use of emergency interventions, plans approved with restrictive and/or intrusive interventions, and adherence to the BTPR Standards (including barriers, improvement efforts, recommendations, and status of recommendations). | CMHPSM Quality Manager Regional CPT Committee | Annual QAPIP Plan 2/28/25 FY24 QAPIP Evaluation 2/28/26 Quarterly February May August November |
| | CMHPSM will explore system abilities to report BTC data electronically more efficiently while maintaining security/privacy and reporting standards. | CMHPSM Quality Manager Regional CPT Committee | FY25 Annual Report 2/28/25 Quarterly February May August November |

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| | 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 Quality Manager | Quarterly March May August November |
| Provider Monitoring | Objectives/Activities | Assigned Person or Committee/Council | Frequency/ Due Date |
| CMHPSM will be in compliance with PIHP Contract Requirements. | Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUSP. Coordinate quality improvement plan development, incorporating goals and objectives for specific growth areas based on the site reviews, and submission of evidence for the follow up reviews. | Regional NMC Committee CMHPSM COO CMHPSM SUS Director | Annual |
| CMHPSM will demonstrate an increase in compliance with the External Quality Review (EQR)-Compliance Review | Implement corrective action plans for areas that were not in full compliance, and quality improvement plans for recommendations. See CAP for specific action steps. Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUSP. | CMHPSM COO CMHPSM Compliance Manager Regional Compliance Committee | Monthly Quarterly |
| CMHPSM will demonstrate full compliance with the EQR-Performance Measure Validation Review | Implement quality improvement plans for recommendations provided by the external quality review team. Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUSP. | CMHPSM CIO CMHPSM COO CMHPSM Quality Manager Regional CPT Committee Regional EOC Committee | 9/30/2025 |
| 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 Quality Manager Regional CPT Committee Regional EOC Committee | 9/30/2025 |

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| 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. Meet the contract timeframe requirements for corrective action plan (CAP) submissions. | CMHPSM COO CMHPSM Compliance Manager | 09/30/25 |
| CMHPSM will demonstrate full compliance with the MDHHS Substance Use Disorder Protocols | Provide evidence to support SUS requirements | CMHPSM COO CMHPSM SUS Director | 09/30/25 |
| CMHPSM will demonstrate assurances of adequate capacity and services for the region, in accordance with the MDHHS Network Adequacy standards. | Submit Network Adequacy Report to MDHHS Complete Network Adequacy Assessment including all required elements. Comply with any state Network Adequacy and Reporting requirements. | CMHPSM COO Regional NMC Committee | 02/28/25 09/30/25 |
| Provider Qualifications | Objectives/Activities | Assigned Person or Committee/Council | Frequency/ Due Date |
| CMHPSM will ensure physicians, other healthcare providers, and non-licensed individuals are qualified to perform their jobs. | CMHPSM will conduct quarterly monitoring of compliance with Organizational credentialing and recredentialing requirements, providing retraining and procedures revisions as needed Data reports of progress will be included in the QAPIP report to the Regional CPT Committee and the CMHPSM governance bodies. | CMHPSM COO Regional NMC Committee | Quarterly |
| CMHPSM will have credentialing policies/ procedures, in accordance with MDHHS Credentialing and Recredentialing 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 recredentialing 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 |

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| <p>CMHPSM ensures all delegates performing credentialing functions comply with all initial (including provisional/temporary) credentialing requirements according to initial credentialing and recredentialing monitoring tools for organizations and LIPs</p> <p>Clinical service providers are credentialed by the CMHSP prior to providing services and ongoing.</p> | <p>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 recredentialing records.</p> <p>Review semi-annual credentialing and recredentialing report to ensure credentialing within the appropriate timeframes.</p> <p>CMHPSM will conduct quarterly monitoring of compliance with credentialing and recredentialing requirements for directly hired CMHSP staff as delegated to the CMHSPs, providing retraining and procedures revisions as needed</p> | <p>CMHPSM COO Regional NMC Committee</p> | <p>Annually</p> |
| <p>Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements.</p> | <p>CMHPSM Oversight and monitoring during CMHSP and SUS Provider reviews of delegated functions.</p> | <p>CMHPSM COO Regional NMC Committee</p> | <p>Semi Annually May 2025 November 2025</p> |
| <p>Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements.</p> | <p>CMHPSM Oversight and monitoring during CMHSP and SUS Provider reviews of delegated functions.</p> | <p>CMHPSM COO Regional NMC Committee</p> | <p>Quarterly reporting</p> |
| <p>Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements.</p> | <p>CMHPSM Oversight and monitoring during CMHSP and SUS Provider reviews of delegated functions.</p> | <p>CMHPSM COO CMHPSM SUS Director Regional NMC Committee</p> | <p>Annually</p> |
| <p>Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements.</p> | <p>CMHPSM Oversight and monitoring during CMHSP and SUS Provider reviews of delegated functions.</p> | <p>CMHPSM COO CMHPSM SUS Director Regional NMC Committee</p> | <p>Annually</p> |

B. Figure 2. FY25 Performance Measures

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

*MDHHS 2023-2026 Continuous Quality Strategy (CQS) Goals:

Goal #1: Ensure high quality and high levels of access to care.

Goal #2: Strengthen person and family-centered approaches.

Goal #3: Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external).

Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes.

Goal #5: Improve quality outcomes through value-based initiatives and payment reform.

| *Continuous Quality Strategy Goal(s) | Michigan Mission Based Performance Indicator System | Committee/Council | FY2024 Performance | FY25 QAPIP Page(s) |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|----------------------------------------|--------------------|
| 1 | CMHPSM will meet or exceed the standard for Indicator 1: Percentage of Children who receive a Prescreen within 3 hours of request (Standard is 95% or above) | Regional CPT Regional EOC | Q4 pending state report, Met in Q3 | 24 |
| 1 | CMHPSM will meet or exceed the standard for Indicator 1: Percentage of Adults who receive a Prescreen within 3 hours of request (Standard is 95% or above) | Regional CPT Regional EOC | Q4 pending state report, Met in Q3 | 24 |
| 1 | CMHPSM will meet or exceed the standard for Indicator 2a: The percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (reported by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children.) Performance measured by total % of all populations (total numerator/denominator) CMHPSM FY22 Baseline = 61.3% = 50TH – 75TH Percentile FY25 Performance Measure: reach or exceed the 75th Percentile (62%) MDHHS Indicator 2 Percentile %s 50th = 57.0% 75th = 62.0% | Regional CPT Regional EOC | Q4 pending state report, Not Met in Q3 | 24 |
| 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 FY25 Performance Measure: reach or exceed the 50TH Percentile (68.2%) MDHHS Indicator 2e Percentile %s 50th = 68.2% | Regional CPT Regional EOC | Q4 pending state report, Not Met in Q3 | 24 |

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| | 75th = 75.3% | | | |
| 1 | <p>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 FY25 Performance Measure: reach or exceed the 75TH Percentile (83.8%) MDHHS Indicator 3 Percentiles %s 50th = 72.9% 75th = 83.8%</p> | <p>Regional CPT Regional EOC</p> | <p>Q4 pending state report, Not Met in Q3</p> | 24 |
| 1, 3 | <p>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)</p> | <p>Regional CPT Regional EOC</p> | <p>Q4 pending state report, Met in Q3</p> | 24 |
| 1, 3 | <p>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)</p> | <p>Regional CPT Regional EOC</p> | <p>Q4 pending state report, Met in Q3</p> | 24 |
| 1, 3 | <p>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)</p> | <p>Regional CPT Regional EOC</p> | <p>Q4 pending state report, Met in Q3</p> | 24 |
| 1, 3 | <p>CMHPSM will meet or exceed the standard for Indicator 10: Re-admission to Psychiatric Unit within 30 Days (Standard is 15% or less) (Child)</p> | <p>Regional CPT Regional EOC</p> | <p>Q4 pending state report, Met in Q3</p> | 24 |
| 1, 3 | <p>CMHPSM will meet or exceed the standard for Indicator 10: Re-admission to Psychiatric Unit within 30 Days (Standard is 15% or less) (Adult)</p> | <p>Regional CPT Regional EOC</p> | <p>Q4 pending state report, Not Met in Q3 (15.22%)</p> | 24 |
| 1, 3 | <p>CMHPSM will demonstrate and increase in compliance with access standards for the SUD priority populations. (Compared to FY24 Data)</p> | <p>Regional CPT Regional EOC</p> | <p>Met</p> | 43 |
| Continuous Quality Strategy Goal(s) | 2026-2029 Behavioral Health Quality Transformation Metrics | Committee | FY2024 Performance | FY25 QAPI Page(s) |
| 3 | <p>CMHPSM will develop a performance measure to improve accuracy and timeliness of encounter (SAL) submissions to that impact state measures of the FY26-29 MDDHS BH Quality Transformation Plan</p> | <p>Regional EOC Regional CPT Regional UM/UR</p> | <p>New FY25 standard</p> | 25-26 |

| Continuous Quality Strategy Goal(s) | BH TEDS Data | Committee | FY2024 Performance | FY25 QAPIP Page(s) |
|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------|---------------------------|
| 2, 3 | Maintain overall BHTEDS completion rates to state 95% standard during FY2025. Improve crisis encounter BHTEDs completion to 95% during FY2025. | Regional EOC Regional CPT | Met per report 9/24 | 26 |
| Continuous Quality Strategy Goal(s) | Performance Improvement Projects | Committee | FY2024 Performance | FY25 QAPIP Page(s) |
| 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. (FY22 Baseline) | Regional EOC Regional CPT | Not met | 28-29 |
| 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 | 28-29 |
| Continuous Quality Strategy Goal(s) | Assessment of Member Experiences | Committee | FY2024 Performance | FY25 QAPIP Page(s) |
| 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 a plan for improvement in areas that fell below the 85% threshold. | Regional Customer Services (CS) Committee | Pending FY24 data report, Met in FY23 Met | 39-40 |
| 1, 2, 3 | Analyze and determine a baseline percentage of individuals in specialized residential and vocational settings who have completed HCBS Surveys in the IPOS Preplan | Regional CPT Committee | New FY25 Measure | 39-40 |
| 1, 2, 3 | Percentage of consumers indicating satisfaction with substance use services. (Standard 85% OR 2.5 Likert score) | Regional Co-Occurring Workgroup | Met (Average 2.5 Likert scale and above in all RSA areas) | 40-41 |

| Continuous Quality Strategy Goal(s) | Member Appeals and Grievance Performance Summary | Committee | FY2024 Performance | FY25 QAPI Page(s) |
|-------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------|-------------------|
| 1, 2, 3 | <p>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%)</p> <p>An improvement from FY2024 in the percentage of appeals cases that meet documentation requirements in the EHR: 85% of appeals will have all required fields and attached documents completed (no fields missing) (FY24 Audit Baseline: 70%) 50% of appeals will meet all narrative content requirements (Documentation Note, Procedures, Resolution/Disposition) accurately and completely (FY24 Audit Baseline: 33%).</p> | <p>Regional UM/UR Committee</p> <p>Regional CPT Committee</p> | <p>Met at 100%</p> <p>New FY25 Baseline</p> | 34-36 |
| 1, 2, 3 | <p>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%)</p> <p>An improvement from FY2024 in the percentage of grievance cases that meet documentation requirements in the EHR: 95% of grievances will have all required fields and attached documents completed (no fields missing) (FY24 Audit Baseline: 78%) 85% of appeals will meet all narrative content requirements (Grievance Issue, Steps Taken Note, Resolution/Disposition) accurately and completely (FY24 Audit Baseline: 70%).</p> | <p>Regional CS Committee</p> <p>Regional CPT Committee</p> | <p>Met at 100%</p> <p>New FY25 Baseline</p> | 39-40 |
| Continuous Quality Strategy Goal(s) | Adverse Event Monitoring and Reporting | Committee | FY2024 Performance | FY25 QAPI Page(s) |
| 3, 5 | 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 | Q4 Pending, Q3 met | 29-32 |
| 3, 5 | The rate, per 1000 persons served, of Non-Suicide Death will demonstrate a decrease from previous year. (CMHSP) (Natural Cause, Accidental, Homicidal) | Regional CPT Committee | Q4 pending, Q3 not met | 29-32 |

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|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------|---------------------------|
| | Ensure compliance with timely and accurate reporting of critical and sentinel events (100%) 100% CEs reporting 100% timely reporting | Regional EOC Committee | Q4 pending; Q3 not met | |
| 3, 5 | Quarterly report and analysis of type, trends over time (including mortality), events per 1,000, regional trends over time for the fiscal year, analysis of trends by service, engagement in treatment, precipitating events. Analysis of CE trends for potential PI projects | Regional CPT Committee Regional EOC Committee | Q4 pending, Q3 met | 29-32 |
| 3, 5 | The rate, per 1000 persons served, of Sentinel Events will demonstrate a decrease from the previous year. | Regional CPT Committee Regional EOC Committee | Q4 pending, Q3 no SE | 29-32 |
| 3, 5 | 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 | Pending Q4, Q3 met | 29-32 |
| Continuous Quality Strategy Goal(s) | Joint Metrics | Committee | FY2024 Performance | FY25 QAPIP Page(s) |
| 3, 4, 5 | Collaboration meeting completed between entities for the ongoing coordination and integration of services. (100%) The percentage of complete care plans in CC360 for care coordination cases with MHPs (Standard - 25%) | Regional EOC Committee Regional CPT Committee | 100% New FY25 Baseline | 27-28 |
| 3, 4, 5 | 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 2024. | Regional EOC Committee Regional CPT Committee | 64% -above Statewide standard (most recent state data 3/31/24) | 27-28 |
| 3, 4, 5 | 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 | Regional EOC Committee | 83% -above Statewide standard | 27-28 |

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| | outpatient encounter or partial hospitalization with mental health practitioner within 30 Days. FUH Report, Follow-Up After Hospitalization Mental Illness Child (Standard-79%) Measurement period will be calendar year 2024. | Regional CPT Committee | (most recent state data 3/31/24) | |
| 3, 4, 5 | Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days Racial/ethnic group disparities will be reduced for beneficiaries six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days. CMHPSM will reduce the racial/ethnic disparity between the index population and at least one minority group. (Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences) Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2023 with calendar year 2024. | Regional EOC Committee Regional CPT Committee | Adult – Disparity decreased – American Indian/Alaskan Native population Child – No change in disparity (most recent state data 3/31/24) | 27-28 |
| 3, 4, 5 | 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 2023 with calendar year 2024 | Regional EOC Committee Regional CPT Committee | 36% - above statewide standard No change in disparity (most recent state data 3/31/24) | 27-28 |
| Continuous Quality Strategy Goal(s) | PIHP Performance Based Incentive Payments | Committee | FY2024 Performance | FY25 QAPIP Page(s) |
| 1, 3, 4, 5 | 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 | Regional EOC Committee Regional CPT Committee | Met | 26-27 |

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| | back to most recent prior update or admission record. Submit completed report to state. | | | |
| 1, 3, 4, 5 | 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 be measured against a minimum standard of 62%, covering the measurement period of calendar year 2024. | Regional EOC Committee Regional CPT Committee | Met | 26-27 |
| 1, 3, 4, 5 | 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) CMHPSM will be measured against a minimum standard of 40% at initiation for the measurement period of calendar year 2024. Data will be stratified and provided by the State by race/ethnicity | Regional EOC Committee Regional CPT Committee | No change in disparity (most recent state data 3/31/24) | 26-27 |
| 1, 3, 4, 5 | 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) CMHPSM will be measured against a minimum standard of 14% at engagement for the measurement period of calendar year 2024. Data will be stratified and provided by the State by race/ethnicity | Regional EOC Committee Regional CPT Committee | Disparity decreased – Asian American population (most recent state data 3/31/24) | 26-27 |
| 1, 3, 4, 5 | CMHPSM will increase participation in patient-centered medical homes/health homes. (narrative report) | Regional CPT Committee | Met | 26-27 |
| 1, 3, 4, 5 | 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 2023 with calendar year 2024 | Regional EOC Committee Regional CPT Committee | 36% - above statewide standard No change in disparity (most recent state data 3/31/24) | 26-27 |
| Continuous Quality | Priority Measures Clinical SUD | Committee | FY2024 Performance | FY25 QAPI Page(s) |

| Strategy Goal(s) | | | | |
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| 1, 3, 4, 5 | <p>CMHPSM SUD providers will meet ASAM Continuum completion rates (Target 75%)</p> <p>CMHPSM SUD providers will improve meeting priority population timelines (Target 75%)</p> <p>CMHPSM SUD provider will show a decrease in expired SUD wrappers without service . (20%) (Indicator 2e)</p> <p>CMHPSM SUD providers will ensure consumers who have not received services within 60 days have their SUD discharge completed (Target 70%).</p> <p>Monthly data reviews and quarterly data analysis reporting. (Target 95%)</p> | Regional CPT Committee | <p>72% (not met)</p> <p>Screening: 85.5% (met)</p> <p>Admission: 48.6% (not met)</p> <p>Q4 data pending</p> <p>New metric FY25</p> <p>Met</p> | 43 |
| Continuous Quality Strategy Goal(s) | Utilization Management/LTSS | Committee | FY2024 Performance | FY25 QAPIP Page(s) |
| 2, 3 | <p>Correct timeframes used for advance action notice (Target 100%)</p> <p>Accurate use of reduction, suspension, or termination decisions. (Target 100%)</p> <p>ABDs provide service denial reasons in language understandable to person served.</p> <p>Analyze type of denial, accuracy of service and denial decision explanation, and compliance with timeframes.</p> | Regional UM/UR Committee | <p>Q4 Pending, last Q3 review Met</p> <p>Not Met</p> <p>Met</p> | 34-36 |
| 2, 3, 5 | <p>Assess overutilization of services: Review of inpatient recidivism as potential overutilization of higher level of care, using following factors:</p> <ul style="list-style-type: none"> • 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 | 34-36 |
| | <p>Underutilization project: Assess HSW members not receiving monthly services that qualify them for HSW enrollment as potential underutilization, including potential</p> | Regional UM/UR Committee | Q4 Pending, last Q1-Q2 review | 34-36 |

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| | <p>risks of maintaining HSW enrollment with the ending of public health emergency and subsequent enrollment exceptions. Including following factors:</p> <ul style="list-style-type: none"> • 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 | | Met, no conclusive | |
| 2, 3, 5 | <p>Evidence of use of parity program for those with established LOC in CMHPSM reviews of CMHSPs clinical records for all populations (Standard 90%). Ensure MichiCANS assessment is incorporated in parity program. Review utilization management data, service decision data, and override trends related to MichiCANS at 6-month and 1-year intervals for FY25 implementation, in order to develop parity parameters specific to MichiCANS in FY26. 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.</p> | <p>Regional UM/UR Committee Regional Children’s Administrative Workgroup</p> | <p>FY23: 64% (not met) N/A New measure for FY25 Not Met</p> | 34-36 |
| 2, 3, 5 | <p>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</p> | Regional UM/UR Committee | Met | 34-36 |
| 1, 2, 3, 5 | <p>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</p> | Regional UM/UR Committee | <p>Pending Q4 data Q1-Q2 was 91% IRR Met</p> | 34-36 |
| Continuous Quality Strategy Goal(s) | Behavior Treatment | Committee | FY2024 Performance | FY25 QAPIP Page(s) |
| 5 | <p>Consistent quarterly reporting of BTC data (100%) Consistent data analysis of BTC data (100%)</p> | Regional CPT Committee | Met Met | 32-33 |
| 3, 5 | <p>The percentage of individuals who have an approved Behavior Treatment Plan which includes restrictive and intrusive techniques.</p> | Regional CPT Committee | Q4 pending; Q3 Met | 32-33 |
| Continuous Quality Strategy Goal(s) | Clinical Practice Guidelines | Committee | FY2024 Performance | FY25 QAPIP Page(s) |

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| 3, 5 | CPGs reviewed at least bi-annually. | Regional CPT Committee | Met | 33-34 |
| 3, 5 | CPGs published to both provider network and members. | Regional CS Committee Regional NMC Committee | Met | 33-34 |
| Continuous Quality Strategy Goal(s) | Provider Monitoring | Committee | FY2024 Performance | FY25 QAPIP Page(s) |
| 1, 5 | Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements. | Regional NMC Committee | Met | 46-47 |
| 1, 5 | Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements. | Regional NMC Committee | Met | 46-47 |
| 1, 5 | Credentialing and recredentialing of organizational providers meet all state/federal requirements and timelines. | Regional NMC Committee | Met | 46-47 |
| 1, 5 | Credentialing and recredentialing of LIP providers meet all state/federal requirements and timelines. | Regional LIP Committee | Met | 46-47 |
| 1, 5 | 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 | SUS 100% CMHSP 50% complete – MDHHS Review incorporated in reviews | 46-47 |
| 1, 3, 5 | 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 | 46-47 |
| Continuous Quality Strategy Goal(s) | Health Home (SUD HH, BHH, CCBHC) Performance Measures | Committee | FY2024 Performance | FY25 QAPIP Page(s) |
| 1, 2, 3, 4, 5 | Meet or exceed SUD HH performance benchmarks. | CMHPM SUS Team | Met for OHH in FY24 | 27 |
| 1, 2, 3, 4, 5 | Meet or exceed BHH performance benchmarks. | Regional BHH Workgroup | Met | 27 |

Attachment #4 – December 2024

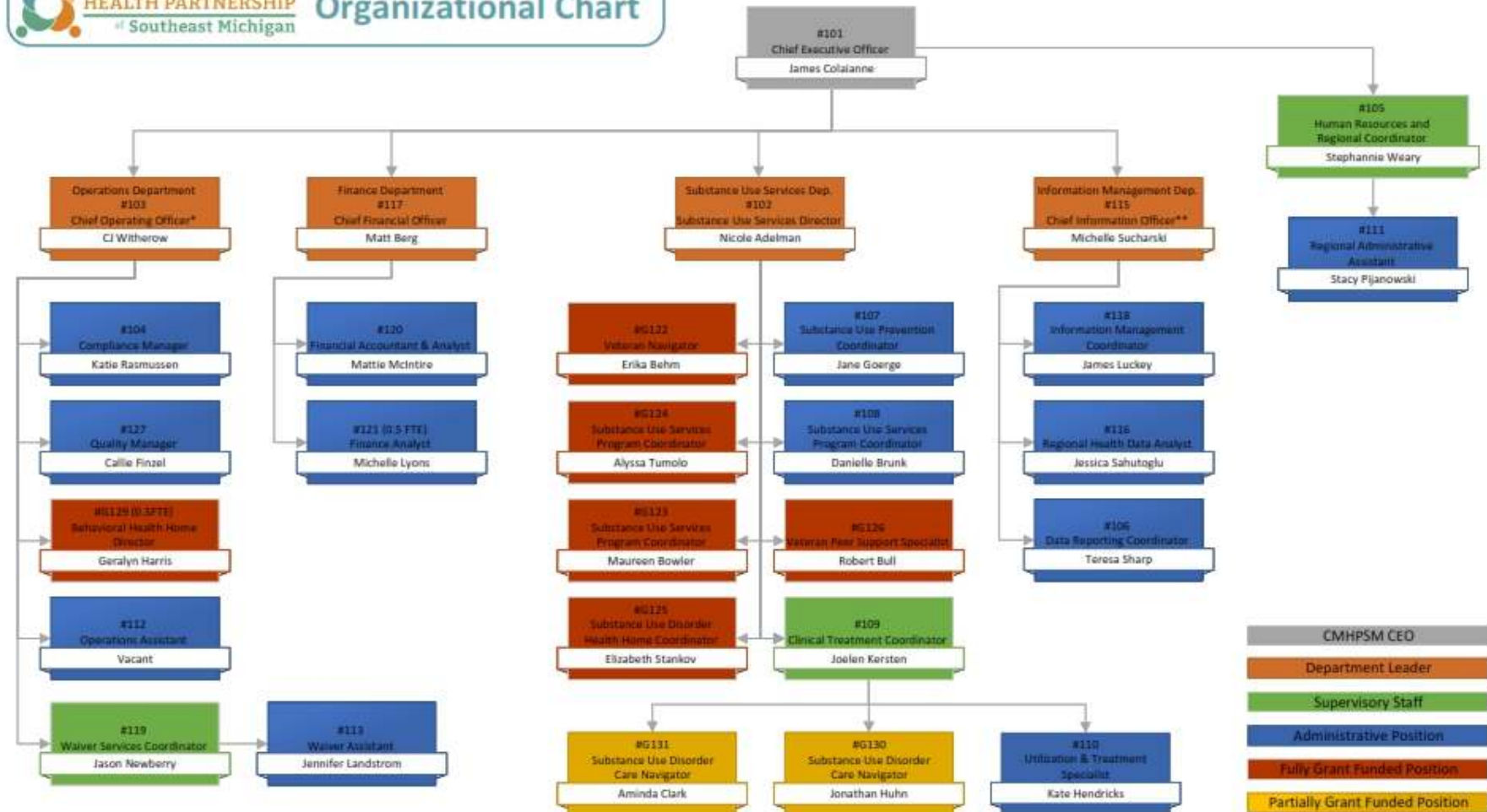
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| 1, 2, 3, 4, 5 | <p>Meet or exceed federally defined QBP measures and benchmarks for CCBHCs.</p> <p>CMHPSM to develop and implement utilization management procedures to comply with the CCBHC requirements of PIHP retrospective review of approved/rendered services to confirm that the care was medically necessary.</p> | <p>Regional CCBHC Workgroup, CMHPSM COO, Regional UM/UR Committee</p> | <p>Met</p> | <p>27</p> <p>36</p> |
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X. Attachments

A. Attachment A: CMHPSM Organizational Structure



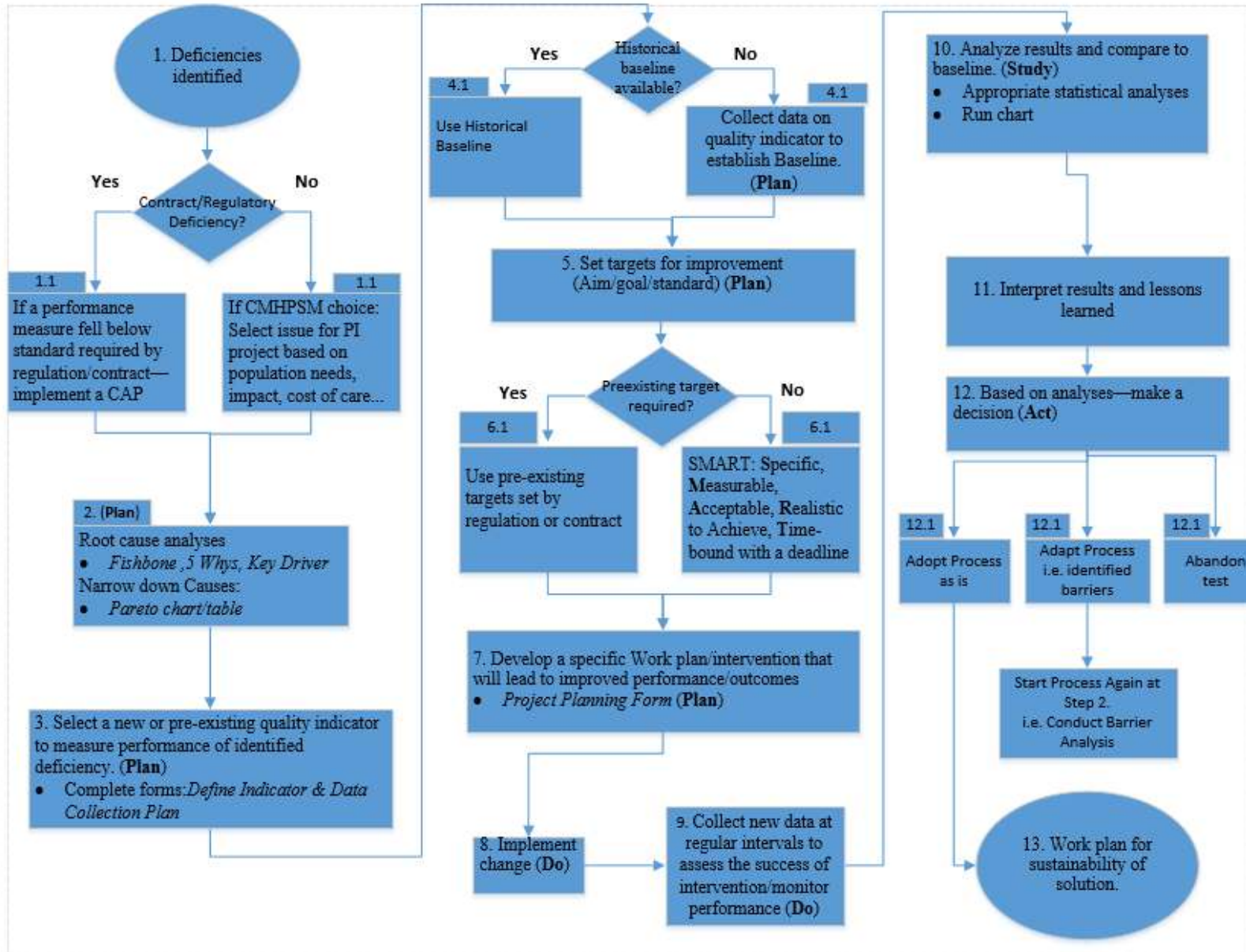
Updated: 11/4/2024



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

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

B. Attachment B: Performance Improvement Framework





**Annual Quality Assessment and Performance Improvement Program (QAPIP) Plan for FY2025
Summary of New or Revised Workplan Priorities and Performance Measures**

Figure 1. FY2025 QAPIP Priorities and Work Plan

| Communication of Process and Outcome Improvements | Objectives/Activities | Assigned Person or Committee/Council | Frequency/ Due Date |
|---------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------------|
| Consumers & Stakeholders receive reports on key performance indicators, consumer satisfaction survey results and performance improvement projects | To present reports on QAPIP activities and performance measures to RCAC on Consumer Services reports on persons experience, satisfaction survey results, grievances, appeals, PIPs, MMBPIS, event data, quality policies/procedures and Customer Service Reports to RCAC. Incorporate RCAC feedback in interventions and recommendations related to survey data and QAPIP activities. Postings to the CMHPSM website. Ability to request information is in informational materials for consumers and stakeholders. | CMHPSM Quality Manager Regional Customer Services Committee | Quarterly Twice annually Twice annually |
| MDHHS Performance Indicators | Objectives/Activities | Assigned Person or Committee/Council | Frequency/ Due Date |
| CMHPSM will meet or exceed the MMBPIS standards for Indicators 1, 2a, 2e, 3, 4, 10 as required by MDHHS. | Complete quality checks on data prior to submission to ensure validity and reliability of data | CMHSPs CPT leads | Quarterly |
| | Verify Medicaid eligibility prior to MMBPIS submission. Submit MMBPIS data to MDHHS quarterly by due date. | CMHPSM Regional Data Coordinator CMHPSM CIO | Quarterly |
| | Conduct quarterly analysis of CMHSP and CMHPSM provider MMBPIS performance. Require and review corrective action plans where standards were not met. Oversee effectiveness of corrective action plans through monthly review of subsequent data. | Regional CPT Committee CMHPSM Quality Manager | Monthly QAPIP data review Quarterly CAP review Q1 Feb |

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| | | | Q2 May Q3 August Q4 November |
| CMHPSM will comply with the state FY25 activities and requirements in preparing for implementation of the MDHHS FY26-29 BH Quality Transformation | <p>CMHPSM will have policies/procedures for ensuring internal data collection and monitoring that meets Behavioral Health Quality Transition standards.</p> <p>CMHPSM will participate in any collaboration activities or data validation as required by MDHHS.</p> <p>CMHPSM will develop a performance measure to improve accuracy and timeliness of encounter (SAL) submissions to that impact state measures of the FY26-29 MDDHS BH Quality Transformation Plan</p> | <p>Regional EOC Committee Regional CPT Committee</p> <p>Regional CPT Committee CMHPSM CIO CMHPSM Health Data Analyst CMHPSM Quality Manager</p> | 9/30/2025 |
| Event Monitoring and Reporting | Objectives/Activities | Assigned Person or Committee/Council | Frequency/ Due Date |
| CMHPSM will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths) are collected, monitored, reported, and followed up on as specified in the PIHP Contract. | Submit Critical Events monthly timely and accurately. | CMHSPs | Monthly |
| | Submit required events to the state CRM CIR system timely and accurately. Complete any required remediation/CIR risk analysis timely and accurately. | CMHPSM Quality Manager CMHPSM COO | Quarterly Q1 February Q2 May Q3 August Q4 November |
| | Conduct analysis of Behavior Treatment Committee data. | CMHPSM Quality Manager | Quarterly |
| | Ensure changes to Adverse Event Reporting requirements (i.e. incorporation of falls, 1915i data, etc.) are reflected in policy and reporting as required, timely and accurately. | CMHPSM COO CMHPSM Quality Manager | As needed |
| | Submit CMH Sentinel Events (MDHHS MiCAL/CRM) (immediate notification) to CMHPSM based on notification requirements of the event. (24 hours, 48 hours, 5 days) | CMHSPs SUS Providers | As Needed |

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| | Submit SUD Sentinel events (MDHHS MiCAL/CRM) (immediate notification) based on notification requirements of the event (24 hours) | CMHPSM SUS Providers (Residential, Recovery Housing) | As Needed |
| | Conduct oversight through Sentinel Event (SE) data review and provider monitoring to ensure appropriate follow up is occurring for all events dependent on the type and severity of the event, 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 Compliance Manager CMHPSM Quality Manager CMHPSM COO Regional CPT Committee | Quarterly Q1 February Q2 May Q3 August Q4 November |
| Utilization Management Plan | Objectives/Activities | Assigned Person or Committee/Council | Frequency/ Due Date |
| CMHPSM will establish a Utilization Management Plan in accordance with the MDHHS requirements | Complete performance summary quarterly reviewing trends, patterns of under-/over-utilization, medical necessity criteria, and the process used to review and approve provision of medical services. Identify CMHSPs/SUSPs requiring improvement and present/provide to relevant committees/ councils. | Regional UM/UR Committee | Quarterly Q1 February Q2 May Q3 August Q4 November |
| | Ensure utilization of parity screening tools and admission criteria. LOCUS, CAFAS, PECFAS, DECA, MichiCANS, MCG, ASAM. | Regional UM/UR Committee Regional CPT Committee | Quarterly (parity) |
| | Complete analysis of parity program compliance with LOC and LOC exceptions. | Regional UM/UR Committee | Quarterly |
| Behavior Treatment | Objectives/Activities | Assigned Person or Committee/Council | Frequency/ Due Date |
| 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 Quality Manager | Quarterly February May August November |
| | Complete Behavior Treatment performance reports that analyze the use of emergency interventions, plans approved with restrictive and/or intrusive interventions, and adherence to the BTPR Standards (including barriers, improvement efforts, recommendations, and status of recommendations). | CMHPSM Quality Manager Regional CPT Committee | Annual QAPIP Plan 2/28/25 FY24 QAPIP Evaluation 2/28/26 |

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| | | | Quarterly February May August November |
| | CMHPSM will explore system abilities to report BTC data electronically more efficiently while maintaining security/privacy and reporting standards. | CMHPSM Quality Manager Regional CPT Committee | FY25 Annual Report 2/28/25 Quarterly February May August November |
| | CMHPSM will conduct quarterly analysis and reporting of BTC data to Regional CPT Committee for any corrective action measures to be taken, and incorporated into the CMHPSM QAPIP documents and reports | CMHSM COO CMHPSM Quality Manager | Quarterly March May August November |
| Provider Monitoring | Objectives/Activities | Assigned Person or Committee/Council | Frequency/ Due Date |
| CMHPSM will demonstrate assurances of adequate capacity and services for the region, in accordance with the MDHHS Network Adequacy standards. | Submit Network Adequacy Report to MDHHS Complete Network Adequacy Assessment including all required elements. Comply with any state Network Adequacy and Reporting requirements. | CMHPSM COO Regional NMC Committee | 02/28/25 09/30/25 |

Figure 2. FY25 Performance Measures

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

*MDHHS 2023-2026 Continuous Quality Strategy (CQS) Goals:

Goal #1: Ensure high quality and high levels of access to care.

Goal #2: Strengthen person and family-centered approaches.

Goal #3: Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external).

Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes.

Goal #5: Improve quality outcomes through value-based initiatives and payment reform.

| *Continuous Quality Strategy Goal(s) | Michigan Mission Based Performance Indicator System | Committee/Council | FY2024 Performance | FY25 QAPIP Page(s) |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|----------------------------------------|--------------------|
| 1 | <p>CMHPSM will meet or exceed the standard for Indicator 2a: The percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (reported by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children.)</p> <p>Performance measured by total % of all populations (total numerator/denominator)</p> <p>CMHPSM FY22 Baseline = 61.3% = 50TH – 75TH Percentile</p> <p>FY25 Performance Measure: reach or exceed the 75th Percentile (62%)</p> <p>MDHHS Indicator 2 Percentile %s</p> <p>50th = 57.0%</p> <p>75th = 62.0%</p> | Regional CPT Regional EOC | Q4 pending state report, Not Met in Q3 | 24 |
| 1 | <p>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.</p> <p>Performance measured by total % of all populations (total numerator/denominator)</p> <p>CMHPSM FY22 Baseline = 60.8% = Below 50TH Percentile</p> <p>FY25 Performance Measure: reach or exceed the 50TH Percentile (68.2%)</p> <p>MDHHS Indicator 2e Percentile %s</p> <p>50th = 68.2%</p> <p>75th = 75.3%</p> | Regional CPT Regional EOC | Q4 pending state report, Not Met in Q3 | 24 |
| 1 | <p>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</p> | Regional CPT Regional EOC | Q4 pending state report, Not Met in Q3 | 24 |

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| | <p>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 FY25 Performance Measure: reach or exceed the 75TH Percentile (83.8%) MDHHS Indicator 3 Percentiles %s 50th = 72.9% 75th = 83.8%</p> | | | |
| Continuous Quality Strategy Goal(s) | 2026-2029 Behavioral Health Quality Transformation Metrics | Committee | FY2024 Performance | FY25 QAPIP Page(s) |
| 3 | CMHPSM will develop a performance measure to improve accuracy and timeliness of encounter (SAL) submissions to that impact state measures of the FY26-29 MDDHS BH Quality Transformation Plan | Regional EOC Regional CPT Regional UM/UR | New FY25 standard | 25-26 |
| Continuous Quality Strategy Goal(s) | Member Appeals and Grievance Performance Summary | Committee | FY2024 Performance | FY25 QAPIP Page(s) |
| 1, 2, 3 | <p>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%)</p> <p>An improvement from FY2024 in the percentage of appeals cases that meet documentation requirements in the EHR: 85% of appeals will have all required fields and attached documents completed (no fields missing) (FY24 Audit Baseline: 70%) 50% of appeals will meet all narrative content requirements (Documentation Note, Procedures, Resolution/Disposition) accurately and completely (FY24 Audit Baseline: 33%).</p> | Regional UM/UR Committee Regional CPT Committee | Met at 100% New FY25 Baseline | 34-36 |
| 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%) | Regional CS Committee | Met at 100% | 39-40 |

| | | | | |
|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------|---------------------------|
| | An improvement from FY2024 in the percentage of grievance cases that meet documentation requirements in the EHR: 95% of grievances will have all required fields and attached documents completed (no fields missing) (FY24 Audit Baseline: 78%) 85% of appeals will meet all narrative content requirements (Grievance Issue, Steps Taken Note, Resolution/Disposition) accurately and completely (FY24 Audit Baseline: 70%). | Regional CPT Committee | New FY25 Baseline | |
| Continuous Quality Strategy Goal(s) | Joint Metrics | Committee | FY2024 Performance | FY25 QAPIP Page(s) |
| | Collaboration meeting completed between entities for the ongoing coordination and integration of services. (100%) The percentage of complete care plans in CC360 for care coordination cases with MHPs (Standard - 25%) | Regional EOC Committee Regional CPT Committee | 100% New FY25 Baseline | 27-28 |
| Continuous Quality Strategy Goal(s) | PIHP Performance Based Incentive Payments | Committee | FY2024 Performance | FY25 QAPIP Page(s) |
| | 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 | 26-27 |
| Continuous Quality Strategy Goal(s) | Priority Measures Clinical SUD | Committee | FY2024 Performance | FY25 QAPIP Page(s) |
| | CMHPSM SUD providers will meet ASAM Continuum completion rates (Target 75%) CMHPSM SUD providers will improve meeting priority population timelines (Target 75%) | Regional CPT Committee | 72% (not met) Screening: 85.5% (met) | 43 |

| | | | | |
|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|---------------------------|
| | <p>CMHPSM SUD provider will show a decrease in expired SUD wrappers without service . (20%) (Indicator 2e)</p> <p>CMHPSM SUD providers will ensure consumers who have not received services within 60 days have their SUD discharge completed (Target 70%).</p> <p>Monthly data reviews and quarterly data analysis reporting. (Target 95%)</p> | | <p>Admission: 48.6% (not met) Q4 data pending New metric FY25</p> <p>Met</p> | |
| Continuous Quality Strategy Goal(s) | Utilization Management/LTSS | Committee | FY2024 Performance | FY25 QAPIP Page(s) |
| | <p>Evidence of use of parity program for those with established LOC in CMHPSM reviews of CMHSPs clinical records for all populations (Standard 90%). Ensure MichiCANS assessment is incorporated in parity program. Review utilization management data, service decision data, and override trends related to MichiCANS at 6-month and 1-year intervals for FY25 implementation, in order to develop parity parameters specific to MichiCANS in FY26. 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.</p> | <p>Regional UM/UR Committee</p> <p>Regional Children’s Administrative Workgroup</p> | <p>FY23: 64% (not met) N/A New measure for FY25</p> <p>Not Met</p> | 34-36 |
| Continuous Quality Strategy Goal(s) | Health Home (SUD HH, BHH, CCBHC) Performance Measures | Committee | FY2024 Performance | FY25 QAPIP Page(s) |
| 1, 2, 3, 4, 5 | Meet or exceed SUD HH performance benchmarks. | CMHPSM SUS Team | Met for OHH in FY24 | 27 |
| 1, 2, 3, 4, 5 | <p>Meet or exceed federally defined QBP measures and benchmarks for CCBHCs.</p> <p>CMHPSM to develop and implement utilization management procedures to comply with the CCBHC requirements of PIHP retrospective review of approved/rendered services to confirm that the care was medically necessary.</p> | <p>Regional CCBHC Workgroup, CMHPSM COO, Regional UM/UR Committee</p> | <p>Met</p> <p>New Measure</p> | 27 |



Regional Board Action Request – Annual Quality Assessment and Performance Improvement Program (QAPIP) Plan for FY2025

- Board Meeting Date:** December 11, 2024
- Action Requested:** Approve the annual plan for quality assessment and improvement plan activities during FY2025.
- Background:** The CMHPSM, as a Pre-paid Inpatient Health Plan, is required to annually assess the need for improvement throughout the regional administrative and service functions and to prepare a plan to make quality improvements that will ensure that recipients of services are provided high quality, timely, cost-effective supports and services.
- The FY2025 QAPIP includes workplans for QAPIP Priorities and Performance Measures.
- Priorities and performance measures that are new or revised from the previous fiscal year are highlighted in green.
- Connection to:** PIHP/MDDHS Contract, AFP, Regional Strategic Plan and Shared Governance Model, and MDHHS FY2023-2026 Continuous Quality Strategy Goals, MDHHS Bureau of Specialty Behavioral Health Services Behavioral Health Quality Transformation Strategy, FY2025-2027. Quality Assessment/Performance Improvement Program and Standards
- Recommend:** Approval

Model Board Motion: *I move to approve the CMHPSM regional Quality Assessment and Performance Improvement Plan for fiscal year 2025.*



Regional Board Action Request – 10-Year Service Proclamation

Board Meeting Date: December 11, 2024

Action Requested: Issuing 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.

Background: Joelen Kersten has been a valued employee of the CMHPSM for the past 10 years. We are incredibly grateful for her 10 years of service at the CMHPSM and the knowledge she brings to our region. She has shown true commitment and dedication to the people we serve, ensuring their needs are met by providing thoughtful and compassionate work. She truly cares about the people we serve, our providers, and our overall team at CMHPSM.

Joelen has worked the front lines, answering Access calls in Monroe County for several years before moving into the role of Clinical Treatment Coordinator 5 ½ years ago. She now oversees a team of three clinical staff who ensure our providers and the people we serve have what they need to access and receive SUD treatment services across our region. She ensures priority populations receive services as quickly as possible, and those already in services receive ongoing treatment as needed with direct oversight of utilization management. She works closely with the regional Access Departments and CMHSPs to ensure the flow of services is as seamless as possible, and that the information sent to the state reflects the hard work of the region.

Joelen is a caring and dedicated team member, showing support to those she supervises and the rest of her team and coworkers. Her knowledge and commitment have greatly benefited the region for the last 10 years, and she is and has been a true asset to our team, our agency, and to the region.

Recommend: Issuance of proclamation.

Model Board Motion: *I move the CMHPSM Regional Board issue the proclamation acknowledging Joelen Kersten'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, Joelen Kersten as of December 15, 2024 will be employed with the CMHPSM for ten years and has striven to accomplish the mission of the Community Mental Health Partnership of Southeast Michigan in multiple roles and now as Clinical Treatment Coordinator; and

Now, therefore, the Community Mental Health Board of Directors does hereby proclaim their appreciation to Joelen Kersten for her ten years of service to the region, today December 11, 2024.



Regional Board Action Request – 10-Year Service Proclamation

Board Meeting Date: December 11, 2024

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

Background: James Colaianne has been an invaluable employee of CMHSPM for the past 10 years, first as the Chief Operating Officer and then to Chief Executive Officer of CMHPSM for the last 5 ½ years. James is a leader with the rare combination of excellent business sense and equal compassion and commitment, ensuring all we do is to best provide for the people we serve in respectful and sustainable ways. James leads in all aspects of our practices with integrity, honesty, transparency, and care. He seeks to bring staff to the organization who think as critically and compassionately, and will question previous practices that may no longer best serve the people we are here to serve. James embodies these same values in his compassion and commitment to staff, seeking to support them to become their best and leading by example. James does not ask staff to do what he would not do himself and has been found on more than one occasion to go above and beyond helping people who present at the office seeking services to get to the right place. The way James practices these values has created a high level of trust and accountability within our agency and to our stakeholders. He is recognized at the state level and beyond for these qualities as well. It is an honor and a privilege to work alongside him.

Below are contributions from CMHPSM staff who wanted to specifically share about James' contributions to CMHPSM:

"I was hired a few weeks prior to James becoming the official CEO of CMHPSM and have witnessed his leadership through many different challenges. From the moment he took on the role of CEO, James has led with open communication, support and compassion. He has led our organization through many challenges (legislative proposals to eliminate PIHPs, moving offices, COVID, just to name a few that occurred in the first 6 months of him taking on the role!). I have always appreciated his thoughtful approach to each challenge and am confident he is dedicated to the success of not only our organization, but each of its employees. CMHPSM is a great organization because of him."

"Every day I am grateful that James is in charge of this operation. He's smart, thoughtful, hard-working, ethical, funny...the whole package. I honestly couldn't

even invent a better person for this role. I just respect him so much. He’s a person to follow.”

“I have worked with James for almost 15 years, from his start as a contract employee with the WCHO to now in his role as CEO of CMHPSM. During that time, I have seen nothing but dedication, honesty, hard work and a will to do the right thing from him. James was instrumental in the founding of CMHPSM and was involved in all that the creation of a new legal entity entails. And on a Wednesday evening in April 2019 when we suddenly found ourselves without a CEO, James answered the Regional Board's call to step into the CEO role at that night's board meeting and on a temporary basis for a few months thereafter. Luckily for us, James chose to stay on as CEO and continues to be a strong leader for his staff and for the region. Thank you, James!”

Recommend: Issuance of proclamation.

Model Board Motion: *I move the CMHPSM Regional Board issue the proclamation acknowledging James Colaianne’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, James Colaianne as of November 2, 2024 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 in multiple roles and now as Chief Executive Officer; and

Now, therefore, the Community Mental Health Board of Directors does hereby proclaim their appreciation to James Colaianne for his ten years of service to the region, today December 11, 2024.



Regional Board Action Request – Contracts

Board Meeting Date: December 11, 2024

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

| Organization - Background | Term | Funding Level | Funding Source | Agreement Type |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|----------------------------|-----------------------------------|----------------|
| <p>Monroe County Community College: Collegiate Recovery Program to build upon and expand services to include: 1) Continue growth of a student-led campus organization focused on recovery from substance use disorder (SUD), with regular involvement in recovery support meetings facilitated by Recovery Advocacy Warriors (RAW) of Monroe, MI. 2) Train a student leader to become certified to lead the recovery support meetings. 3) Campus education and training resources for students in recovery seeking to work in peer support services.</p> | 10/1/2024 – 9/30/2025 | Not to exceed \$20,000.00 | ARPA | New Contract |
| <p>CRC Recovery DBA Ann Arbor Treatment Center – Jail Based MAT/MOUD: Fiduciary contract for provider to work with the Washtenaw County Jail, under an agreement with WCCMH, to maintain this program in Washtenaw County. The CMHPSM was not able to fund this project in FY2025 per the CMHPSM procurement process results.</p> | 11/25/2024 - 9/30/2025 | Not to exceed \$250,000.00 | Fiduciary - WCCMH Millage Funding | New Contract |

Recommend: Approval

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



CEO Report

Community Mental Health Partnership of Southeast Michigan

Submitted to the CMHPSM Board of Directors
December 5, 2024 for December 11, 2024 Meeting

CMHPSM Update

- We have completed all state and regional cost settlement activities related to FY2018, FY2019, FY2020, FY2021 and FY2022. We are officially cost settled and the deficits from FY2018 and FY2019 have been fully resolved.
- A verbal update on FY2025 contract status will be provided at the December Board meeting.
- Open enrollment activities are set to kickoff on Monday December 9, 2024. We were originally scheduled to hold open enrollment on November 25, 2024 but needed to re-schedule.
- 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 posted position. We are actively recruiting for the Operations Assistant position.
- We would like to thank Teresa for her ten years of service to the CMHPSM and wish her all the best in her well-deserved retirement!
- 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.

Statewide Update

- The monthly PIHP statewide CEO meeting was held on December 3, 2024. Our group is working on scheduling the 2025 meetings due to some meeting conflicts.
- The monthly PIHP CEO/MDHHS behavioral health leadership staff meeting was held on December 5, 2024. Our October and November meetings were both cancelled by MDHHS. I provide a summary of those meetings to our regional CMHSP directors at our Regional Operations Committee meetings.
- There were no updates provided related to Conflict Free Access and Planning at our December MDHHS meeting.

Legislative Updates

- No updates.

Future Updates

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

No scheduled January 2025 meeting.

February 2025

- FY2024 QAPIP Evaluation

Respectfully Submitted,



James Colaianne, MPA