Community Mental Health Partnership of Southeast Michigan

2023 Quality Assessment and Performance Improvement Program Evaluation

Fiscal Year 2023

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I. Overview/Mission Statement

The Community Mental Health Partnership of Southeast Michigan (CMHPSM) is one of Michigan's ten Medicaid Prepaid Inpatient Health Plans and is responsible for the counties of Lenawee, Livingston, Monroe, and Washtenaw. We provide oversight of the management and integration of Medicaid behavioral health services for adults and children with intellectual/developmental disabilities, serious mental illness/severe emotional disturbance and oversee substance use disorder services across the four-county region. Behavioral health services are delivered through the Community Mental Health Service Providers in each respective county: Lenawee Community Mental Health Authority, Livingston Community Mental Health Authority, Monroe Community Mental Health Authority and Washtenaw County Community Mental Health. Our mission is to ensure and support the provision of high-quality integrated care that is cost effective and focuses on improving the health, wellness, and quality of life of people living in our region, through effective partnerships.

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

It is the intention of the CMHPSM to ensure consistent implementation and management of services provided. CMHPSM develops a strategic plan guided by our Vision, Mission, and Values, with quarterly reports submitted to the CMHPSM Board. The previous FY21-23 and current FY24-26 CMHPSM Strategic Plan Metrics/Milestones are available to MDHHS upon request. Strategic plan goals relative to the QAPIP work plan are identified in Figure 2.

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

A. Mission Vision and Values

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

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

Values:

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

B. Guiding Principles:

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

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

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

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

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

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

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

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

II. Scope of Plan

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

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

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

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

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

III. Definitions/Acronyms

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

Behavior Treatment Plan Review Committee (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.

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

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

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

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

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

Hospitalization due to Injury or Medication Error: Hospitalization due to injury related to the use of physical management.

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

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

External Quality Review (EQR): is a federally required review by which and entity external from MDHHS conducts reviews and audits PIHPs compliance with federal/state Medicaid Managed Care standards and performance measures PIHPs.

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

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

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

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

Michigan Mission Based Performance Indicator System MMBPIS: includes domains and state reporting structures that address for access to care, adequacy and appropriateness of services

provide, efficiency (administrative cost vs. service costs), and outcomes (i.e., employment, housing, inpatient readmission).

MDHHS: Michigan Department of Health and Services

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

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

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

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

Quality Assessment and Performance Improvement Program (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 Code of Federal Regulations (CFR)438.358 of 2002.

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

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

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

QAPI: Quality Assurance Performance Improvement.

Research: (as defined by 45 CFR, Part 46.102) means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities.

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

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

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

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

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

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

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

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

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

IV. Organizational Structure and Authority:

A. Governance

CMHPSM Board

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

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

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

Chief Executive Officer

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

CMHPSM Leadership Staff

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

Regional Operations Committee

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

Regional Clinical Performance Team (CPT) Committee

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

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

CPT Committee responsibilities include:

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

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

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

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

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

B. Committee Structure

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

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

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

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

CMHPSM staff and the CPT Committee are responsible for general oversight of the QAPIP. The CMHPSM Chief Operations Officer and the Compliance and Quality Manager are the PIHP staff

responsible for the oversight of QAPIP Implementation. *(See* Attachment A—CMHPSM Organizational Chart*).*

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

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

C. Provider Network Structure

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

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

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

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

Regional Clinical Practice Team (CPT) Committee

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

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

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

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

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

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

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

Regional Customer Services (CS) Committee

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

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

Culturally & Linguistically Relevant Services Customer Services Notice of Privacy Practices

Regional Electronic IM Operations (EOC) Committee

The EOC Committee assures maintenance and development of core electronic medical record (EMR) software functions, the optimization and standardization of EMR processes whenever possible, and supporting data integrity. The committee oversees the maintenance of core EMR functions including the incorporation of federal and state requirements, emerging best practices, and feedback from the regional EOC Satisfaction Survey submitted annually to CMHSP partners. The EOC Committee develops and implements this satisfaction survey. The committee is

comprised of the CMHPSM Chief Information Officer (CIO) as chair and the CMHSP information technology staff appointed by the respective CMHSP CEO/Executive Director. CMHSP members ensure local implementation and local data integrity of EOC Committee oversight functions.

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

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

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

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

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

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

Regional Compliance Committee (RCC)

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

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

Confidentiality and Access to Consumer Records
Conflict Free Case Management
Corporate Compliance Policy
Peer Review
Service Verification

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

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

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

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

D. Communication of Process and Outcomes

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

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

v. Performance Management

A. Determination of Performance Measures:

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

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

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

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

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

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

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

B. Prioritizing Measures

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

1. Adherence to law, regulatory, accreditation requirement and/or clinical standards of care. And performance in the previous year regarding audits of compliance standards, audits.
2. The needs of the community, stakeholder feedback, efficient use of resources, and providing person -centered and effective services. This can include community assessments, and the prevalence of a condition among, or need for a specific service by, the organization's individuals; consumer demographic characteristics and health risks; and the interest of individuals in the aspect of service to be addressed.
3. The effect on a significant portion of persons served, with a potentially significant effect on quality of care, services, or satisfaction.
4. Specific clinical and non-clinical performance measures, or indicators. Indicators are indirect measures used to assess and improve quality and can indicate certain areas that require more attention. These are based on compliance with regulations, contract requirements, chosen projects, and external audits. CMHPSM also chooses indicators based on:
   - Relevance to the outcome or process that we want to assess and improve.
   - Measurability, given finite resources.
   - Accuracy: whether the performance measure is based on accepted guidelines.
   - Feasibility: Can the performance rate for an indicator realistically be improved?

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

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

C. Data Collection and Analysis

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

• Baseline
• Standard/Target/Goal

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

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

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

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

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

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

D. Framework for Performance Improvement Projects

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

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

** Italics signify examples of a diagram/tool that may be used to guide and document work.*

Systematic steps for performance improvement projects and CAPs are implemented according to the following framework/guide (also available as a process flowchart in Attachment B):

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

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

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

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

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

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

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

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

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

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

6. Implement change; gather new data at regular intervals to assess the success of intervention (**Do**)

- Carry out the test.
- Collect data and monitor performance periodically (*Monitoring Interventions*)

7. Analyze results and compare them to baseline. (**Study**)

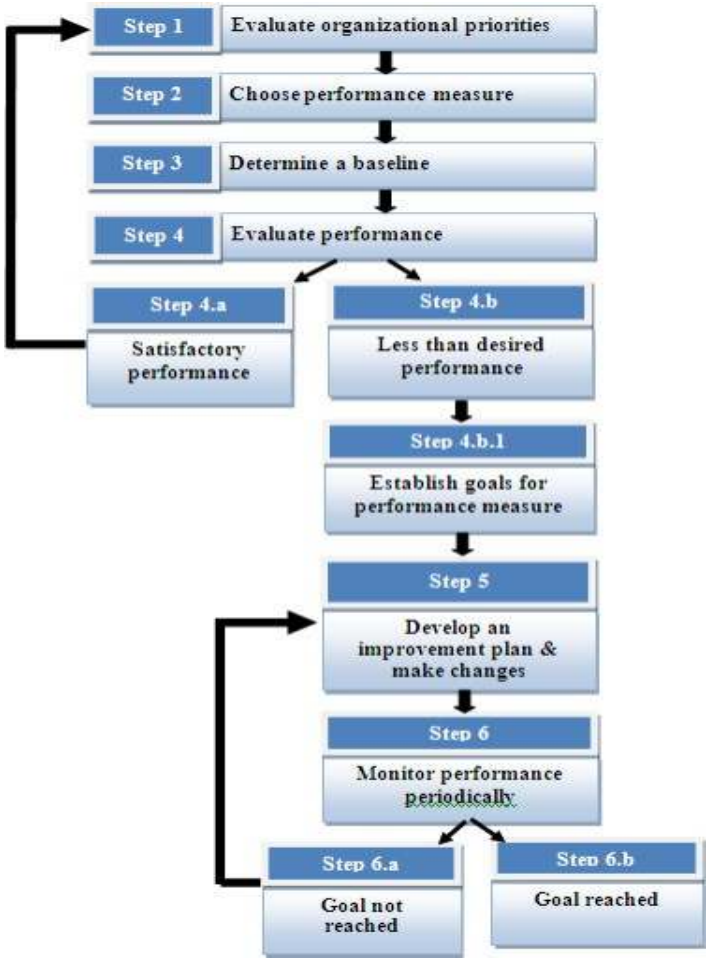
- Analyze results and compare to baseline.
    - Appropriate statistical analyses
    - Run chart.
- Interpret results and lessons learned.

8. Based on analyses—make a decision (**Act**)

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

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

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



VI. CMHPSM Measures of Performance

A. Performance Measures

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

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

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

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

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

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

Michigan Mission Based Performance Indicators (MMBPIS) FY2023 Performance Measures and Outcomes

Project Description	**Indicator/Performance Measure**	**Goal/ Benchmark**	**FY2023 Outcomes**	**Causes and Trends for Not Met**
Pre-Admission Screening within 3 hours	**1.** The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within 3 hours	95%	FY Averages Child: 99.47 Adult: 99.38%	Goal met for all four quarters for Outcome met for FY2023
Access/1st Request Timeliness	**2a.** The percentage of new persons during the quarter receiving a completed bio-	Base-line period	FY Averages Child SED 56.59%	N/A, no state measure required for FY2023.

	psycho-social assessment within 14 calendar days of a non-emergency request for service.		Adult MI 53.33% Child IDD 63.60% Adult IDD 56.35%	CMHPSM tracked general performance with internal goal of 70%
Access/1st Request Timeliness	**2b.** The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with Substance Use Disorders.	Base-line Period	FY Average SUD 59.65%	N/A, no measure required yet for FY2023. CMHPSM tracked general performance with internal goal of 70%
Access/1st Service Timelines for all CMH populations and SUD	**3.** Percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment.	Base-line Period	See IET-AD Data of state reported 41.36% performance rate for CMHPSM	N/A, no measure required yet for FY2023. CMHPSM tracked general performance
Hospital Discharges Follow-up-Psychiatric Inpatient	**4.a.** The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days (child and adult).	95%	FY Averages Child 95.48% Adult 95.36%	Child*: Benchmark not met for Quarters 1 and 4. Benchmark met for Quarters 2 and 3. Adult*: Benchmark not met for Quarters 1. Benchmark met for Quarters 2, 3, and 4.
Hospital Discharges Follow-up – SUD Detox	**4b** - The percentage of discharges from an SUD detox unit during the quarter that were seen for follow-up care within 7 days.	95%	FY Average 98.35 %	Goal met for all four quarters. Outcome met for FY2023
Inpatient Recidivism	**10-** The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	15% or less	FY Averages Child 5.12% Adult 11.73% All 7.34%	Goal met for all four quarters Goal met for all four quarters Outcome met for FY2023

CMHPSM MMBPIS Indicators FY23

affiliatn	Indicator	Type	2023_Q1	2023_Q2	2023_Q3	2023_Q4	Annual Average
CMHPSM	1 Child	CMHPSM	(175/175) 100.00%	(197/197) 100.00%	(168/169) 99.01%	(106/107) 99.07%	99.47%
CMHPSM	1 Adult	CMHPSM	(662/665) 99.55%	(632/638) 99.06%	(646/648) 99.54%	(650/654) 99.39%	99.38%
CMHPSM	2 MIC	CMHPSM	(187/301) 62.13%	(209/356) 58.87%	(175/327) 53.52%	(140/270) 51.85%	56.59%
CMHPSM	2 MIA	CMHPSM	(337/577) 58.41%	(367/857) 64.34%	(341/673) 50.67%	(341/683) 49.93%	53.33%
CMHPSM	2 DDC	CMHPSM	(67/101) 66.34%	(78/116) 67.24%	(58/100) 58.00%	(71/113) 62.83%	63.60%
CMHPSM	2 DDA	CMHPSM	(19/32) 59.38%	(17/37) 45.95%	(23/42) 54.76%	(32/48) 65.31%	56.35%
CMHPSM	2 SUD	CMHPSM	(668/1076) 62.17%	(670/1155) 58.01%	(721/1191) 60.54%	(656/1132) 57.95%	59.65%
CMHPSM	3 MIC	CMHPSM	(172/237) 72.57%	(179/261) 68.56%	(156/231) 67.53%	(121/178) 67.98%	69.17%
CMHPSM	3 MIA	CMHPSM	(262/360) 72.31%	(307/424) 72.41%	(249/389) 64.01%	(253/414) 61.11%	67.46%
CMHPSM	3 DDC	CMHPSM	(90/94) 95.11%	(67/94) 71.28%	(64/77) 83.12%	(67/67) 77.01%	79.13%
CMHPSM	3 DDA	CMHPSM	(25/28) 89.29%	(25/28) 89.29%	(23/27) 85.19%	(27/36) 75.00%	84.69%
CMHPSM	4 Child	CMHPSM	(51/54) 94.44%	(46/46) 97.83%	(52/52) 100.00%	(26/29) 89.66%	95.48%
CMHPSM	4 Adult	CMHPSM	(168/175) 94.86%	(168/175) 96.00%	(175/184) 95.11%	(190/199) 95.48%	95.36%
CMHPSM	4 SUD	CMHPSM	(112/117) 95.73%	(131/133) 98.50%	(118/119) 99.16%	(127/127) 100.00%	98.35%
CMHPSM	10 Child	CMHPSM	(4/63) 6.35%	(3/50) 6.00%	(3/57) 5.26%	(1/35) 2.86%	5.12%
CMHPSM	10 Adult	CMHPSM	(38/267) 14.23%	(21/224) 9.38%	(26/245) 10.61%	(37/291) 12.71%	11.73%
CMHPSM	5 ALL	CMHPSM	(48/798) 6.01%	(63/868) 7.26%	(64/782) 8.18%	(59/744) 7.93%	7.34%

Analysis of MMBPIS Outcomes

- Annual averages show indicators 1, 4, 10, and 5 were met overall for FY2023.
- The majority of indicators requiring a review or corrective action plan were related to indicators 4a.
- While indicators 2a, 2b, and 3 don't yet have a state required measurement, CMHPSM reviewed trends and sought interventions for general improvements in the performance of these indicators. In depth analysis of Indicator 2a was conducted as this indicator is incorporated in the CMHPSM FY22-25 Performance Improvement Project (PIP) per state and federal requirements.

Trends (in order of significance/occurrence) related to Indicators 2, 3 and 4:

- Individual not showing for scheduled appointment.
- Individual/guardian wanting a different appointment outside the timeframe.
- Staff error in ensuring timeframe or in documenting reasons for not meeting the indicator.
- Ongoing challenges with receiving all notifications (ADT or otherwise) of a discharge.
- Whether an individual was actively open within the CMHPSM or new to the system, especially related to SUD provider system.
- Ongoing challenges related to long term effects of the COVID pandemic with people's ability or willingness to make appointments.

Primary interventions for improvements included:

- Staff training
- Increase in more frequent internal audits
- Offering same day appointments at intake,
- Providing more telehealth options where applicable
- Transportation assistance
- access to real-time data for more accurate internal auditing

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

B. PIHP-Specific Performance Based Incentive Measures

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

CMHPSM will improve or maintain data quality on BH-TEDS military and veteran fields.
This project aims to use BHTEDS to:

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

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

FY2023 BHTEDS Performance Measures

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

FY2023 BHTEDS Outcomes

1. **95% compliance with reported BHTEDS encounters**

In FY2023 CMHPSM maintained BHTEDS completion rates over 95% compliance for crisis and non-crisis encounters. The most recent data verified by the state for the fiscal year shows the following performance for CMHPSM:

MDHHS Report Data	Crisis BHTEDS	MH Encounters Non-Crisis BHTEDS	SUD Encounters with BHTEDS records
	98.45%	98.54%	99.39%

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

The CMHPSM continues to directly employ one full time Veteran Navigator (VN) and one full time Veteran Certified Peer Support Specialist (VPSS) to address the relevant goals of the Strategic Plan for Veteran and Military Family Members (V/MF). In FY2023, this Veteran Peer Support Specialist continued to build on his work alongside the VN, greatly increasing capacity in numbers and in expertise and regularly involved across all four counties in the region. During FY2023, these two staff members became even more integrated into the substance use services

team, finding ways to work together with other staff to be inclusive of V/MF across the spectrum of services.

The VN and VPSS had ongoing contact with 647 individuals (not unduplicated), including 514 new unique contacts, showing significant numbers of V/MF receiving services ongoing. The VPSS position allowed for a significant increase in outreach and contacts with V/MF.
Finally, during 2023 the CMHPSM VN and VPSS continued working with the Walking with Warriors campaign, which will again continue into FY 2024. One of the additional primary areas of focus this year was around housing, and the great need for emergency shelter and housing for V/MF across the region, as well as other social determinants of health.

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

This report was submitted to MDHHS by the due date, with a passing finding.

Increase Data Sharing with Other Providers Through Sending Admission, Discharge, Transfer (ADT) Messages for Purposes of Care Coordination through Health Information Exchange (HIE):

FY2023 ADT Performance Measures
Increased data sharing with other providers through sending ADT messages for purposes of care coordination through health information exchange. (narrative report)

FY2023 ADT Outcomes
This measure was met in the goal of increasing the sharing of behavioral health data and submitting the narrative report to MDHHS by the due date.

Increase Participation in Patient-Centered Medical Homes/Health Homes (narrative report):

FY2023 Health Home Performance Measures
CMHPSM will increase participation in patient-centered medical homes/health homes. (narrative report)

FY2023 Health Home Outcomes
The narrative report was completed to the state by the due date.
All four CMHSPs in our region continue to operate Behavioral Health Homes, increasing BHH enrollees in FY2023.
Opioid Health Home increased to five (5) certified OHH providers in our region.
Monroe CMHA achieved CCBHC certification bringing the region to two (2) CCBHCs.

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

MDHHS has established specific performance indicators that are shared between the PIHPs and the Medicaid Health Plans (MHPs), which work in collaboration to improve specific behavioral health outcomes for people served across both systems. Data includes all services, including those not funded by the PIHP and covered by Medicaid Health Plans. The state data is based on

Medicaid claims data and there is often an 8-12 month delay in the data. For FY2023 these metrics include:

Care Coordination for High Risk/High Utilization:

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.

FY2023 Care Coordination Measures

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

FY2023 Care Coordination Outcomes

For FY2023 CMHPSM, the MHPs, and the CMHSPs continued to meet this indicator at 100% compliance by pulling monthly reports from CC360, identifying those with high risk or high utilization of services to include in reviews, and meeting monthly to review potential interventions to better serve and stabilize those consumers.

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

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

CMHPSM and the MHPs meet quarterly to address barriers and opportunities to improve outcomes for this measure, which entails:

1. The percentage of discharges for adults (18 years or older) who were hospitalized for treatment of selected mental illness and who had a follow-up visit with a mental health practitioner within 30 days after discharge.
2. The percentage of discharges for children (ages 6-17 years) who were hospitalized for treatment of selected mental illness and who had a follow-up visit with a mental health practitioner within 30 days after discharge.
3. Racial/ethnic group disparities will be reduced for both children and adults: 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.

FY2023 FUH Measures

1. The percentage of discharges for individuals age six and older, who were hospitalized for mental illness or intentional self-harm diagnoses, and who had a follow-up visit with a mental health practitioner within 30 days of discharge.
2. Benchmarks: ages six (6) to 17= at least 70%; ages 18 and older = at least 58%.
3. Racial/ethnic group disparities will be reduced. CMHPSM will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following a psychiatric hospitalization (adults and children). (Disparities will be calculated

using the scoring methodology developed by MDHHS to detect statistically significant differences)

FY2023 FUH Outcomes

Based on the state FUH database which has a significant lag time, with the most recent state data for FY2023 ending 6/31/2023.

1. FUH-Children: The CMHPSM is above the 70% benchmark at 83.5%. All MHPs in our region also met the benchmark for children.
2. FUH Adults: CMHPSM Region is above the 58% benchmark at 67%. Three of the MHPs in our region did not meet the benchmark for adults.
3. Rate cell colors are based on a comparison to the median State Medicaid Total (for the given measure) over time. Rates greater than the typical statewide value are green hued. Rates lower than the typical statewide value are red hued.
4. CMHPSM performance in this indicator was greater than the typical statewide value for both age factors.

By Health Plan		FUH-30AD			FUH-30CH		
End date	Organization	denom	num	rate	denom	num	rate
6/30/23	CMHPSM Total	1117	757	0.6777	224	187	0.8348
	AETNA BETTER HEALTH OF MICHIGAN	37	22	0.5946	4	4	1.0000
	BLUE CROSS COMPLETE	345	239	0.6928	68	51	0.7500
	MCLAREN HEALTH PLAN	63	36	0.5714	11	9	0.8182
	MERIDIAN HEALTH PLAN	302	220	0.7285	91	82	0.9011
	MOLINA HEALTH CARE	105	64	0.6095	18	15	0.8333
	UNITED HEALTHCARE COMMUNITY PLAN	115	79	0.6870	19	17	0.8947

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

CMHPSM and the MHPs meet quarterly to address barriers and opportunities to improve outcomes for this measure, which entails:

1. 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.
2. Reduce the disparity measures for FUA. CMHPSM will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following an emergency department visit for alcohol or drug use. Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences.

FY2023 FUA Measures

1. The percentage of emergency department (ED) visits for individuals age 13 and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who also had a follow up visit for AOD within 30 days of the ED visit.
   The state performance standard is 27%. The measurement period is calendar year 2021. Data are extracted from the CMHPSM EHR and MDHHS Care Connect 360.

2. Reduce the disparity measures for FUA. The state database has a significant lag time, with the most recent data for FY2023 ending 6/31/2023.
   The state performance standard is 27%. The measurement period is calendar year 2021.
   FUA data is maintained by MDHHS and reported to PIHPs.

FY2023 FUA Outcomes

Based on the state FUH database which has a significant lag time, with the most recent state data for FY2023 ending 6/31/2023. State FUA Report 6/31/2023:

1. CMHPSM is above the benchmark of 27%, at 44.7%
2. Data indicate no current racial/ethnic disparities.
   - There is a wider array of MHP services that count towards this measure as compared to CMHPSM covered services.
   - There is a larger denominator and numerator for CMHPSM compared to the MHPs.
   - CMHPSM services that have been effective in assisting persons being followed up post ER visit, such as recovery peer supports, are not included as encounters that meet this measure.

By Health Plan		FUA-30		
End date	Organization	denom	num	rate
6/30/23	CMHPSM Total	1311	586	0.4470
	AETNA BETTER HEALTH OF MICHIGAN	52	23	0.4423
	BLUE CROSS COMPLETE	425	190	0.4471
	MCLAREN HEALTH PLAN	82	30	0.3659
	MERIDAN HEALTH PLAN	374	190	0.5080
	MOLINA HEALTH CARE	146	63	0.4315
	UNITED HEALTHCARE COMMUNITY PLAN	143	56	0.3916

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

CMHPSM will participate in DHHS-planned and DHHS-provided data validation regarding the percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who:

1. Initiate treatment within 14 calendar days of the diagnosis received (1. Initiation of AOD Treatment) and;
2. Who had two or more additional AOD services or medication treatment within 34 days of the initiation visit. (Engagement of AOD Treatment).

FY2023 IET Measures

This project measures the percentage of beneficiaries aged 18 to 64 with a new episode of alcohol or other drug (AOD) abuse or dependence during the measurement period who initiated or engaged in treatment:

1. Initiation of AOD Treatment

Initiation of AOD Treatment. Percentage of beneficiaries who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis.

2. Engagement of AOD Treatment.

Percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or medication treatment within 34 days of the initiation visit.

No state threshold was set for FY2023.

FY2023 IET Outcomes

1. CMHPSM met the performance measure by participating in DHHS-planned and DHHS-provided data validation regarding these measures and seeking improvements to the data. CMHPSM staff who work on this project with the state became recognized by the state as leaders and innovators in seeking improvements.
2. Racial ethnic disparity at baseline (FY2020) and the disparity was not significantly reduced in FY2023.
3. Services provided by the PIHP/CMHSP system that count towards this indicator are less than those that count in the MHP system. CMHPSM continued to advocate for the state to expand measurable services to include PIHP services such as peer recovery supports.

D. Performance Improvement Projects (PIPs)

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

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

In conducting a literature review for this topic, studies show individuals with greater health or social service needs are at higher risk for not attending an initial appointment for treatment and are more likely to have mental health risk factors, greater use of emergent or medical services, and

legal problems. This suggests the need for greater outreach, and an assumption that persons served who do not show up for an initial assessment are in as much or greater need of services and supports as those who do present for care.

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

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

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

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

FY2023 PIP Measures

1. Increase the percentage of new persons receiving a completed bio-psycho-social assessment within 14 calendar days of a non-emergency request for service for all populations.
2. Reduce identified 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.
3. Completion of PIP submission to HSAG by due date.
4. Passing score of HSAG PIP submission.
5. Implementation of interventions during FY2023, and measurement of outcomes.

FY2023 PIP Outcomes

1. The PIP submission was completed and submitted to HSAG by the due date.
2. CMHPSM received a score of 100% on the PIP after resubmission.
3. Interventions developed in FY2022 were initiated 1/1/2023 and measured compared to the baseline during FY2023, hence FY2023 was the Remeasurement Period 1 for this project. Interventions applied included offering same day appointments, training intake staff on culturally/racially respectful dialogue with persons seeking services and providing transportation assistance.
4. Remeasurement period 1 did not show overall improvements in increasing the percentage of new persons receiving a completed bio-psycho-social assessment within 14 calendar days of a non-emergency request for service.
5. Interventions for FY2023 were implemented and measured monthly.
    a) There was some local CMH reduction in identified 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, however overall, the region showed a statistically significant disparity.

b) While local data may show improvements in either increasing those who receive an assessment in 14 days, or no decrease in racial disparity, data is measured and reported as a PIHP total.

c) Barriers to achieving the outcomes included staffing shortages, instability with staffing/high staff turnover which affected the ability to offer same day appointments, loss of the ability to conduct telephone assessments after the public health emergency.

		PI Indicator 2A			No Show Preventing 2A			No Show Preventing 2A			disparity
Year ending	affiliate	denom	num	rate	denom	num	rate	denom	num	rate	
9/30/23	All	4921	2672	54.3%	3123	553	17.7%	1163	357	30.7%	*
6/30/23	All	4846	2718	56.1%	3124	539	17.3%	1122	330	29.4%	*
3/31/23	All	4639	2696	58.1%	2980	498	16.7%	1060	303	28.1%	*
12/31/22	All	4705	2787	59.2%	3071	518	16.9%	1064	296	27.8%	*

FY2024 will include a review of the barriers to interventions applied in the previous year, and proposed changes to interventions during FY2024.

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

Structure

The Regional CPT Committee reviews and analyzes data related to critical events, sentinel events, and risk events reported by CMHSPs and SUD providers, including that which qualifies as "reportable events" according to the MDHHS Critical Event Reporting System. Event data is analyzed current trends and trends over time, appropriate use of root cause analyses, monitor action plans and corrective action plans (CAP) related to events data, determine educational needs, and verify compliance with policy and procedures. Sentinel events and identified trends may require a root cause analysis and a CAP to prevent future occurrences. Critical and sentinel event reporting is required per the MDHHS-CMHPSM contract.

CMHPSM ensures that each CMHSP/SUD provider has a system in place to monitor these events, utilizing staff with appropriate credentials for the scope of care, and reporting or follow up within the required timeframes.

Regional Policies:

Regional Critical Incident, Sentinel Event, and Risk Event Policy

Regional Performance Improvement Policy

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

Reporting

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

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

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

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

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

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

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

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

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

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

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

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

During FY24 CMHPSM will convene a regional workgroup with representation of staff with varying credentials who are responsible for event reporting to conducting a quarterly analysis of the data; reviewing the appropriateness of RCAs and corrective actions; making recommendations for improvement when trends are identified and determining educational needs for staff and providers. The workgroup will report and make recommendations to Regional CPT Committee as a component to monitoring compliance of delegated functions related to critical incidents, sentinel events, and risk events.

FY2023 Critical Events Measures

1. CMHPSM to submit timely and accurately Critical Events on a monthly basis or more immediately if required.
2. Conduct analysis on critical events to monitor compliance with reporting, trends, and opportunities for performance improvements. CMHPSM will complete data analysis of critical events and develop a baseline for areas of improvements that will result in:
    - More accurate and timely reporting of events
    - CIs for residential treatment providers.
    - Include all unexpected deaths (those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect), including aggregated mortality data over time to identify possible trends.
    - Include events that put individuals at risk of harm. These events minimally include: actions taken by individuals who receive services that cause harm to themselves; actions taken by individuals who receive services that cause harm to others; and two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period.
3. Submission CMH Sentinel Events (MDHHS CRM) immediate notification) to CMHPSM based on notification requirements of the event (24 hour, 48 hours, 5 days) with 100% compliance.

FY2023 Critical Events Outcomes

1. Critical events were reported timely and accurately using the state data entry system.
2. Analysis of critical events and data was completed on a quarterly basis during FY2023, incorporating all state and federal requirements with measures. Data analysis was reported quarterly to the Regional CPT Committee.
3. CMHPSM critical events data analysis was recognized as outstanding during the FY2023 federal External Quality Review (EQR) of Medicaid Managed Care functions conducted by the Health Services Advisory Group (HSAG).

Critical Events Recommendations

No outstanding trends were identified that resulted in any regional performance improvement projects. The possibility of conducting comparative analysis of critical events with MMBPIS indicators 4 (Services received within 7 days of discharge from a hospital stay) and 10 (inpatient recidivism will be reviewed for FY2024.

F. Behavioral Treatment Review

Structure

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

Regional Policy:

Behavior Treatment Committee Policy

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

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

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

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

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

Monitoring/Review
The regional CPT Committee reviews CMHPSM data analysis and reporting of BTC performance measures.
The CMHPSM site reviews and auditing of delegated functions includes CMHSP compliance with BTC performance measures at least annually, and more frequently if performance improvements projects are implemented, as determined by the project development process.
FY2023 Behavioral Treatment Measures

1. Consistent and accurate quarterly reporting of BTC data (100%)
2. Consistent data analysis of BTC data (100%)
3. Development of BTC data baselines at the completion of BTC quarterly reporting and data analysis in FY2023.

FY2023 Behavioral Treatment Outcomes

1. Behavior treatment data for FY2023 reported timely and accurately and according to the above state requirements.
2. A regional workgroup of BTC chairs was conducted to create efficiencies and improvements in data reporting.
3. Analysis of behavior treatment data was completed on a quarterly basis, incorporating all state and federal requirements with measures. Data analysis was reported quarterly to the Regional CPT Committee.
4. CMHPSM behavior treatment data analysis was recognized as outstanding during the FY2023 federal External Quality Review (EQR) of Medicaid Managed Care functions conducted by the Health Services Advisory Group (HSAG).

Behavior Treatment Data Recommendations

No outstanding trends were identified that resulted in any regional performance improvement projects.
Since the data report changed, FY2023 was considered a baseline year, with comparative analysis to begin in FY2024.
CMHPSM to incorporate BTC specific audits in FY2024 monitoring of CMHSPs.
Increase improvement in all elements completed for BTC reporting based on FY2023 outcomes.
Increase improvement interventions used (no blank data) for FY2024 reporting (95% accuracy).

G. Clinical Practice Guidelines

Structure

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

Regional Policy:
Clinical Practice Guidelines Policy

Reporting

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

Monitoring/Review

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

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

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

FY2023 Clinical Practice Guidelines Measures

1. Ensure Clinical Practice Guidelines (CPGs) are reviewed and updated at least annually (100%). Identify by 9/30/23 in the CPG review where guidelines are being used in the region/system of care with 100% completion.
2. CPGs are published to both provider network and members.

FY2023 Clinical Practice Guidelines Outcomes

1. For FY2023 CPGs were reviewed and approved by Regional CPT Committee by ROC by the required timeframes. The CPG review of where guidelines are being used in the region/system of care was completed, with updates provided for SUD services.
2. CPGs were published on the websites of CMHPSM and the ability to access them was communicated and distributed to providers and persons served.

H. Utilization Management

Structure

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

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

Devereux Early Childhood Assessment (DECA) - for the assessment of infant mental health services for infants and young children, 1 month to 47 months, with suspected serious emotional disturbance.
Preschool and Early Childhood Functional Assessment Scale (PECFAS) – for the assessment of young children, 4 to 7 years of age, with suspected serious emotional disturbance.
Level of Care Utilization System (LOCUS) - for adults age 18/21 and up with a mental health diagnosis.
Milliman Care Guidelines (MCG) for Behavioral Health – for adults and children in need of acute behavioral healthcare services such as an inpatient stay.
Supports Intensity Scale (SIS) – for individuals age 16 and older with an intellectual/developmental disability or cognitive impairment.

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

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

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

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

Monitoring/Review
The 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 FY2020-FY2022 and implemented at the onset of FY2023 by the Regional Parity Workgroup.
The Committee determined a need to monitor the LOCUS as this parity-required assessment has less external fidelity assurances compared to other parity population assessments and hence poses a higher risk of error. With parity analysis beginning in FY2024 that incorporates the LOCUS, the committee will assess if this LOCUS specific project would be ended for FY2024.

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

Utilization Review Decisions

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

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

With the regional implementation of a parity program in FY2023, the UM/UR Committee will also conduct analysis on compliance with the program for all populations relevant to state parity requirements, as well as patterns and percentages of parity exceptions that made require modifications to the system.

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

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

FY2023 UM/UR Measures

1. Assess validity and reliability of LOCUS application across the region.
    a. Increase in timely completion of LOCUS (at intake, before annual BPS signed
    b. Percentage of LOCUS score changes over time. Significant score changes show medical necessity
    c. Percentage of LOCUS overrides do not exceed 10%
    d. Clear documentation of overrides
    e. LOCUS score is accurately reflected in parity Level of Care in clinical record

2. Correct timeframes used for advance action notice (Target 100%)
    a. Accurate use of reduction, suspension, or termination decisions. (Target 100%)
    b. ABDs provide service denial reasons in language understandable to person served.
    c. Analyze type of denial, accuracy of service and denial decision explanation, and compliance with timeframes.

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

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

5. Evidence of use of parity program for those with established LOC in CMHPSM reviews of CMHSPs clinical records for all populations (Standard 90%).

6. Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages (Standard <=5%).

7. 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.

FY2023 UM/UR Outcomes

1. Assess validity and reliability of LOCUS application across the region.
   a. Increase in timely completion of LOCUS (at intake, before annual BPS signed)
      There was an increase in performance, however with the ability and need to complete a LOCUS after an annual the significance of this improvement was inconclusive. This component of LOCUS timeliness will be incorporated in the FY2024 parity analysis project.
   b. Percentage of LOCUS score changes over time. Significant score changes show medical necessity.
      For FY2023 2,712 of 16,248 LOCUS scores were changed overtime, with 31 of 2712, or 1.1% missing documentation of reason in the LOCUS assessment. **98.9% of cases showed medical necessity.**
   c. Percentage of LOCUS overrides do not exceed 10%
      564/4118, or 13% of cases were overridden, hence the 10% measure was not met for FY2023. This measure will be further explored for interventions to improve performance in FY2024.
   d. Clear documentation of overrides
      Only 6 of the 4118 overridden cases, .14% did not have documentation of the LOCUS override in the LOCUS assessment. **99.86% of cases were in compliance.**
   e. LOCUS score is accurately reflected in parity Level of Care in clinical record
      This outcome could not be analyzed in FY23 due to delays in parity implementation and the need to have over a full year cycle of data. Analysis will begin in FY2024 as a retro review and a comparison of FY2023, including establishing a baseline and improvement measure.

2. Correct timeframes used for advance action notice (Target 100%)
   a. Accurate use of reduction, suspension, or termination decisions. (Target 100%)

Of the total 6,668 Medicaid notices provided in FY2023, 3,886 were relevant to reduction, suspension, or termination decisions. **Analysis showed 100% compliance with this measure.**

b. ABDs provide service denial reasons in language understandable to person served.

Initial analysis showed 175 of 6,668 notices (2.6%) seemed to have no explanation, resulting in **97.4% compliance with this measure**. However, when a 10% random sample of those 175 was conducted, the notices did have an explanation. Therefore, the data report will be assessed and modified for FY2024 to bridge these discrepancies.

c. Analyze type of denial, accuracy of service and denial decision explanation, and compliance with timeframes.

Timeframes were met an average of 95%

Notice Timeframes	In Compliance	Out of Compliance
FY2023 Q1	94.5% (315/333)	5.5% (18/333)
FY2023 Q2	95% (418/440)	5% (22/440)
FY2023 Q3	96% (410/428)	4% (18/428)
FY 2023 Q4	95% (305/322)	5% (17/322)
TOTALS	95% (1448/1523)	5% (75/1523)

- FY2023 data analysis showed trends in errors in the timeframes between when an Access decision was made and when the notice was sent for ABDs
- The overuse and inaccurate use of Other as a reason for ABDs when a more specific reason applied.
- CMHSPs provided corrective action plans for improvements.
- There were also system issues in the date the electronic health record chooses as a request for service if it's a decision not made based on an initial request. System modifications were requested for FY2024 for more accurate data reporting of when the request was made.

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

During FY2023 an overutilization project was developed by UM/UR Committee and approved by ROC: ***To review inpatient recidivism as potential overutilization of higher level of care.***
The data structure was developed in FY2023. Analysis is to begin at the onset of FY2024.
Persons receiving LTSS, on a waiver, trends over time, and provider stability were identified in the data where applicable and incorporated in assessments and analysis.

4. Assess underutilization of services:
   a. Identify any services by population that indicate underutilization.
   b. Where indicated develop interventions to address underutilization.
   c. Incorporate LTSS, c waiver utilization, trends over time, provider stability factors.

d. Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person-centered plan.

During FY2023 an overutilization project was developed by UM/UR Committee and approved by ROC: ***Assess HSW members not receiving monthly services that qualify them for HSW enrollment as potential underutilization, including potential risks of maintaining HSW enrollment with the ending of public health emergency and subsequent enrollment exceptions***. The data structure was developed in FY2023. Analysis is to begin at the onset of FY2024. Persons receiving LTSS, on a waiver, trends over time, and provider stability were identified in the data where applicable and incorporated in assessments and analysis.

5. Evidence of use of parity program for those with established LOC in CMHPSM reviews of CMHSPs clinical records for all populations (Standard 90%).

This outcome could not be analyzed in FY23 due to delays in parity implementation and the need to have over a full year cycle of data. Analysis will begin in FY2024 as a retro review and a comparison of FY2023, including establishing a baseline and improvement measure.

6. Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages (Standard <=5%).

This outcome could not be analyzed in FY23 due to delays in parity implementation and the need to have over a full year cycle of data. Analysis will begin in FY2024 as a retro review and a comparison of FY2023, including establishing a baseline and improvement measure.

7. Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines. (Target 100%).

The MCG inner rater reliability (IRR) system that assesses parity and reliability/validity of service decisions for psychiatric inpatient, crisis residential, and partial hospitalization services was implemented in FY2023. Parameters and outcomes were established in assigning and testing IRR cases, and a training program was provided for all regional staff using the system to assign cases. Due to implementation barriers with all staff having an active account in the MCG system, the due date for completion was extended to the end of FY2023. Therefore, data analysis with this outcome will be completed in FY2024.

I. Vulnerable Individuals

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

CMHPSM ensures that long term supports and services are consistently provided in a manner that considers the health, safety, and welfare of consumers, family, providers, and other stakeholders.

When health and safety, and/or welfare concerns are identified, those concerns will be acknowledged, and actions taken as appropriate.

CMHPSM assesses the quality and appropriateness of care furnished by monitoring of population health through data analytics software to identify adverse utilization patterns and to reduce health disparities, and by conducting individual clinical chart reviews during program specific reviews to ensure assessed needs are addressed and in the individual's plan of service using practices that adhere to person centered and self-determination principles, and during transitions between care settings.
CMHPSM monitors compliance with federal and state regulations annually through a process that may include any combination of desk review, site review verification activities and/or other appropriate oversight and compliance enforcement strategies, as necessary. CMHSP organizations and SUD treatment providers that are unable to demonstrate acceptable performance may be subject to additional PIHP oversight and intervention.

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

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

FY2023 Measures for Oversight of Vulnerable Individuals

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

FY2023 Outcomes for Oversight of Vulnerable Individuals

1. State standards of utilization and services that meet HSW enrollment were modified in FY2023 that reduced allowable services that count for this measure 7707/8476
   91% of allowable services that meet enrollment requirements were billed, with 8% not billed. Of that 8%, 5% had an authorization for those services.
   Reasons why services that meet HSW enrollment requirements are varied and often person specific. Further analysis will be conducted in FY2024 and incorporated in the Regional UM/UR Committee parity analysis.

2. Monthly monitoring was completed with the following outcomes:

Habilitation Support Waiver FY2023 Quarter	Total Enrolled	Number of Past Due Recertifications	Timeliness Percentage Compliance	Documentation Compliance
Q1	711	24	96.6%	100%
Q2	712	9	98.7%	100%
Q3	718	20	97.2%	100%
Q4	729	25	96.6%	100%

Documentation compliance was met as the CMHPSM Waiver Manager reviews each application and returns any missing or unclear documentation to the CMH prior to submission to the state. Regular training and monitoring resulted in a decrease in past due recertifications.

FY2024 Recommendations for Oversight of Vulnerable Individuals

1. Continue the project for FY2024.
2. Collaborate with the CMHPSM Waiver Manager to Integrate these measures with the FY2024 underutilization project overseen by Regional UM/UR Committee
3. Include HSW slot analysis in FY2024 QAPIP to ensure 100% enrollment.

J. Long-Term Services and Supports (LTSS)

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

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

CMHPSM incorporated identification of LTSS in FY2023 data analysis, including QAPIP projects where applicable and possible, such as critical incidents, sentinel events, risk events, behavior treatment, member satisfaction results, practice guidelines, credentialing and recredentialing, verification of Medicaid services, over- and underutilization, provider network capacity and monitoring, trends in service delivery and health outcomes over time, and monitoring of progress

on performance goals and objectives. LTSS is defined as those persons functional limitations and/or chronic illnesses that support their goals of being a participant in their community in ways meaningful to them, and the supports and services that assist in this aim.

FY2023 LTSS Measures

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

FY2023 LTSS Outcomes

During FY2023 LTSS was included in the following QAPIP activities and/or performance measures: member satisfaction results credentialing and recredentialing, verification of Medicaid services, over- and underutilization, provider network capacity and monitoring.
LTSS was included in the oversight and data reporting for Home and Community Based Services waiver monitoring and upcoming and FY2023 MDHHS required 1915(i) enrollment, including if services are being provided and those in need of LTSS are accurately reported.
CMHPSM staff were trained in the identification of those needing or receiving LTSS for MDHHS 1915i enrollment requirements.
LTSS was included as a data set in analysis of critical incidents, sentinel events, risk events, behavior treatment, practice guidelines, grievance and appeals data, and monitoring of progress on clinically-related performance goals and objectives.

FY2024 LTSS Recommendations

1. Develop HCBC auditing system that incorporates and identifies providers that serve persons in need of LTSS.
2. Identify baseline, performance measures, and interventions for FY2024 related to outcomes for persons served.
3. Improve data analysis and procedures in identification of those persons served eligible for LTSS through 1915i enrollments and reduce reporting errors.

K. Member Experience with Services

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

The aggregated results of the surveys and/or assessments are collected, analyzed, and reported by Regional Customer Service Committee to the Regional CPT Committee, Regional Consumer Advisory Council, and other relevant committees/councils, who identify strengths, areas for improvement and make recommendations for action and follow up as appropriate. Regional

benchmarks and/or national benchmarks are used for comparison when available. The data is used to identify best practices, demonstrate improvements, or identify growth areas. The Regional CPT Committee, RCAC, and CMHPSM Board determines appropriate action for improvements. The findings are incorporated into program improvement action plans as appropriate. The CMHSPs/SUD providers 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 SUD Providers and are accessible on the CMHPSM website. Findings are also shared with stakeholders on a local level through such means as advisory councils, staff/provider meetings and printed materials.

Regional Customer Services: Consumer Satisfaction Survey

CMHPSM conducts periodic quantitative (surveys) and qualitative (focus groups) assessments of consumer experiences (including those receiving long-term supports). These assessments are representative of the persons served, and services and supports offered. A random sample of persons served, families and/or guardians from all populations served will be asked to participate in customer satisfaction surveys. Other types of surveys/focus groups may be general or population specific depending on the topic or interventions developed from PI projects.

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

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

For FY2023 the CMHPSM explored the use of surveys, and other opportunities for the voice of persons served, in the analysis and implementation of PIP Project 1 and PI Project 2 relevant to access to the initial intake described in Section VI of this plan.

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

Recovery Self-Assessment (RSA)

CMHPSM distributes the Recovery Self-Assessment-Revised survey (RSA-R) (O'Conell, Tondora, Croog, Evans, & Davidson, 2005) to contracted providers in the region that use the Recovery Oriented System of Care (ROSC) model. "A ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with a risk of alcohol and drug problems" (SAMHSA, 2010). The CMHPSM seeks to accurately assess and measure the effectiveness of Substance Use Disorder (SUD) and Community Mental Health (CMH) providers in the implementation of recovery focused services from the perspective of clients, provider staff, and administrative staff. Oversight, monitoring and reporting of RSA survey data and results is conducted by the Regional Co-Occurring Workgroup, which reports to the Regional CPT Committee. Each CMHSP develops a work plan based on survey findings, to focus on local planning of improvements.
Current fiscal year data is analyzed to include year-to-year comparisons and long-term trends from at least the last five years. Survey questions use a 5-point Likert Scale and include a comment box. Survey or assessment results are included in the annual CMHPSM QAPIP Evaluation and presented to CMHSPs, SUD Providers, the CMHPSM governing body and Regional Consumer Advisory Council including recommendations and pursuit of governing body feedback on recommendations.

For FY23 the Likert scale was changed from 5-point scale in prior years to a 3-point scale, in an attempt to identify more significant difference in rating between each question

Each survey was broken down into six domains:	FY23 3-point Likert
1. Life Goals	1 = Disagree
2. Involvement	2 = Neutral
3. Diversity of Treatment Options	3 = Agree
4. Choice	N/A = Not Applicable
5. Individually Tailored Services	D/K = Don't Know
6. Inviting Space	

FY2023 Measures and Outcomes of Persons Served Experiences

A. Customer Satisfaction Survey Data

FY2023 Survey Measures:

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

For FY2023 random samples of individuals served from all populations of children and adults (SED, MI, IDD/CI) were pulled and at least 30 individuals from each population were surveyed using the same questions/statements.
Areas that had outcomes of 80% or less were reviewed for causes, trends, and potential interventions to improve performance.
The assessment included the following statements:

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

FY2023 Survey Outcomes

- Ten of the eleven items in the survey scored at 80% satisfaction or higher.
- Item #10 - I know how to file a complaint - scored at 64%, indicating a need to intervene to ensure individuals were aware of how they can express their dissatisfaction and who to contact.
- In analyzing the answers to item #10, the causes were not clear, making interventions difficult to ascertain.
- The FY2023 survey could not be compared to FY2020-FY2022 as these surveys focused on the impacts of the COVID pandemic and people's experience with the increase in telehealth services.

FY2024 Survey Recommendations

The Regional Customer Services Committee therefore made the following recommendations FY2024:

1. Include more specific follow-up questions to item #10 – I know how to file a complaint to ascertain causes from which interventions and baseline performance can be developed.
2. Increase information in lobbies and websites about how to contact someone at the CMH/CMHPSM about concerns.
3. Seek feedback from the RCAC on the development of the revised survey for FY2024 and potential ways to provide education to individuals served.

B. Recovery Self-Assessment (RSA) Survey Data

FY2023 Recovery Self-Assessment (RSA) Survey Measures

1. Achieve at least an Agree (Likert score of 4*) for Client responses in all domains.
2. Achieve improvement in Involvement domain from FY2022.

Each survey question contained an answer choice based on a 3-point Scale:
*For FY23 the Likert scale was changed from 5-point scale in prior years to a 3-point scale, in an attempt to identify more significant difference in rating between each question. Additionally, the survey contained a comment box for each question. Therefore, comparisons from FY22 were modified.

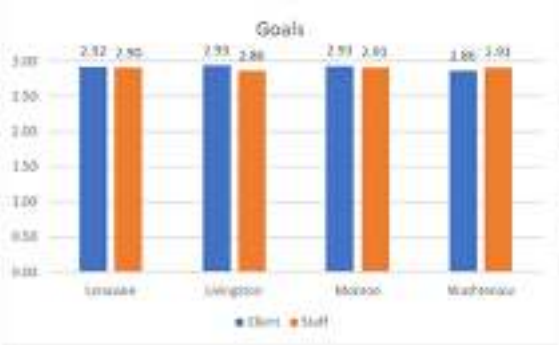
FY2023 Recovery Self-Assessment (RSA) Survey Outcomes

A total of 512 individuals participated in this analysis. Some individuals skipped answering some questions which accounts for the lower total amounts represented below:

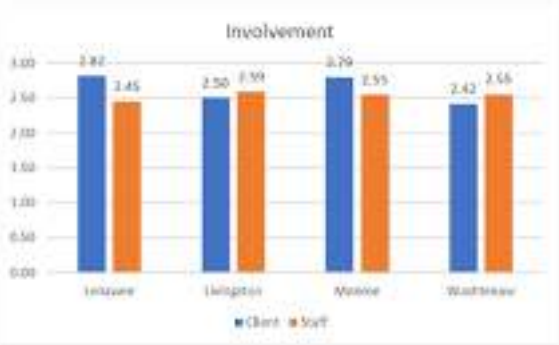
Participant	Total	Lenawee	Livingston	Monroe	Washtenaw
Clients	368	56	103	121	84
Provider Staff	148	38	39	24	39

Across the region, consumer ratings remained comparable to recent years- relatively high, with averages of most questions ranging at 2.8 or higher on the 3-point scale. The Involvement domain scored the lowest in all four counties on both survey versions.
The graphs below show comparisons of client and staff averages for all domains from FY2022 and FY2023:

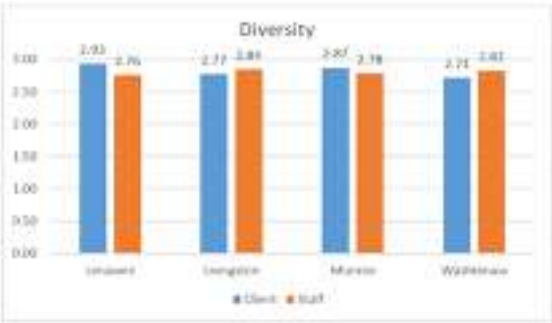
Life Goals



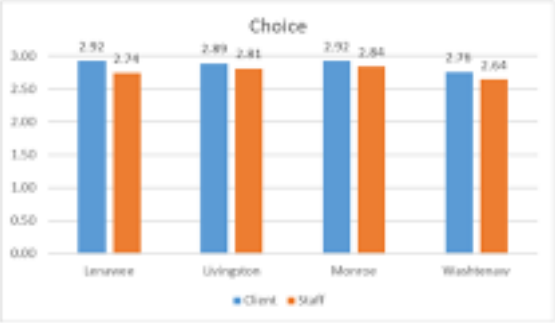
Involvement



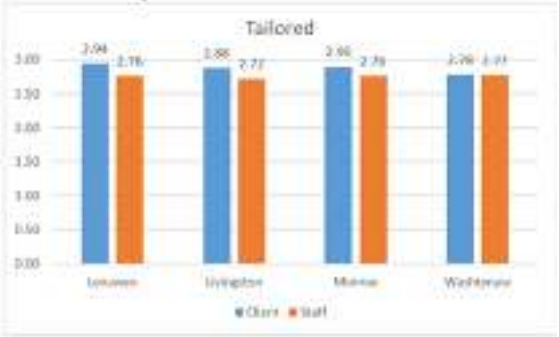
Diversity



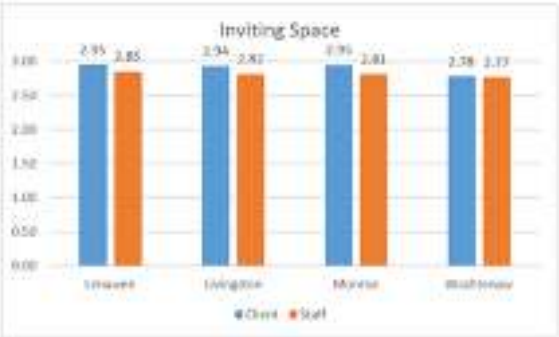
Choice



Individually Tailored Services



Inviting Space



FY2024 Recovery Self-Assessment (RSA) Survey Recommendations

Each county will develop a county-specific plan to address their local report responses. As MDHHS no longer requires use of the RSA, the CMHPSM will determine if another survey measure can be implemented to meet the requirements in reviewing persons experiences with SUD services, or if the RSA will be continued for FY2024.

C. Grievance Data

FY2023 Grievance Data Measures

The percentage (rate per 1000) of Medicaid grievances are resolved with a compliant written disposition sent to the consumer within 90 calendar days of the request for a grievance. (Standard

95%). Below is the FY2023 analysis of grievances per county with trends reported by Regional Customer Services staff.

FY2023 Grievance Data	Lenawee	Livingston	Monroe	Washtenaw	Timeframes Met	Timeframes Not Met
Grievance Type						
Abuse, Neglect, Exploitation	0	0	0	0	N/A	N/A
Accommodations	0	0	2	0	2	0
Case Management	0	1	0	0	1	0
Customer Service Interaction with Provider/Plan	0	0	0	0	N/A	N/A
Denial of Expedited Appeal	0	0	0	0		
Financial	0	0	0	0		
Interaction w/Provider/Plan	0	1	0	0	1	0
Provider Choice	0	0	0	1	1	0
Quality of Care	15	13	42	7	77	0
Rights (Consumer's)	0	0	0	0		
Safety/Risk Management	0	0	0	0		
Service Concerns/Availability	0	1	9	3	13	0
Service Environment	0	0	0	1	1	0
Service Timeliness	0	0	3	1	4	0
Transportation	0	0	1	0	1	0
Other	0	0	1	0	1	0
TOTAL GRIEVANCES	14	16	58	13	101	0
Involving Persons Receiving LTSS	12	13	56	7	88	0

FY2023 Grievance Data Outcomes

- Overall, the number of grievances filed and resolved in FY2023 decreased compared to FY2022 (196). Part of this decrease was related to a correction in what was counted as a grievance from the FY2023 federal external review.
- On average, the region as a whole saw 4.4 grievances made per 1000 members served.
- In relation to Medicaid regulations and QAPIP goals, all CMHs in the region met or exceeded timeliness standards. 100% of grievances were resolved within the 60 days required by the MDHHS contract.
- The majority of grievances in FY2023 were Resolved in Favor of Consumer (74%), with the majority of interventions involved assigning a new provider or case manager (59%)
- 97% of grievances in FY2023 were made by consumers with Mental Illness (MI) diagnoses, compared with 96% in FY2022 (96%).
- 30% of grievances in FY2023 were made by persons with Intellectual or Developmental Disabilities (IDD), compared with 32% in FY2022.
- 7.8% of grievances in FY2023 were enrolled in Certified Community Behavioral Health Clinic (CCBHC) Services, compared with 11% in FY2022.

- A grievance procedure on documentation was completed and staff training completed to improve accuracy of the data and use of the data reporting system.

Grievance Data Recommendations for FY2024

- Review grievances categorized as Quality of Care for potential clearer type identification.
- Ensure all cases have at least one intervention added.
- Ensure accuracy of interventions used.
- Identify in FY2024 if there are specific needs or differences within consumer care populations (i.e., demographics, SUD/DD/MI) in type of grievance or intervention used.
- Explore trends with categories of grievances by different locations/providers.
- Conduct auditing of grievance documentation and apply staff training and local data correction as needed.

D. Appeals Data

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

FY2023 Appeals Data Measures

The percentage (rate per 1000) of Medicaid local 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%)

FY2023 Local Appeals	Lenawee	Livingston	Monroe	Washtenaw	SUD	Timeframes Met	Timeframes Not Met
Appeal Type							
Service Denial	**6**	**0**	**3**	**3**	**0**	**12**	**0**
Service Request not Determined within 14 days	**0**	**0**	**0**	**0**	**0**	**N/A**	**N/A**
Service not Started within 14 days	**1**	**0**	**0**	**2**	**0**	**3**	**0**
Service Reduction	**0**	**1**	**0**	**3**	**1**	**5**	**0**
Service Suspension	**0**	**1**	**0**	**0**	**3**	**4**	**0**
Service Termination	**10**	**3**	**4**	**2**	**1**	**20**	**0**
Denial of Payment	**0**	**0**	**0**	**0**	**0**	**N/A**	**N/A**
Financial Liability Denial	**0**	**0**	**0**	**0**	**0**	**N/A**	**N/A**
Denial of an Out of Network Service Request	**0**	**0**	**0**	**0**	**0**	**N/A**	**N/A**
Grievance not Resolved within Required Days	**0**	**0**	**0**	**0**	**0**	**N/A**	**N/A**
TOTAL LOCAL APPEALS	**17**	**5**	**7**	**10**	**5**	**44**	
Involving Persons Receiving LTSS						**13**	**0**

Local Appeal Outcome							
Approved (Decision Reversed)	**2**	**0**	**2**	**0**	**0**		
Denied (Decision Upheld)	**14**	**1**	**5**	**8**	**4**		
Partially Denied	**0**	**0**	**0**	**2**	**0**		
Withdrawn by Consumer	**1**	**4**	**0**	**0**	**0**		

FY2023 Local Appeals Data Outcomes

- There was a total of 44 Local Appeals in FY2023, compared with 34 in FY2022. The average appeals per 1000 members served in FY2023 was 0.98.
- Community Living Supports (CLS) and SUD Medication Assisted Treatment remain the services that are appealed most often.
- 83% of appeals were Upheld, meaning the initial decision by the CMH was determined to be appropriate.
- 100% of completing appeals timeframes have been met.
- The highest percentage of appeals (45.1%) were denied due to medical necessity criteria not met.
- 64% of appeals for all counties in FY2023 were made by consumers with Mental Illness (MI) diagnoses, compared with 63% in FY2022. 42% represented Intellectual/Developmental Disability (IDD) diagnoses in FY2023, compared with 48% in FY2022.
- There was a total of 13, or 29% of local appeals related to person's receiving Long Term Supports and Services (LTSS).
- 19% of appeals were persons enrolled in Certified Community Behavioral Health Clinic (CCBHC) services in FY2023, compared with 6% in FY2022. This growth is likely due to the expansion of the program at Monroe CMHA in FY2023.

FY2023 State Level Appeals Outcomes

While there are not QAPIP measures specific to state level appeals as the state department managing this level of appeal is held to the timeframes, state appeal data and outcomes are reviewed by the Regional UM/UR Committee and reported to Regional Customer Services and CPT Committees for any trends and potential performance improvement projects

FY2023 State Appeals	Lenawee	Livingston	Monroe	Washtenaw	SUD
Reason for Appeal					
Service Denial	**1**	**0**	**0**	**1**	**0**
Service Request not Determined within 14 days	**0**	**0**	**0**	**0**	**0**
Service not Started within 14 days	**0**	**0**	**0**	**0**	**0**
Service Reduction	**0**	**0**	**0**	**0**	**3**
Service Suspension	**0**	**0**	**0**	**0**	**2**
Service Termination	**0**	**0**	**0**	**0**	**1**
Denial of Payment	**0**	**0**	**0**	**0**	**0**
Financial Liability Denial	**0**	**0**	**0**	**0**	**0**
Denial of an Out of Network Service Request	**0**	**0**	**0**	**0**	**0**

Grievance not Resolved within Required Days	0	0	0	0	0
TOTAL State Level Appeals	1	0	0	1	6
Involving Persons with LTSS	1			1	
State Appeal Outcome					
Dismissed	0	0	0	0	3
Reversed	0	0	0	0	0
Upheld	1	0	0	1	2
Withdrawn by Person/Consumer	0	0	0	0	1

Summary of State Level Appeals Outcomes

- The region had a total of 8 State Level Medicaid Fair Hearings in FY2023. This showed a slight decrease in state level hearings compared to 10 in FY2022.
- In FY2023 there were six hearings related to SUD services of methadone medication assisted treatment, which was a significant increase in FY2023, and was specific to one provider noting persons' needs for a higher level of care. Four of these six SUD hearings were dismissed or withdrawn. The PIHP worked with this provider on alternative ways to work with persons served and the PIHP SUD UM staff to address these care concerns.
- All requires timeframes were met for state level appeals in FY2023
- None of the state level hearing involved persons enrolled in a CCBHC.

Appeals Data Recommendations for FY2024

- Ensure documentation of cases is thorough and accurate using more specific case reviews and requiring corrections.
- Ensure complete data reporting of actions taken, staff name and role involved in appeal review, and services appealed.

E. National Core Indicators/Benchmarks

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

FY2023 National Core Measures

Review National Core Indicators (NCI) for any relevance to CMHPSM areas identified in satisfaction surveys, grievances, recipient rights, or appeals data.
Incorporated measures and interventions for any NCI identified areas not currently addressed in regional data relevant to individual experience with CMHPSM supports and services.

FY2023 National Core Outcomes

National Core Indicators usually have a one-year time lag, however the most recent survey data analysis was not completed during FY2023 as surveys are still being conducted. Therefore, FY2021 data was reviewed again. While the NCI data showed opportunities in Michigan for employment opportunities and people's interest in seeking meaningful work, and ideas for further empowerment of persons served in the person-centered planning process, these were not area noted locally in member experience survey results collected in our region, nor has it been a factor of grievances or appeals.

FY2024 National Core Indicators Recommendations

CMHSPM has a regional Customer Services representative involved in the statewide NCI workgroup and will continue to seek guidance from MDHHS in FY2024 on what applications this data could provide in local measures.

The Regional Customer Services Committee will review data related to person centered planning choices people make, such as HCBS vocational data and availability/use of independent facilitators.

VII. Provider Standards

A. Provider Qualifications

Structure

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

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

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

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

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

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

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

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

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

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

CMHPSM will conduct annual reviews of how CMHSPs ensure internal and external providers determine that healthcare professionals, who are licensed by the State and who are employees of

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

Network Adequacy Plan: In accordance the MDHHS PIHP contract and federal regulations 42 CFR §438.207 §438.68 and §438.206(c)(1), CMHPSM PIHP conducts a network adequacy plan in conjunction with the regional Network Management Committee that assesses at minimum:

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

FY2023 Provider Qualifications Measures

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

FY2023 Provider Qualifications Outcomes

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

This measure was conducted through auditing of providers through Medicaid Services Verification, monitoring of CMHSPs, auditing of staff qualifications through credentialing and recredentialing reviews of providers, and review of credentialing and recredentialing data reported to the state. CMHPSM also decided to incorporate the outcomes of the FY2023 MDHHS Site Review and subsequent corrective actions plans as part of PIHP compliance oversight for this measure. Outcomes for FY2023 are as follows:

- Medicaid Services Verification: 100% of cases reviewed showed evidence of licensed providers in compliance with staff qualifications.
- Monitoring of CMHSPs: A baseline review of FY2023 Quarter 1 data was completed of staff qualifications for CMHSP licensed professional staff providing CMH direct operated

services, with some improvements in documentation needed with training and screen shot verifications. A regional workgroup of CMHSP Human Resources staff was conducted to review the findings and address needed improvements with state data reporting. Due to limitations of staffing resources, there was a reduction in the frequency of auditing. A FY2024 Q1 review will be conducted for comparison of the FY2023 baseline to identify improvements and/or further corrective action.

- Auditing of Providers: Credentialing/recredentialing of fifty (50) organizations and seventeen (17) LIPs resulted in no findings that prevented approval of credentialing/recredentialing applications.
  Audits of SUD and MH providers that were conducted in FY23 resulted in some corrective actions in maintaining correct and current documentation of staff qualifications, but no finding that resulted in contractual sanctions or terminations of providers.
- State Reporting: Credentialing and recredentialing data is reviewed and reported to the state twice a year. FY2023 findings did not result in any substantial changes or provider corrections.

Provider Type	FY23 Q1-Q2	FY23 Q3-4	Percentage In Compliance	Percentage Out of Compliance
Organizations	26	24	92% (46/50)	8% (4/50)
LIPs	6	11	95% (16/17)	5% (1/17)
CMHSP Staff	251	301	99.8% (551/552)	.02% (1/552)
TOTAL	283	336		
FY 2023 Averages			(99%) 613/619	(1%) 6/619

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

This measure was conducted through auditing of providers through Medicaid Services Verification, monitoring of CMHSPs, auditing of staff qualifications through credentialing and recredentialing reviews of providers, and review of credentialing and recredentialing data reported to the state. CMHPSM also decided to incorporate the outcomes of the FY2023 MDHHS Site Review and subsequent corrective actions plans as part of PIHP compliance oversight for this measure. Outcomes for FY2023 are as follows:

- Medicaid Services Verification: 100% of cases reviewed showed evidence of licensed providers in compliance with staff qualifications.
- Monitoring of CMHSPs: A baseline review of FY2023 Quarter 1 data was completed of staff qualifications for CMHSP licensed professional staff providing CMH direct operated services, with some improvements in documentation needed with training and screen shot verifications. A regional workgroup of CMHSP Human Resources staff was conducted to review the findings and address needed improvements with state data reporting. Due to limitations of staffing resources, there was a reduction in the frequency of auditing. A FY2024 Q1 review will be conducted for comparison of the FY2023 baseline to identify improvements and/or further corrective action.

- Auditing of Providers: Credentialing/recredentialing of fifty (50) organizations and seventeen (17) LIPs resulted in no findings that prevented approval of credentialing/recredentialing applications.
  Audits of SUD and MH providers that were conducted in FY23 resulted in some corrective actions in maintaining correct and current documentation of staff qualifications, but no finding that resulted in contractual sanctions or terminations of providers.
- State Reporting: Credentialing and recredentialing data is reviewed and reported to the state twice a year. FY2023 findings did not result in any substantial changes or provider corrections.

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CMHSP Staff	251	301	99.8% (551/552)	.02% (1/552)
TOTAL	283	336		
FY 2023 Averages			(99%) 613/619	(1%) 6/619

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

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

FY2024 Provider Qualifications Recommendations

1. CMHPSM will conduct at least two reviews of credentialing and qualifications of CMHSP professional staff.
2. CMHPSM will complete auditing and monitoring of CMHSPs and SUD providers.
3. CMHPSM will develop processes to collect more applicable data on the CMHSP auditing of sub contractual providers for credentialing compliance of licensed and non-licensed provider staff. CMHPSM will incorporate any relevant MDHHS Site review findings in this data analysis.

B. Credentialing and Recredentialing

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

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

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

Competence for all CMHSPM and CMHSP employees is assessed at the time of hire and annually thereafter. Employees must meet qualifications for education, work experience, cultural competence, and certification or licensure as required by law. CMHSPs and CMHPSM also provide training and continuing education for staff development. Before assigning clinical responsibilities, the CMHSP/SUD Provider verifies identity, applicable licensure, training, and other evidence of the ability to perform the assigned responsibilities.
CMHPSM monitors the CMHSPs and SUD Provider compliance with federal, state, and local regulations and requirements annually through an established process including desk review, site review verification activities and/or other appropriate oversight and compliance enforcement strategies. CMHPSM policies and procedures are established to address the selection, orientation, and training of directly employed or contracted staff. PIHP employees receive annual reviews of performance and competency. Individual competency issues are addressed through staff development plans. CMHPSM is responsible for ensuring that each provider, employed and contracted, meets all applicable licensing, scope of practice, contractual, and Medicaid Provider Manual requirements, including relevant work experience and education, and cultural competence. The CMHSPs/SUD Providers are likewise responsible for the selection, orientation, training and evaluation of the performance and competency of their own staff and subcontractors.

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

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

CMHPSM conducts regular audits of CMHSPs and providers to ensure compliance with staff qualifications and credentialing/recredentialing requirements. For FY23 additional performance improvement projects will be conducted and reported to the Regional Network Management Committee will review samples of credentialing and recredentialing cases to ensure compliance with policy and state/federal requirements for organizational licensed/non-licensed staff, LIPs and CMHSP licensed and non-licensed staff.

FY2023 Provider Credentialing and Recredentialing Measures

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

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

FY2023 Provider Credentialing and Recredentialing Outcomes

Measures 1-4 were conducted through auditing of providers through Medicaid Services Verification, monitoring of CMHSPs, auditing of staff qualifications through credentialing and recredentialing reviews of providers, and review of credentialing and recredentialing data reported to the state. CMHPSM also decided to incorporate the outcomes of the FY2023 MDHHS Site Review and subsequent corrective actions plans as part of PIHP compliance oversight for this measure. Outcomes for FY2023 are as follows:

- Medicaid Services Verification: 100% of cases reviewed showed evidence of licensed providers in compliance with staff qualifications.
- Monitoring of CMHSPs: A baseline review of FY2023 Quarter 1 data was completed of staff qualifications for CMHSP licensed professional staff providing CMH direct operated services, with some improvements in documentation needed with training and screen shot verifications. A regional workgroup of CMHSP Human Resources staff was conducted to review the findings and address needed improvements with state data reporting. Due to limitations of staffing resources, there was a reduction in the frequency of auditing. A FY2024 Q1 review will be conducted for comparison of the FY2023 baseline to identify improvements and/or further corrective action.
- Auditing of Providers: Credentialing/recredentialing of fifty (50) organizations and seventeen (17) LIPs resulted in no findings that prevented approval of credentialing/recredentialing applications.
  Audits of SUD and MH providers that were conducted in FY23 resulted in some corrective actions in maintaining correct and current documentation of staff qualifications, but no finding that resulted in contractual sanctions or terminations of providers.
- State Reporting: Credentialing and recredentialing data is reviewed and reported to the state twice a year. FY2023 findings did not result in any substantial changes or provider corrections.

Provider Type	FY23 Q1-Q2	FY23 Q3-4	Percentage In Compliance	Percentage Out of Compliance
Organizations	26	24	92% (46/50)	8% (4/50)
LIPs	6	11	95% (16/17)	5% (1/17)
CMHSP Staff	251	301	99.8% (551/552)	.02% (1/552)
TOTAL	283	336		
FY 2023 Averages			(99%) 613/619	(1%) 6/619

FY2024 Provider Credentialing and Recredentialing Recommendations

1. Ensure accurate reporting of CMH employee staff, including training and auditing of cases to compare with the FY23 baseline data.

2. Increase random sample monitoring of credentialing and recredentialing records to assess for improvements based on FY2023 baseline data.
3. More frequent outcome reporting of CMHSP auditing sub contractual providers based on these measures.
4. Incorporate any related findings from the FY2023 MDHHS Site Review into monitoring and oversight of measures in FY2024.

C. Verification of Services

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

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

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

Regional Policies
Service Verification Policy
Services Suited to Condition Policy

FY2023 Service Verification Measures

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

FY2023 Service Verification Outcomes

1. CMHPSM will meet or exceed a 95% rate of compliance of Medicaid delivered services in accordance with MDHHS requirements.
   The FY2023 MEV review resulted in 100% compliance, no follow up required.
2. CMHPSM will complete Medicaid Event verification reviews in accordance with CMHPSM policy and procedure.
   All elements of the MEV were completed, 100% compliance.
3. CMHPSM will achieve 100% compliance with MDHHS contract requirements by completing and submitting the MEV Annual Methodology Report as required and by the due date, including identifying trends, patterns, strengths, and opportunities for improvement to MDHHS.
   The MEV was completed and submitted to MDHHS by the 12/31/23 due date.

D. Cultural Competence

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

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

Regional Policies
Culturally and Linguistically Relevant Services Policy
Customer Services Policy

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

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

FY2023 Cultural Competence Measures

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

FY2023 Cultural Competence Outcomes

The CMHPSM regional training platform maintains data on trainings completed annually. Cultural competence training is included in the monitoring tools related to provider performance. There were no findings in provider auditing during FY2023 that resulted in provider performance issues or contractual sanctions related to cultural competence.

E. Provider Monitoring

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

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

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

In FY22 an additional component of CMHPSM monitoring CMHSP Access systems for both CMH and SUD access services was initiated to support assessments of potential barriers related to the 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 FY23.

FY2023 Provider Monitoring Measures

1. Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP. 100% completion of planned audits. 100% of providers will have remedial action sufficient wherein no contractual action needs to be taken.
2. Coordinate quality improvement plan development, incorporating goals and objectives for specific growth areas based on the site reviews, and submission of evidence for the follow up reviews. 100% of corrective action plans are completed and submitted as required.

FY2023 Provider Monitoring Outcomes

1. Monitoring tools were updated for FY2023 based on external audit findings, for the monitoring of MH and SUD provider networks.
   SUD provider monitoring was completed for FY2023 with no outcomes requiring any contractual action, thus maintaining the provider network.
   Due to staffing resources, two of the four CMHSP delegated functions reviews were completed in FY2023, with plans to complete the remaining two CMHSPs in FY2024. Any corrective action plans from the MDHHS Site Review findings will also be incorporated in CMHPSM monitoring of the CMHSPs.
2. MDHHS Site review findings remain pending at this time and will be incorporated into the FY2024 QAPIP plan as applicable when received.

F. External Quality Reviews (EQR)

In compliance with federal laws, CMHPSM is subject to annual external quality reviews (EQR) of compliance with Medicaid Managed Care and MDHHS-PIHP contract requirements, through MDHHS and an external quality reviewer. MDHHS is required to contract with a qualified external quality reviewer to ensure PIHP quality and compliance with all regulatory requirements; MDHHS contracts with the Health Services Advisory Group (HSAG) for this EQR function. CMHPSM collaborates with MDHHS and HSAG to provide relevant evidence to support compliance.

The review cycle conducted by HSAG is a 3-year cycle, wherein the first half of required standards are reviewed in the first year, the second half of required standards are reviewed in the second year, and the third year is a review of all corrective action taken from any findings of the prior 2 years of reviews.

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

FY2023 External Quality Review Provider Measures

1. Score of Met for all applicable EQR Medicaid Managed Care standards reviewed by HSAG for FY2023.
2. Substantial compliance with MDHHS waiver requirements.

FY2023 External Quality Review Provider Outcomes

1. HSAG EQR FY2023 Review of FY21/FY22 Corrective Action Plan Implementation

CMHPSM successfully remediated 37 of 39 elements, indicating the necessary policies, procedures, and initiatives were implemented and demonstrated compliance with the requirements under review.

Two elements were scored as Not Complete, both of which were related Health Information Systems for:

1) Implementing an Application Programming Interface (API) publicly accessible provider directory information, and
2) 2) Implementing an API regarding persons served access to and exchange of claims and encounter data.

A project plan was submitted and accepted by HSAG in achieving both these standards, with some actions requiring a broader state level system structure. CMHPSM is involved in the state CIO workgroup that is addressing the changes needed in these areas.

Summary of CMHPSM EQR CAP Implementation

Standard	Total CAP Elements	# of CAP Elements *Complete*	# of CAP Elements *Not Complete*
Standard I—Member Rights and Member Information	3	3	0
Standard III—Availability of Services	2	2	0
Standard IV—Assurances of Adequate Capacity and Services	3	3	0
Standard V—Coordination and Continuity of Care	3	3	0
Standard VI—Coverage and Authorization of Services	2	2	0
Standard VII—Provider Selection	4	4	0
Standard VIII—Confidentiality	1	1	0
Standard IX—Grievance and Appeal Systems	9	9	0
Standard X—Subcontractual Relationships and Delegation	1	1	0
Standard XI—Practice Guidelines	1	1	0
Standard XII—Health Information Systems[3]	2	0	2
Standard XIII—Quality Assessment and Performance Improvement Program	8	8	0
Total	39	37	2

Total CAP Elements: The total number of elements within each standard that required a CAP during the SFY 2021 and SFY 2022 compliance review activities.

# of CAP Elements *Complete*: The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirement under review.

# of CAP Elements *Not Complete*: The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirement under review.

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

VIII. Resources

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

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

MDHHS PIHP CONTRACT, DEFINITIONS/EXPLANATION OF TERMS, (current FY22/FY23).

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

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

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

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

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

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

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

IX. CMHPSM Quality Assessment and Performance Improvement Program QAPIP Priorities and Workplan Priorities FY2023

The QAPIP priorities shall guide quality efforts for FY23. Figure 1 provides the QAPIP Priorities and Quality Work Plan for FY23. The FY23 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 CMHPSM Strategic Plan Metrics and Milestones that support CMHPSM Mission, Vision and Values contributing to for the individuals we serve. Figure 2 provides the FY23 QAPIP Performance Measures.

FY2023 Workplan Priority Outcomes:	Green- Met Outcome	White – Partially Met Outcome.	Orange – Outcome Not Met.	Grey – No benchmark or establishing baseline.

A. Figure 1. FY23 QAPIP Priorities and Work Plan

Governance	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency / Due Date**	**FY2023 Outcomes**
CMHPSM Board of Directors will approve the QAPIP Plan and Report	Submit the annual QAPIP Plan to the Board. Submit the annual QAPIP Evaluation to the Board	CMHPSM COO	12/14/22 02/08/23	Met
Board of Directors review QAPIP Progress Reports	Submit QAPIP progress reports to the Board.	CMHPSM COO	Quarterly	Met
CMHPSM QAPIP will be submitted to Michigan Department of Health and Human Services	Submit the Board approved QAPIP Plan, Report (Evaluation), and Governing Body Form to MDHHS. (via MDHHS FTP Site)	CMHPSM Compliance/Quality Manager	2/28/23	Met
Communication of Process and Outcome Improvements	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency / Due Date**	**FY2023 Outcomes**
The QAPIP Plan and Report will be provided annually to network providers and to members upon request.	Post to the CMHPSM website. Ensure CMHSP contractors receive the QAPIP. Provide QAPIP Plan and Evaluation reporting at CMHPSM provider meetings. Communications to providers on the availability of QAPIP reports on the CMHPSM website. Communications to regional committees. Ensure Regional Customer Services Committee includes members ability to request QAPIP documents in informational materials	CMHPSM Compliance/Quality Manager CMHPSM Network Management Committee Regional Customer Services Committee	03/03/2023	Met

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. Postings to the CMHPSM website. Ability to request information is in informational materials for consumers and stakeholders.	CMHPSM Compliance/Quality Manager Regional Customer Services Committee	Quarterly Annually Annually	Met
Performance Measurement and Quality reports are made available to stakeholders and general public.	Post to the CMHPSM website. Ensure CMHSP contractors receive the QAPIP and inform communities of its availability on the website.	CMHPSM COO Regional NMC Committee	Annually	Met
MDHHS Performance Indicators	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency / Due Date**	**FY2023 Outcomes**
CMHPSM will meet or exceed the MMBPIS standards for Indicators 1, 4, 10 as required by MDHHS.	Complete quality checks on data prior to submission to ensure validity and reliability of data	CMHSPs leads	Quarterly	Met
	Verify Medicaid eligibility prior to MMBPIS submission. Submit MMBPIS data to MDHHS quarterly by due date.	CMHPSM Regional Data Coordinator CMHPSM CIO	Quarterly	Met
	Conduct quarterly analysis of CMHSP and CMHPSM provider MMBPIS performance. Require and review corrective action plans where standards were not met. Oversee effectiveness of corrective action plans through monthly review of subsequent data.	Regional CPT Committee CMHPSM Compliance/Quality Manager	Monthly QAPIP data review Quarterly CAP review Q1 Feb Q2 May Q3 August Q4 November	Met

CMHPSM will demonstrate an increase in compliance with access standards.	Establish a mechanism to monitor access requirements for priority populations. Establish a mechanism to monitor access requirements for persons enrolled in health homes (OHH, BHH, CCBHC).	Regional CPT Committee CMHPSM Compliance/Quality Manager CMHPSM SUD Services Director	Monthly QAPIP data review Quarterly CAP review Q1 Feb Q2 May Q3 August Q4 November	Met
CMHPSM will show an increase in compliance with access standards for SUD priority populations.	Conduct quarterly analysis of CMHSP and SUD provider performance of access standards for priority populations. Develop baseline measure and performance expectations. Require and review corrective action plans where standards were not met. Oversee effectiveness of corrective action plans through monthly review of subsequent data. Incorporate SUD care navigator position to meet access timeliness standards for SUD priority populations. Warm hand off challenge. Hiring PP care navigator – increase access timeframes to timeliness standards	Regional CPT Committee CMHPSM Compliance/Quality Manager CMHPSM SUD Services Director	Monthly QAPIP data review Quarterly CAP review Q1 Feb Q2 May Q3 August Q4 November	Baseline
BH-TEDS	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency / Due Date**	**FY2023 Outcomes**
CMHPSM will demonstrate an improvement or maintain data quality for the BH-TEDS	CMHPSM will identify areas of discrepancy for the BH-TEDS data for FY23. (Veterans' data (military fields), employment data-minimum wage, Living arrangements.	CMHPSM CIO Regional EOC Committee Regional CPT Committee		Met
	CMHSPM will maintain or exceed 95% compliance with BHTEDS reporting, including the total number of individual veterans reported on	CMHPSM CIO Regional EOC Committee	January 2023 07/01/2023	Met

	BH-TEDS and the Veterans Service Navigator (VSN). Causal factors with action steps will be determined to address incomplete data or errors based on review BHTEDS data. CMHPSM will complete a FY21 10/1/20-3/31/21 comparison resubmission; FY21 4/1-9/30 comparison submission; and FY22 comparison October 1 through March 31	Regional CPT Committee		
	Narrative completed comparing BH-TEDS (veteran's military fields) and VN Report for FY22 and FY23 data, including actions steps.	CMHPSM CIO	07/01/2023	Met
Performance Improvement Projects	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency / Due Date**	**FY2023 Outcomes**
CMHPSM will engage in two performance improvement projects for the FY22-25 PIP cycle. 1. Reducing Racial Disparities Specific to No-Shows for the Initial Biopsychosocial Assessment (BPS) in Individuals Accessing CMH services. 2. Overall increase in performance in new persons receiving a completed bio-psycho-social initial assessment within 14 calendar days of a non-emergency request for service.	Implement CMHPS specific interventions identified in causal barrier analysis in FY22. Conduct monthly trends and quarterly analysis of performance with PIP indicators. Determine casual barriers and factors where disparity was not reduced. Require and review corrective action plans and interventions where standards were not met. Oversee effectiveness of corrective action plans through monthly review of subsequent data.	Regional CPT Committee Regional EOC Committee CMHPSM Compliance/Quality Manager CMHPSM CIO CMHPSM Health Data Analyst	01/02/2023 Monthly Quarterly	Met
	Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations). Review with relevant committees/councils.	Regional CPT Committee CMHPSM Compliance/Quality Manager	Monthly data review Quarterly reporting to Regional CPT RCAC, and CMHPSM Board	Data Review Met Overall increase in Indicator 2 Not Met

	Complete and submit PIP 1 to HSAG as required for validation.	CMHPSM Compliance/Quality Manager	06/30/23	Met
Quantitative and Qualitative Assessment of Member Experiences	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency / Due Date**	**FY2023 Outcomes**
CMHPSM will obtain a qualitative and quantitative assessment of member experiences for all representative populations, including members receiving LTSS, and take specific action as needed, identifying sources of dissatisfaction, outlining systematic action steps and interventions, evaluating for effectiveness to improve satisfaction, communicating results.	Develop surveys for all populations. Incorporate identification of persons receiving LTSS in survey data	Regional Customer Services Committee CMHPSM SUD Services Director	03/31/2023	Met
	Incorporate the analysis of Michigan specific National Core Indicator Data to identify trends and areas for improvement.	Regional Customer Services Committee CMHPSM Compliance/Quality Manager	09/30/2023	Met
	Complete annual assessment of the member experience report to include the trends, causal sources of dissatisfaction, and interventions in collaboration with relevant committees/councils. Report the results of the member satisfaction survey to RCAC and CMHPSM Board for input and feedback on planned interventions.	Regional Customer Services Committee CMHPSM SUD Services Director	09/30/2023	Met
	Conduct analysis of a potential new SUD community survey tool to replace the RSA. Continue RSA for FY23 if new survey undetermined.	CMHPSM SUD Services Director	04/30/2023	Met
CMHPSM will meet or exceed the standard for Grievance resolution in accordance with federal and state standards.	CMHPSM will complete a grievance procedure on utilization of the regional EHR grievance module to ensure compliance with all state and federal standards of grievance documentation and resolution. CMHPSM will conduct monthly monitoring of compliance with data collection/documentation that meets state and federal grievance standards,	CMHPSM COO CMHPSM Compliance/Quality Manager Regional Customer Services Committee	12/31/2023 Monthly Quarterly Q1 February Q2 May	Met

	providing retraining and interventions, as needed up to the point where there is 100% compliance (no findings) for 3 consecutive monthly reviews, after which quarterly reviews will be conducted.		Q3 August Q4 November	
Event Monitoring and Reporting	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency / Due Date**	**FY2023 Outcomes**
CMHPSM will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths) are collected, monitored, reported, and followed up on as specified in the PIHP Contract.	Submit Critical Events monthly timely and accurately. Conduct analysis of Behavior Treatment Committee data quarterly. Convene regional workgroup of PIHP and CMHSP staff involved in events data reporting and of varying credentials to conduct quarterly analysis of events data; review the appropriateness of RCAs and corrective actions; make recommendations for improvement when trends are identified; determining educational needs for staff and providers; and monitoring compliance of delegated functions related to critical incidents, sentinel events, and risk events. The workgroup that will provide data reports to the Regional CPT Committee.	CMHSPs CMHPSM Compliance /Quality Manager CMHPSM COO	Monthly Quarterly Q1 February Q2 May Q3 August Q4 November	Met
	Submit CMH Sentinel Events (MDHHS CRM) immediate notification) to CMHPSM based on notification requirements of the event. (24 hour, 48 hours, 5 days)	CMHSPs SUD Providers	As Needed	Met
	Submit SUD Sentinel events bi-annually as required	CMHPSM SUD Providers (Residential, Recovery Housing)	April 2023 October 2023	Met
	Conduct oversight through SE data review and provider monitoring to ensure appropriate follow up is occurring for all events dependent on the type and severity of the event, including a root cause analysis, mortality review, immediate	CMHPSM Compliance/Quality Manager CMHPSM COO	Quarterly Q1 February Q2 May Q3 August Q4 November	Met

	notification to MDHHS as applicable, and meeting required timeframes. Conduct primary source verification of critical incidents and sentinel events.	Regional CPT Committee		
CMHPSM will ensure Adverse Events (Sentinel/Critical/Risk/ Unexpected Deaths) are monitored and followed up on as specified in the PIHP Contract.	Conduct analysis on critical events to monitor compliance with reporting, trends, and opportunities for performance improvements.	CMHPSM Compliance/Quality Manager CMHPSM COO Regional CPT Committee	Quarterly Q1 February Q2 May Q3 August Q4 November	Met
Medicaid Services Verification	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency / Due Date**	**FY2023 Outcomes**
CMHPSM will meet or exceed a 95% rate of compliance of Medicaid delivered services in accordance with MDHHS requirements.	Complete Medicaid Event verification reviews in accordance with CMHPSM policy and procedure.	CMHPSM COO CMHPSM CFO	12/31/2023	Met
	Complete The MEV Annual Methodology Report identifying trends, patterns, strengths, and opportunities for improvement.	CMHPSM COO	12/31/2023	Met
	Submit the Annual MEV Methodology Report to MDHHS as required	CMHPSM COO	12/31/2023	Met
Utilization Management Plan	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency / Due Date**	**FY2023 Outcomes**
CMHPSM will establish a Utilization Management Plan in accordance with the MDHHS requirements	Complete performance summary quarterly reviewing trends, patterns of under/over utilization, medical necessity criteria, and the process used to review and approve provision of medical services. Identify CMHSPs/SUDPs requiring improvement and present/provide to relevant committees/ councils.	Regional UM/UR Committee	Quarterly Q1 February Q2 May Q3 August Q4 November	Met
	Ensure utilization of uniform screening tools and admission criteria. LOCUS, CAFAS, PECFAS DECA. MCG, ASAM, SIS.	Regional UM/UR Committee Regional CPT Committee	Quarterly (parity)	Met

	Complete analysis of parity program compliance with LOC and LOC exceptions	Regional UM/UR Committee	Quarterly	Partially Met
CMHPSM will demonstrate full compliance with timeframes of service authorization decisions in accordance with the MDHHS requirements.	Oversight of compliance with policy through primary source verification during CMHPSM reviews of ABD state data reports and reviews of delegated functions of CMHSPs.	Regional UM/UR Committee	Quarterly Q1 February Q2 May Q3 August Q4 November	Met
	Analysis of ABD data reports in meeting service decision timeframes.			Met
CMHPSM will meet or exceed the standard for compliance with the adverse benefit determination notices completed in accordance with the 42 CFR 438.404 Includes assurance that ABDs accurately provide service denial reasons in language understandable to person served, type of denial, accuracy of service and denial decision explanation, and compliance with timeframes	Revise ABD training for staff. Staff to complete training	Regional UM/UR Committee	03/30/2023	Partially Met
	Oversight of compliance with policy through primary source verification during CMHPSM reviews of ABD state data reports and reviews of delegated functions of CMHSPs.	Regional UM/UR Committee	Quarterly Q1 February Q2 May Q3 August Q4 November	Met
CMHPSM will meet or exceed the standard for appeal resolution in accordance with federal and state standards.	CMHPSM will complete an appeals procedure on utilization of the regional EHR appeals module to ensure compliance with all state and federal standards of grievance documentation and resolution. CMHPSM will conduct monthly monitoring of compliance with data collection/documentation that meets state and federal appeals standards, providing retraining and interventions, as needed up to the point where there is 100% compliance (no findings) for 3 consecutive monthly reviews, after which quarterly reviews will be conducted.	CMHPSM COO CMHPSM Compliance/Quality Manager Regional UM/UR Committee	12/15/2023 Monthly	Met
Practice Guidelines	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency / Due Date**	**FY2023 Outcomes**

CMHPSM will adopt, develop, implement nationally accepted or mutually agreed upon (CMHPSM/MDHHS) clinical practice guidelines/standards, evidenced based practices, best practice, and promising practices relevant to the individual served.	Review of CPGs for any updates or revisions to CPGs being utilized in the region.	Regional CPT Committee CMHPSM COO Regional NMC Committee	Quarterly Q1 February Q2 May Q3 August Q4 November	Met
	Update CPG list, including providers that implement/offer CPGs.		12/31/22	Met
	Communicate available CPGs to provider networks		February 2023 December 2023	Met
CMHPSM will demonstrate full compliance with MDHHS required practice guidelines.	Oversight during CMHPSM reviews of managed care delegated functions to ensure providers adhere to practice guidelines as required.	CMHPSM COO CMHPSM Compliance/Quality Manager	Annually	Met
Oversight of Vulnerable Individuals and Long Term Supports and Services	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency / Due Date**	**FY2023 Outcomes**
CMHPSM will evaluate health, safety and welfare of persons served considered vulnerable and receiving LTSS order to determine opportunities for improving oversight of their care and their outcomes.	Ensure the identification of LTSS 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	January 2023 Quarterly data review Q1 February Q2 May Q3 August Q4 November	Met
Assure accurate identification of persons served within HCBS, 1915i services, and LTSS.	Report development and data analysis of completion and accuracy of HCBS and 1915i assessment and documentation in the clinical record. 90% compliance with clinical documentation of those persons qualified for HCBS/1915i identified in the EHR. 100% of 1915i recipients enrolled in MDHHA WSA Define LTSS in functionality of data analysis.	CMHPSM COO CMHPSM Health Data Analyst Regional CPT Committee	Report development January 2023 Quarterly Report analysis Q1 February Q2 May Q3 August Q4 November	Partially Met

CMHPSM will assess the quality and appropriateness of care furnished to members(vulnerable people) receiving LTSS including an assessment of care between care settings, a comparison of services and supports received	Include analysis of regional committee performance reports (including barriers, improvement efforts, recommendations, and status of recommendations) for efforts to support community integration. critical incidents, sentinel events, risk events, behavior treatment plans, member satisfaction results, practice guidelines, credentialing and recredentialing, verification of Medicaid services, over and underutilization, and provider network monitoring	CMHPSM COO CMHPSM Compliance/Quality Manager Regional CPT Committee Regional CS Committee Regional NMC Committee	Quarterly Q1 February Q2 May Q3 August Q4 November	Met LTTS not yet available in state database
Behavior Treatment	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency / Due Date**	**FY2023 Outcomes**
CMHPSM will demonstrate an increase in compliance with Behavior Treatment data collection and analysis.	Submit data on Behavior Treatment Plans where intrusive and or restrictive techniques have been approved by the behavior treatment committee and where emergency interventions have been used.	CMHPSM BTC Chairs CMHPSM Compliance/Quality Manager	FY23 Quarterly February May August, November	Met HSAG (EQR) Recognition
	Complete Behavior Treatment performance reports that analyze the use of emergency interventions, plans approved with restrictive and/or intrusive interventions, and adherence to the BTPR Standards (including barriers, improvement efforts, recommendations, and status of recommendations).	CMHPSM Compliance/Quality Manager Regional CPT Committee	FY22 Annual Report 2/28/23 FY23 Quarterly February May August, November	Met HSAG (EQR) Recognition
	CMHPSM will explore system abilities to report BTC data electronically more efficiently while maintaining security/privacy and reporting standards.	CMHPSM Compliance/Quality Manager Regional CPT Committee	04/30/23 FY22 Annual Report 2/28/23 FY23 quarterly February May August, November	Met
	CMHPSM will conduct quarterly analysis and reporting of BTC data reinstated by PIHP staff by 2/28/23, reported to Regional CPT Committee for any corrective action measures to be taken, and	CMHSM COO	FY22 Annual Report 02/28/23 FY23 quarterly	Met

	incorporated into the CMHPSM QAPIP documents and reports	CMHPSM Compliance/Quality Manager	March May August, November	
Provider Monitoring	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**FY2023 Outcomes**
CMHPSM will be in compliance with PIHP Contract Requirements.	Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUD providers. Coordinate quality improvement plan development, incorporating goals and objectives for specific growth areas based on the site reviews, and submission of evidence for follow up reviews.	Regional NMC Committee CMHPSM COO CMHPSM SUD Services Director	Annual	Met for SUD Partially Met for CMHSPs
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. Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	CMHPSM COO CMHPSM Compliance/Quality Manager Regional Compliance Committee	Monthly Quarterly	Met
CMHPSM will demonstrate full compliance with the EQR-Performance Measure Validation Review	Implement quality improvement plans for recommendations provided by the external quality review team. Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	CMHPSM CIO CMHPSM COO CMHPSM Compliance/Quality Manager Regional CPT Committee Regional EOC Committee	Annual	Met
CMHPSM will receive a score of "Met" for the EQR Performance Improvement Project Validation	Implement and comply with all PIP Validation submission requirements	CMHPSM CIO CMHPSM COO CMHPSM Compliance/Quality Manager Regional CPT Committee	Annual	Met

		Regional EOC Committee		
CMHPSM will demonstrate an increase in compliance with the MDHHS 1915 Reviews.	Monitor systematic remediation for effectiveness through delegated managed care reviews and performance monitoring through data.	CMHPSM COO CMHPSM Compliance/Quality Manager	09/30/23	Met
CMHPSM will demonstrate full compliance with the MDHHS Substance Use Disorder Protocols	Provide evidence to support SUD requirements	CMHPSM COO CMHPSM SUD Services Director	09/30/23	Met
CMHPSM will demonstrate assurances of adequate capacity and services for the region, in accordance with the MDHHS Network Adequacy standards.	Submit Network Adequacy Report to MDHHS Complete Network Adequacy Assessment including all required elements.	CMHPSM COO Regional NMC Committee	02/28/23 09/30/23	Met
Provider Qualifications	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**FY2023 Outcomes**
CMHPSM will ensure physicians, other healthcare providers, and non-licensed individuals are qualified to perform their jobs.	CMHPSM will conduct monthly monitoring of compliance with Organizational credentialing and re-credentialing requirements, providing retraining and procedures revisions as needed up to the point where there are no findings for 3 consecutive monthly reviews, after which quarterly reviews will be conducted. 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	Monthly Quarterly	Partially Met
CMHPSM will have credentialing policies/ procedures, in accordance with MDHHS Credentialing and Re-Credentialing Process, for ensuring that all providers rendering services to individuals are appropriately credentialed within the state and are qualified to perform their services.	CMHPSM monthly monitoring of compliance with LIP credentialing and re-credentialing requirements providing retraining and procedures revisions as needed up to the point where there are no findings for 3 consecutive monthly reviews, after which quarterly reviews will be conducted. 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	Monthly Quarterly	Policies /Procedures Completed Monitoring Partially Met

CMHPSM ensures all delegates performing credentialing functions comply with all initial (including provisional/temporary) credentialing requirements according to initial credentialing and re-credentialing monitoring tools for organizations and LIPs Clinical service providers are credentialed by the CMHSP prior to providing services and ongoing.	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 increase monitoring for providers scoring less than 90% on the file review and will be subject to additional review of credentialing and re-credentialing records. Review semi-annual credentialing and re-credentialing report to ensure credentialing within the appropriate timeframes. CMHPSM will convene a regional workgroup of CMHSP staff involved in credentialing of clinical service staff to develop policy, procedures, and monitoring tools/documents that meet the credentialing and re-credentialing requirements for directly hired CMHSP staff as delegated to the CMHSPs.	CMHPSM COO Regional NMC Committee	Annually	Met Awaiting MDHHS Site review results
		CMHPSM COO Regional NMC Committee	Semi Annually May 2023 November 2023	Partially Met
		CMHPSM COO Regional NMC Committee	Monthly workgroup Quarterly reporting	Met
Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements.	CMHPSM Oversight and monitoring during auditing of CMHSP delegated functions. CMHSP and SUD Provider reviews of delegated functions.	CMHPSM COO CMHPSM SUD Services Director Regional NMC Committee	Annually	Partially Met Met
Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements.	CMHPSM Oversight and monitoring during auditing of CMHSP delegated functions. CMHSP and SUD Provider reviews of delegated functions.	CMHPSM COO CMHPSM SUD Services Director Regional NMC Committee	Annually	Partially Met Met

B. Figure 2. FY23 Performance Measures

FY21-23 CMHPSM Strategic Plan Metrics/Milestones Relevant to FY23 QAPIP Performance Measures:
Strategic Plan Goal #3. Improve the comprehensiveness and validity of the health data within our regional electronic health record: CRCT.
Strategic Plan Goal #7. Improve regional compliance reviews to support components of the quadruple aim.
Strategic Plan Goal #6. Improve documentation for all critically important CMHPSM functions.
Strategic Plan Goal #8. Improve the capacity, effectiveness, and quality of SUD services.

FY2023 Performance Measure Outcomes:	Green- Meeting or Exceeding State Benchmark	White – in-process or data is not yet available as of this status report.	Orange – Not currently meeting benchmark as of this status report.	Grey – No benchmark, or establishing baseline, or is a baseline year.

Strategic Plan Goal(s)	**Michigan Mission Based Performance Indicator System**	**Committee/ Council**	**FY2023 Outcomes**
3, 7	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	99.47%
3, 7	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	98.38%
3, 7	CMHPSM will meet or exceed the standard for Indicator 2. A The percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children. (No Standard)	Regional CPT Regional EOC	Overall decrease MI Adult 55.33% SED Child 56.59% DD Child 63.60% DD 56.35%
3, 7, 8	CMHPSM will meet or exceed the standard for Indicator 2 b. 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. (No Standard)	Regional CPT Regional EOC	59.65%
3, 7	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 (by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children). (No Standard)	Regional CPT Regional EOC	Overall increase MI Adult 67.46% SED Child 69.7% DD Adult 79.13% DD 84.69%
3, 7	CMHPSM will meet or exceed the standard for Indicator 4a1: Follow-Up within 7 Days of Discharge from a Psychiatric Unit	Regional CPT Regional EOC	95.48%

	(Standard is 95% or above) (Child)		
3, 7	CMHPSM will meet or exceed the standard for Indicator 4a2: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (Standard is 95% or above) (Adult)	Regional CPT Regional EOC	95.36%
3, 7, 8	CMHPSM will meet or exceed the standard for Indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (Standard is 95% or above)	Regional CPT Regional EOC	98.35%
3, 7	CMHPSM will meet or exceed the standard for Indicator 10: Re-admission to Psychiatric Unit within 30 Days (Standard is 15% or less) (Child)	Regional CPT Regional EOC	5.1%
3, 7	CMHPSM will meet or exceed the standard for Indicator 10: Re-admission to Psychiatric Unit within 30 Days (Standard is 15% or less) (Adult)	Regional CPT Regional EOC	11.7%
3, 7, 8	CMHPSM will demonstrate and increase in compliance with access standards for the SUD priority populations. (Baseline)	Regional CPT Regional EOC	Baseline
Strategic Plan Goal(s)	**BH TEDS Data**	**Committee**	**FY2023 Outcomes**
3, 7	Increase identification of veterans (military fields) to support increase in utilization of Veterans Navigation services. Maintain overall BHTEDS completion rates to state 95% standard during FY2023. Improve crisis encounter BHTEDs completion to 95% during FY2023.	Regional EOC Regional CPT	Met 98.45% 98.54%
Strategic Plan Goal(s)	**Performance Improvement Projects**	**Committee**	**FY2023 Outcomes**
3, 7, 6	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	FY22 Baseline 22.94% (Minority) 12.22% (White)
3, 7, 6	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. FY22 Baseline: MI Adult 64.75% SED Child 56.96% DD Child 68.35% DD Adult 62.16% SUD 59.37%	Regional EOC Regional CPT	MI Adult 67.46% SED Child 69.7% DD Adult 79.13% DD 84.69%
Strategic Plan Goal(s)	**Assessment of Member Experiences**	**Committee**	**FY2023 Outcomes**

3, 7, 6	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%)	Regional Customer Services Committee	Ten of the eleven items in the survey scored above threshold Item #10 - I know how to file a complaint - scored at 64%,
3, 7, 8	Percentage of consumers indicating satisfaction with SUD services. (Standard 3 Likert score)	CMHPSM SUD Director Regional Co-Occurring Workgroup	Averages of most questions ranging at 2.8 or higher on the 3-point scale. The Involvement domain scored below 2.8 for all 4 counties at 2.56%
Strategic Plan Goal(s)	**Member Appeals and Grievance Performance Summary**	**Committee**	**FY2023 Outcomes**
3, 7, 6, 8	The percentage (rate per 1000) 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%)	Regional UM/UR Committee Regional CPT Committee	.98 per 100 100% Met
3, 7, 6, 8	The percentage (rate per 1000) 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 Regional CPT Committee	4.4 per 100 4.5 100% Met
Strategic Plan Goal(s)	**Adverse Event Monitoring and Reporting**	**Committee**	**FY2023 Outcomes**
3, 7, 6, 8	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	Baseline: 3.8 per 1000 FY2022 (0.96) to FY2023 (1.18)
3, 7, 6, 8	The rate, per 1000 persons served, of Non-Suicide Death will demonstrate a decrease from previous year. (CMHSP)(Natural Cause, Accidental, Homicidal) Ensure compliance with timely and accurate reporting of critical and sentinel events (100%) 100% CEs reporting 100% timely reporting	Regional CPT Committee Regional EOC Committee	FY23 displayed an 18% decrease over FY2022 (52.6 to 43.0), meeting this target.

3, 7, 6, 8	Quarterly report and analysis of type, trends over time (including mortality), events per 1,000, regional trends over time starting with 2020, analysis of trends by service, engagement in treatment, precipitating events. Analysis of CE trends for potential PI projects	Regional CPT Committee Regional EOC Committee	Met
3, 7, 6, 8	The rate, per 1000 persons served, of Sentinel Events will demonstrate a decrease from the previous year.	Regional CPT Committee Regional EOC Committee	Baseline
3, 7, 6, 8	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 3day review of critical events (CEs) that are sentinel events (SEs) 100% RCA completion	Regional CPT Committee Regional EOC Committee	Met
Strategic Plan Goal(s)	**Joint Metrics**	**Committee**	**FY2023 Outcomes**
3, 7, 6, 8	Collaboration meeting completed between entities for the ongoing coordination and integration of services. (100%)	Regional EOC Committee Regional CPT Committee	100%
3, 7, 6	The percentage of discharges for adults (18 years or older) who were hospitalized for treatment of selected mental illness and who had a follow-up visit with a mental health practitioner within 30 days after discharge. FUH Report, Follow-Up After Hospitalization Mental Illness Adult (Standard-58%) Measurement period will be calendar year 2021.	Regional EOC Committee Regional CPT Committee	68%
3, 7, 6	The percentage of discharges for children (ages 6-17 years) who were hospitalized for treatment of selected mental illness and who had a follow-up visit with a mental health practitioner within 30 days after discharge. FUH Report, Follow-Up After Hospitalization Mental Illness Adult (Standard-70%) Measurement period will be calendar year 2021.	Regional EOC Committee Regional CPT Committee	83%
3, 7, 6	Racial/ethnic group disparities will be reduced. CMHPSM will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following a psychiatric hospitalization (adults and children) (Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences)	Regional EOC Committee Regional CPT Committee	Rates greater than the typical statewide value

	Measurement period will be a comparison of calendar year 2020 with calendar year 2021.		
3, 7, 8	Follow up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence 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. (Standard 27%) Measurement period will be calendar year 2021.	Regional EOC Committee Regional CPT Committee	44.77%
3, 7, 8	Reduce the disparity measures for FUA. Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following an emergency department visit for alcohol or drug use. (Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences) The measurement period will be a comparison of calendar year 2020 with calendar year 2021.	Regional EOC Committee Regional CPT Committee	In compliance
Strategic Plan Goal(s)	**Performance Based Incentive Payments**	**Committee**	**FY2023 Outcomes**
3, 7, 6	CMHPSM will improve or maintain data quality on BH-TEDS military and veteran fields. Data will be analyzed and monitored for discrepancies between VSN and BH-TEDS data. Identification of beneficiaries who may be eligible for services through the Veterans Administration.	Regional EOC Committee Regional CPT Committee	In compliance
3, 7	Increased data sharing with other providers through sending ADT messages for purposes of care coordination through health information exchange. (narrative report)	Regional EOC Committee Regional CPT Committee	Complete
3, 7, 8	CMHPSM will participate in DHHS-planned and DHHS-provided data validation 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) *No state threshold set yet*	Regional EOC Committee Regional CPT Committee	Complete
3, 7, 8	CMHPSM will participate in DHHS-planned and DHHS-provided data validation 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) *No state threshold set yet*	Regional EOC Committee Regional CPT Committee	Complete

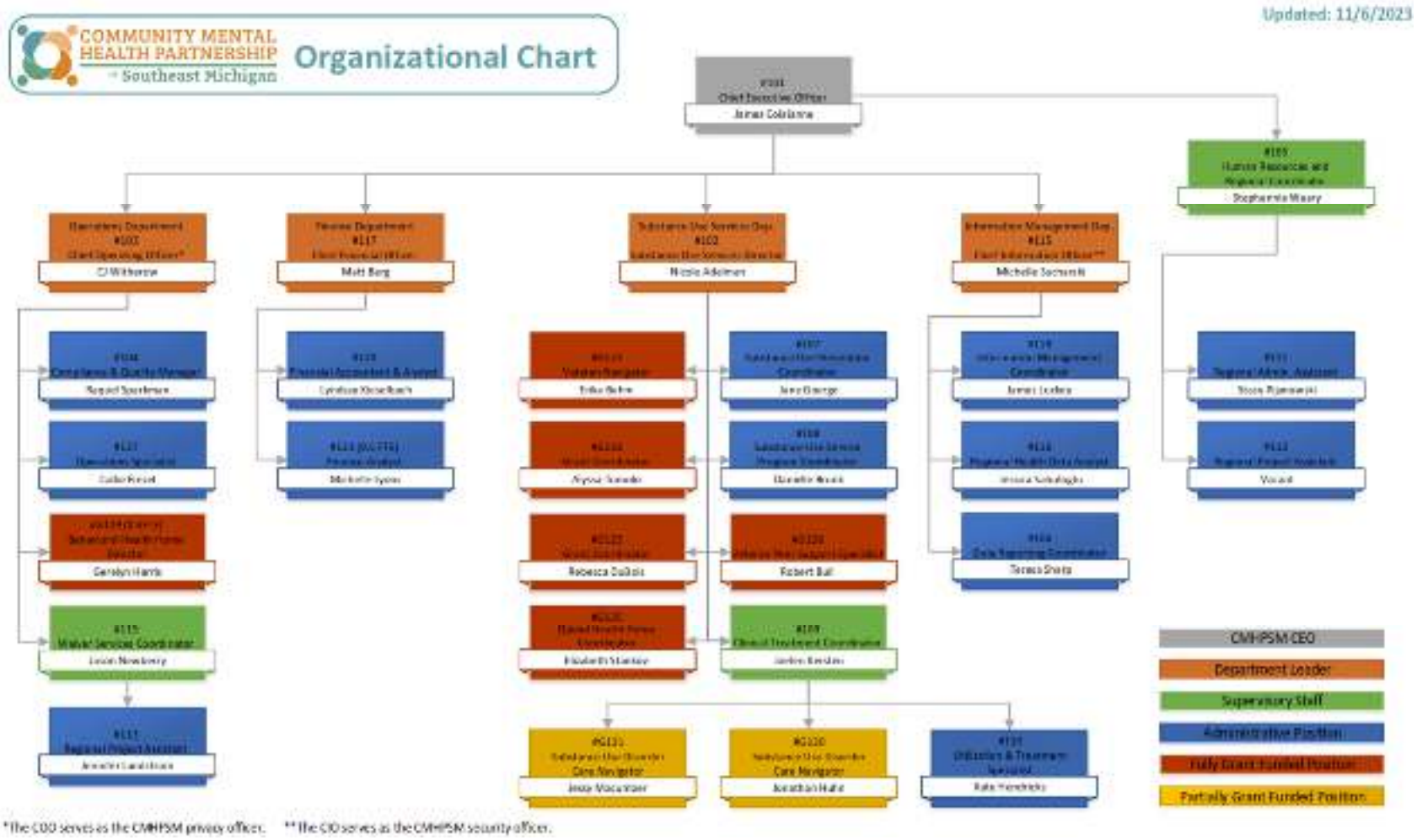
	CMHPSM will increase participation in patient-centered medical homes/health homes. (narrative report)	Regional CPT Committee	Complete
Strategic Plan Goal(s)	**Priority Measures**	**Committee**	**FY2023 Outcomes**
	Clinical SUD		
3, 7, 8	CMHPSM SUD providers will meet ASAM continuum completion rates (Target 95%) CMHPSM SUD providers will meet priority population timelines (Target 95%) CMHPSM SUD Provider decrease in open SUD wrapper admissions without service and increase in closed cases. (above 20%) Monthly data reviews and quarterly data analysis reporting. (Target 95%)	Regional CPT Committee	**ASAM Measure reset at 75%** FY23 Baseline 83% **Priority Measure reset at 75%** FY23 Average: 80% SUD Wrappers 28% 97%
Strategic Plan Goal(s)	**Utilization Management/LTSS**	**Committee**	**FY2023 Outcomes**
3, 7, 6	Assess validity and reliability of LOCUS application across the region. a. Increase in timely completion of LOCUS (at intake, before annual BPS signed) b. Percentage of LOCUS score changes over time. Significant score changes show medical necessity. c. Percentage of LOCUS overrides do not exceed 10% d. Clear documentation of overrides e. LOCUS score is accurately reflected in parity Level of Care in clinical record	Regional UM/UR Committee	a. 72% (from 70%) b. 98.9% c. 13% d. 99.86% e. Deferred to FY24
3, 6	Correct timeframes used for advance action notice (Target 100%) Accurate use of reduction, suspension, or termination decisions. (Target 100%) ABDs provide service denial reasons in language understandable to person served. (95%) Analyze type of denial, accuracy of service and denial decision explanation, and compliance with timeframes. (95%)	Regional UM/UR Committee	100% 100% 97.4% 95%

3, 6	Assess overutilization of services: Identify any services by population that indicate overutilization. Where indicated develop interventions to address overutilization. Incorporate LTSS, c waiver utilization, trends over time, provider stability factors. Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person-centered plan.	Regional UM/UR Committee	Baseline
	Assess underutilization of services: Identify any services by population that indicate underutilization. Where indicated develop interventions to address underutilization. Incorporate LTSS, c waiver utilization, trends over time, provider stability factors. Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person-centered plan.	Regional UM/UR Committee	Baseline
3, 7, 6, 8	Evidence of use of parity program for those with established LOC in CMHPSM reviews of CMHSPs clinical records for all populations (Standard 90%).	Regional UM/UR Committee	Deferred for FY24 onset
3, 7, 8	Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages (Standard <=5%).	Regional UM/UR Committee	Deferred for FY24 onset
3, 7	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.	Regional UM/UR Committee	Deferred for FY24 onset Met
Strategic Plan Goal(s)	**Behavior Treatment**	**Committee**	**FY2023 Outcomes**
3	Consistent quarterly reporting of BTC data (100%) Consistent data analysis of BTC data (100%)	Regional CPT Committee	100%
3, 7, 6	Development of BTC data baselines at the completion of BTC quarterly reporting and data analysis in FY2023.	Regional CPT Committee	Met
Strategic Plan Goal(s)	**Clinical Practice Guidelines**	**Committee**	**FY2023 Outcomes**
6	CPGs reviewed at least annually.	Regional CPT Committee	Completed
6	CPGs published to both provider network and members.	Regional CS Committee Regional NMC Committee	50%
Strategic Plan Goal(s)	**Provider Monitoring**	**Committee**	**FY2023 Outcomes**

3, 7, 6, 8	Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements.	Regional NMC Committee	99.8% CMHSP
3, 7, 6, 8	Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements.	Regional NMC Committee	PIHP review: 92% Pending FY23 MDHHS Site Review findings
3, 7, 6, 8	Credentialing and re-credentialing of organizational providers meet all state/federal requirements and timelines.	Regional NMC Committee	92% 174/203
3, 7, 6	Credentialing and re-credentialing of LIP providers meet all state/federal requirements and timelines.	Regional LIP Committee	95% (16/17)
	Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP. 100% completion of planned audits. 100% of providers will have remedial action sufficient wherein no contractual action needs to be taken. Coordinate quality improvement plan development, incorporating goals and objectives for specific growth areas based on the site reviews, and submission of evidence for the follow up reviews. 100% of corrective action plans are completed and submitted as required.	CMHPSM COO Regional CPT Committee Regional Compliance Committee	100% SUD 50% CMHSP Pending FY23 MDHHS Site Review findings
3, 7, 6	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	20 HCBS sites
Strategic Plan Goal(s)	**Health Home (OHH, BHH, CCBHC) Performance Measures**	**Committee**	**FY2023 Outcomes**
3, 7, 6, 8	Meet or exceed OHH performance benchmarks.		Met
3, 7, 6	Meet or exceed BHH performance benchmarks.	Regional BHH Workgroup	Met
3, 7, 6, 8	Meet or exceed federally defined QBP measures and benchmarks for CCBHCs.	Regional CCBHC Workgroup	Met

x. Attachments

A. Attachment A: CMHPSM Organizational Structure



B. *Attachment B: Performance Improvement Framework*