MSHN

Mid-State Health Network

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

Annual Report FY2022

Prepared By: MSHN Quality Manager – 11/29/2022
Reviewed and Approved By: Quality Improvement Council – 12/2022
Reviewed By: MSHN Leadership – 12/14/2022
Reviewed By: MSHN Operations Council – 12/19/2022
Reviewed and Approved By: MSHN Board – 01/10/2023

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I. Introduction

The Mid State Health Network (MSHN) Quality Assessment and Performance Improvement Program (QAPIP) is reviewed annually for effectiveness. The review includes the components of the QAPIP, the performance measures, and improvement initiatives, as required based on the MDHHS PIHP contract and the BBA standards. In addition to ensuring the components continue to meet the requirements, each strategic initiative is reviewed to determine if the expected outcome has been achieved. Following the review of the Annual QAPIP Report, recommendations are made for the Annual QAPIP Plan which includes a description of each activity and a work plan for the upcoming year. The Board of Directors receives the Annual QAPIP Report and approves the Annual QAPIP Plan for following year. The measurement period for this annual QAPIP Report is October 1, 2021, through September 30, 2022. The scope of MSHN's QAPIP is inclusive of all CMHSP Participants, the Substance Use Disorder Providers, and their respective provider networks in the MSHN region.

II. Organizational Structure

a) Structure

The structure of the QAPIP allows each contracted behavioral health provider to establish and maintain its own unique arrangement for monitoring, evaluating, and improving quality. The MSHN Quality Improvement Council, under the direction of the Operations Council, is responsible for ensuring the effectiveness of the QAPIP. Process improvements will be assigned under the auspices of MSHN to an active PIHP council, committee, workgroup, or task specific Process Improvement Team.

b) Components

Recipients

MSHN continues the legacy of its founding CMHSP Participants by promoting and encouraging active consumer involvement and participation within the PIHP, the respective CMHSP participants and their local communities. Recipients of services participate in the QAPIP through involvement on workgroups, process improvement teams, advisory boards, and Quality Improvement (QI) Councils at the local and regional level. Recipients provide input into policy and program development, performance indicator monitoring, affiliation activities/direction, self- determination efforts, QI projects, satisfaction findings, consumer advocacy, local access and service delivery, and consumer/family education, etc. In addition to the participation of recipients of services in quality improvement activities, MSHN and the CMHSP Participants/SUD Providers strive to involve other stakeholders including but not limited to providers, family members, community members, and other service agencies whenever possible and appropriate. Opportunities for stakeholder participation include the PIHP governing body membership; Consumer Advisory activities at the local, regional, and state levels; completion of satisfaction surveys; participation on quality improvement work teams or monitoring committees; and focus group participation. Stakeholder input will be utilized in the planning, program development, and evaluation of services, policy development, and improvement in service delivery processes.

MSHN will provide oversight and monitoring of all members of its contracted behavioral health network in compliance with applicable regulatory guidance. For the purposes of the Quality Management functions germane to successful PIHP operations, the following core elements shall be delegated to the Community Mental Health Services Programs and SUD Providers within the region:

- Implementation of Compliance Monitoring activities as outlined in the MSHN Corporate Compliance Plan
- Development and Implementation of Quality Improvement Program in accordance with PIHP Quality Assessment and Performance Improvement Plan
- Staff Oversight and Education
- Conducting Research (if applicable)

MSHN will provide guidance on standards, requirements, and regulations from the MDHHS, the External Quality Review, the Balanced Budget Act, and/or other authority that directly or indirectly affects MSHN PIHP operations. Communication related to standards and requirements will occur through policy and procedure development, constant contact, training, and committees/councils. MSHN will retain responsibility for developing, maintaining, and evaluating an annual QAPIP and report in collaboration with its CMHSP Participants and Substance Use Disorder Providers. MSHN will comply with 42 CFR Program Integrity Requirements, including designating a PIHP Compliance Officer. Assurances for uniformity and reciprocity are as established in MSHN provider network policies and procedures.

Communication of Process and Outcomes

The MSHN Quality Improvement Council (QIC) is responsible for monitoring and reviewing performance measurement activities including identification and monitoring of opportunities for process and outcome improvements in collaboration with other committees and councils, and the CMHSP Participants and SUD Providers. A quality structure should identify clear linkages and reporting structures. Quarterly, members of the committees, councils, and other relevant MSHN staff review the status of the organizational performance measures to identify trends, correlations, and causal factors, establishing a quality improvement plan to address organizational deficiencies.

For any performance measure that falls below regulatory standards and/or established targets, quality improvement plans are required. After QIC meetings, reports are communicated through regular reporting via Councils, Committees, the Board of Directors, and Consumer Advisory Council meetings. Status of key performance indicators, consumer satisfaction survey results, and performance improvement (PI) projects are reported to consumers and stakeholders, as dictated by the data collection cycle. The Board of Directors receives an annual report on the status of organizational performance. Final performance and quality reports are made available to stakeholders and the general public as requested and through routine website updates.

MSHN is responsible for reporting the status of regional PI projects and verification of Medicaid services to MDHHS. These reports summarize regional activities, achievements, and include interventions resulting from data analysis.

The expectation of the use of practice guidelines are included in provider contracts. Practice guidelines are reviewed and updated annually or as needed and are disseminated to appropriate providers through relevant committees/councils/workgroups. All practice guidelines adopted for use are available on the MSHN website.

c) Governance

Board of Directors

The MSHN's Board of Directors employs the Chief Executive Officer (CEO), sets policy related to quality management, and approves the PIHP's QAPIP, including the priorities as identified in this plan. The QAPIP Plan is evaluated and updated annually, or as needed, by the MSHN Quality Improvement Council.

Through the Operations Council, Substance Use Disorder Oversight Policy Board and MSHN CEO, the MSHN's Board of Directors will receive and approve the Annual Quality Assessment and Performance Improvement Program (QAPIP) Report evaluating the effectiveness of the quality management program and recommending priorities for improvement initiatives for the next year. The report describes quality management activities, performance improvement projects, and actions taken to improve performance. After review and approval by the Board of Directors, the QAPIP Report, including a list of the Board of Directors' and the QAPIP Plan is submitted to the Michigan Department of Health and Human Services (MDHHS).

Chief Executive Officer

MSHN'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 MSHN CEO has designated the Quality Manager as the chair of the MSHN Quality Improvement Council. In this capacity, the Quality Manager under the direction of the Chief Compliance and Quality Officer, is responsible for the development, review, and evaluation of the Quality Assessment and Performance Improvement Plan and Program in collaboration with the MSHN regional committees/ and councils.

The MSHN 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 Operations Council to maintain quality and consumer safety. Additionally, the CEO is committed to the goals of the quality improvement plan and to creating an environment that is conducive to the success of quality improvement efforts, ensuring affiliation involvement, removing barriers to positive outcomes, and monitoring results of the quality improvement program across the PIHP. The CEO reports to the PIHP Board of Directors recommending policies and/or procedures for action and approval. The CEO is responsible for managing contractual relationships with the CMHSP Participants and Substance Use Disorder Providers and for issuing formal communications to the CMHSP Participants/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 performance improvement plans as required.

Medical Director

The MSHN Medical Director and MSHN Addictions Treatment Medical Director consults with MSHN staff regarding service utilization and eligibility decisions and is available to provide input as required for the regional QAPIP.

The MSHN Medical Director is an ad hoc member of the MSHN Quality Improvement Council and demonstrates an ongoing commitment to quality improvement; participating on committees and work teams as needed, reviewing quality improvement reports, sentinel events, and critical incidents; and assisting in establishing clinical outcomes for the PIHP.

CMHSP Participants/SUD Providers

A quality representative from each CMHSP is appointed by the CMHSP CEO to participate in the MSHN Quality Improvement Council. Substance Use Disorders services are represented at the Council by MSHN SUD Staff. CMHSP Participant/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, and work groups.
- Reporting clinical care errors, informing consumers of risks, and making suggestions to improve the safety of consumers.
- Responsible for communication between the PIHP QIC and their local organization.

Councils and Committees

MSHN Councils and Committees are responsible for providing recommendations and reviewing regional policies regarding related managed care operational decisions. Each council/committee develops and annually reviews and approves a charter that identifies the following: Purpose, Decision Making Context and Scope, Defined Goals, Monitoring, Reporting and Accountability, Membership, Roles and Responsibilities Meeting Frequency, Member Conduct and Rules, and Upcoming Goals supporting the MSHN Strategic Plan. The Operations Council approves all council/committee charters. Each council/committee guides the Operations Council who advises the MSHN CEO. These recommendations are considered by the Operations Council on the basis of obtaining a consensus or simple majority vote of the twelve CMHSP participants. Any issues remaining unresolved after Operations Council consideration will be subject to a vote with the majority position being communicated to the MSHN Board. The MSHN CEO retains authority for final decisions or for recommending action to the MSHN Board.

Among other duties, these councils/committees identify, receive, and respond on a regular basis to opportunities and recommendations for system improvements arising from the MSHN Quality Assessment and Performance Improvement Program and reports annually on the progress of accomplishments and goals.

Regional Medical Directors

The Regional Medical Directors Committee, which includes membership of the MSHN Medical Director and the CMHSP participant Medical Directors, provides leadership related to clinical service quality and service utilization standards and trends.

SUD Oversight Policy Board

Pursuant to section 287 95) of Public Act 500 of 2012, MSHN established a Substance Use Disorder Oversight Policy Board (OPB) through a contractual agreement with and membership appointed by each of the twenty-one 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 MSHN Board on other areas of SUD strategic priority, local community needs, and performance improvement opportunities.

Regional Consumer Advisory Council (RCAC)

The RCAC is charged with serving as the primary source of consumer input to the MSHN Board of Directors related to the development and implementation of Medicaid specialty services and supports requirements in the region.

SUD-Advisory Councils

The MSHN SUD provider network utilizes work groups to serve in an advisory capacity to MSHN to represent SUD providers and to offer input regarding SUD policies, procedures, strategic planning, quality improvement initiatives, monitoring and oversight processes, and to support MSHN's focus on evidence-based, best practice service and delivery to persons served. Each SUD provider work group is specific to a Level of Care (LOC) and functional area including, Women's Specialty Services, Medication Assisted Treatment, Residential, Recovery Housing, and Outpatient work groups.

III. Annual Reports

a) MSHN Councils Annual Reports FY22

Team Name: Mid-State Health Network Operations Council

Team Leader: Joseph Sedlock, MSHN Chief Executive Officer

Report Period Covered: 10.1.21-9.30.22

Purpose of the Operations Council:

The MSHN Board has created an OC to advise the Pre-paid Inpatient Health Plan's (PIHP) Chief Executive Officer (CEO) concerning the operations of the Entity. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the MSHN CEO to bring local perspectives, local needs, and greater vision to the operations of the Entity so that effective and efficient service delivery systems are in place that are accountable to the entity board, funders and the citizens who make our work possible.1

Responsibilities and Duties[2]:

The responsibilities and duties of the OC shall include the following:

- Advise the MSHN CEO in the development of the long-term plans of MSHN.
- Advise the MSHN CEO in establishing priorities for the Board's consideration.
- Make recommendations to the MSHN CEO on policy and fiscal matters.
- Review recommendations from Finance, Quality Improvement, and Information Services Councils other Councils/Committees asassigned.
- Assure policies and practices are operational, effective, efficient and in compliance with applicable contracting and regulatory bodies[3];and
- Undertake such other duties as may be delegated by the Entity Board.

Defined Goals, Monitoring, Reporting and Accountability[4]

The Operations Council shall establish metrics and monitoring criteria to evaluate progress on the following primary goals:

- Expanded service access (penetration rates),

[1] Article III, Section 3.2, MSHN/CMHSP Operating Agreement

[2] Ibid., unless otherwise footnoted

[3] Operations Council Charter, February 2014

[4] Ibid.

- Fiscal accountability,
- Compliance, and Improved health outcomes/satisfaction.

Additionally, the OC seeks to assess and achieve the following secondary goals:

- Retained function contracts achieved defined results,
- Collaborative relationships are retained (Evaluation of principles and values),
- Board satisfaction with OC advisory role,
- Staff perception and sense of knowing what is going on,
- Efficiencies are realized through standardization and performance improvement, and
- Benefits are realized through our collective strength.

Annual Evaluation Process:

a. Past Year's (FY22) Accomplishments:

- Reviewed and approved the FY22 Utilization Management Plan
- Medicaid Event Verification provide function on behalf of region (October 2021)
- Ongoing advocacy of opposition to Legislative System Redesign Bills
- Approved Performance Improvement Project (PIP) Project #1, MSHN Penetration Rate by Race, for submission to MDHHS
- Region approved continuation to cover provider costs related to COVID associated with compliance with the OSHA Emergency Temporary Standards. Cost of testing per EMT should be passed along to employee
- Approved to move forward with negotiations and presenting a contract to Board of Directors regarding Regional Crisis Residential Service
- Approved the Optional Performance Improvement Project (PIP) for FY22-25: MSHN New Persons Starting Treatment Within 14 Days of Bio-psychosocial Assessment.
- Approved the FY22 Guide to Services-Change Log
- Proposed funding strategies of a pooled fund arrangement to address workforce shortages. Created guidance and an application form for providers to request funding.
- Ordered and Distributed 50,000 KN95 masks
- Reviewed the FY21 Annual Compliance Summary
- Approved the FY21 QAPIP report and the FY22 QAPIP Plan
- Reviewed the North Shores Crisis Residential Contract and all CMHSPs, except Newaygo, have agreed to sign the contract.
- Supported the creation of a limited Self-Determination focused regional workgroup.
- Refined, clarified and initiated regional provider staffing crisis stabilization initiative program guidance. Reviewed applications received and discussed
- Discussed/developed strategies to introduce new MDHHS leadership to regional successes and collaborations.
- Continued collaborating on COVID-related operational parameters to promote regional consistency
- Addressed house redesign proposals and developed action plans for follow-up.
- Ordered and Distributed PPE supplies to SAPTR providers
- Approved the FY21 Network Adequacy Assessment
- Took action to improve consistency and standardization relating to the Provider Network Management Credentialing.
- Supported the formation of the Children's Workgroup to begin October 2022
- Supported the Self Direction Workgroup recommendations for MSHN to facilitate meetings with CMHSPs in the region to establish regional templates for Self-Determination agreement, Medicaid

Provider agreement, Employment agreement, Purchase of Service agreement, and Agency Supported Self-Direction Provider agreement.

- Supported changes to the FY23 Medicaid Subcontract and Change Log
- Supported changes to the FY23 IPHU Regional Contract and Change Log
- Supported changes to the FY23 ABA Regional Contract and Change Log
- Supported changes to the FY23 FMS Regional Contract and Change Log
- Supported MSHN taking a stronger approach to concerns related to State Inpatient Discharges and admission limitations

b. Upcoming Goals for Fiscal Year Ending, September 30, 2023:

- Continue COVID-pandemic related regional provider stabilization initiatives.
- Advocate for system reform changes that work for beneficiaries in the region while addressing, responding to, and planning for changes to the public behavioral health system as a result of legislative/other proposals for system redesign.
- Implement applicable portions of the MSHN Strategic Plan for FY 2023.

Team Name: Finance Council

Team Leaders: Leslie Thomas MSHN Chief Financial Officer

Report Period Covered: 10.1.21-9.30.22

Purpose of the Finance Council

The Finance Council shall make recommendations to the Mid-State Health Network (MSHN) Chief Finance Officer (CFO), Chief Executive Officer (CEO) and the Operations Council (OC) to establish all funding formulas not otherwise determined by law, allocation methods, and the Entity's budgets. The Finance Council may advise and make recommendations on contracts for personnel, facility leases, audit services, retained functions, and software. The Finance Council may advise and make recommendations on policy, procedure, and provider network performance. The Council will also regularly study the practices of the Entity to determine economic efficiencies to be considered.

Responsibilities and Duties:

Areas of responsibility:

- Budgeting – general accounting and financial reporting
- Revenue analyses
- Expense monitoring and management - service unit and recipient centered
- Cost analyses and rate-setting
- Risk analyses, risk modeling and underwriting
- Insurance, re-insurance, and management of risk pools
- Supervision of audit and financial consulting relationships
- Claims adjudication and payment; and
- Audits.

Monitoring and reporting of the following delegated financial management functions:

- Tracking of Medicaid expenditures
- Data compilation and cost determination for rate setting
- FSR, EQI or other MDHHS costing initiatives
- Verification of the delivery of Medicaid services; and
- Billing of all third-party payers.

Monitoring and reporting of the following retained financial management functions:

- PIHP capitated funds receipt, dissemination, and reserves
- Region wide cost information for weighted average rates
- MDHHS reporting; and
- Risk management plan

Defined Goals, Monitoring, Reporting and Accountability

- Favorable fiscal and compliance audit: CMHSP and PIHP fiscal audits are performed between December 2021 and February 2022. The audits will be available to the PIHP once they are reviewed by their respective Board of Directors. The goal is to have all CMHSP reports by April 2022. A favorable fiscal audit will be defined as those issued with an unqualified opinion. A favorable compliance audit will be defined as one that complies in all material aspects with relevant contractual requirements.
- Meet targeted goals for spending and reserve funds: Determination will be made when the FY 2021

Final Reports due to MDHHS February 28, 2022, are received from the CMHSPs to the PIHP. The goal for FY 2021 will be to spend at a level to maintain MSHN's anticipated combined reserves to 15% as identified by the board. This goal does not override the need to ensure consumers in the region receive medically necessary care.

- Work toward a uniform costing methodology:The PIHP CFO will participate in a Statewide workgroup initiated by MDHHS and Community Mental Health Association to establish standard cost allocation methods. The goal is to reduce unit cost variances for each CPT or HCPCS. Review of the Region's Encounter Quality Initiative (EQI) report will provide useful in facilitating this analysis.
- Regionally, Finance Council will review rates per service and costs per case for service codes identified in the Service Use and Analysis report suite. Finance Council will evaluate if action is needed based on State comparisons.
- Uniform Administrative Costing – MSHN's CFO participates in the PIHP CFO council. MDHHS and Milliman have embarked on a statewide Standard Cost Allocation methodology in an effort to reduce unit rate variability by ensure similar service cost inputs. The new Standard Cost Allocation (SCA) tool was implemented statewide effective FY 2022. Eight of Twelve CMHSPs in MSHN's region received approval to defer SCA implementation. CMHSPs should work towards implementation by FY 2023 pending the appropriate contract negotiations processes occur for this change.
- MSHN will monitor the impact of Certified Community Behavioral Health Center (CCBHC) fiscal activity and its impact.
- Improve accuracy of interim reporting and projections in order to plan for potential risk related to use of reserve funds.
- Monitor changes related to 1115 waiver and its impact on the region's funding.

Annual Evaluation Process

a. Past Year's (FY22) Accomplishments

- FY 2021 fiscal audits were complete and submitted by the PIHP and 12 CMHSPs. The PIHP's and all CMHSP audits rendered an unqualified opinion. Compliance Examinations were finalized for the PIHP and all CMHSPs. The PIHP's Compliance Examination is completed after the CMHSPs to ensure all adjustments to Medicaid and Healthy Michigan Plan are included. The PIHP and its 12 CMHSPs complied in all material aspects with attestation standards set forth by the American Institute of Certified Public Accountants.
- MSHN achieved a fully funded (7.5%) Internal Service Fund for FY 2021. In addition, the region boasted maximizing its 7.5% savings potential at approximately $50.6 for a total risk reserve of 15%.
- MSHN's region continues its work in this area to fully implement SCA methodology in FY 2023. MDHHS/Milliman have a final draft for the SCA tool and methodology which is slated to be released in the near future. PIHPs and CMHSPs were informed existing cost allocation tools may be used as long as SCA methodology is adopted with those tools.
- The SED and CW are incorporated into Medicaid funding for MDHHS reporting. MSHN also tracks each revenue source to ensure sufficiency for covering CMHSP expenses. In FY 2021 revenues are sufficient to meet service needs
- MSHN successfully submitted FY 2021 Encounter Quality Initiative (EQI) reports to MDHHS. EQI reporting replaced Utilization Cost Reports submitted in previous fiscal years.

- FY 2021 Medicaid FSR reporting from the interim to the final report showed a variance of less than 1%.
- The full impact of CCBHC financing in unknown. CCBHC sites have successfully implemented the use of code T1040 which is used to calculate the number of reimbursable daily visits. Each T1040 generates a Prospective Payment System-1 reimbursement to the CCBHC sites.

MSHN's Region continued its efforts to maintain provider fiscal stability during the COVID-19 pandemic. The goal was to ensure providers continued service delivery including implementing many changes such as audio only telehealth expansion and increased in-person safety measures. MSHN expended provider stability funds with existing FY 2022 revenue as MDHHS did not disburse additional funds for this initiative. In addition, effective in April 2022, MSHN's region implemented a Provider Staffing Stabilization program to address the statewide staffing crisis associated with retention and attraction of new employees.

Further, in FY 2022 Direct Care Workers (DCW) were granted a $2.35 per hour premium pay increase for MDHHS identified services. This effort was a continuation from initial efforts implemented in FY 2020.

b. **Upcoming Goals for Fiscal Year Ending September 30, 2023:**

- FY 2022 Favorable fiscal and compliance audit: CMHSP and PIHP fiscal audits are performed between December 2022 and February 2023. The audits will be available to the PIHP once they are reviewed by their respective Board of Directors. The goal is to have all fiscal CMHSP reports by April 2023 and compliance exams by June 2023. A favorable fiscal audit will be defined as those issued with an unqualified opinion. A favorable compliance audit will be defined as one that complies in all material aspects with relevant contractual requirements.
- Meet targeted goals for spending and reserve funds: Determination will be made when the FY 2022 Final Reports due to MDHHS March 31, 2023, are received from the CMHSPs to the PIHP. The goal for FY 2022 will be to spend at a level to maintain MSHN's anticipated combined reserves to 15% as identified by the board. This goal does not override the need to ensure consumers in the region receive medically necessary care.
- Work toward a uniform costing methodology: The PIHP CFO will participate in a Statewide workgroup initiated by MDHHS and Milliman to establish standard cost allocation methods. Regionally, Finance Council will review rates per service and costs per case for service codes identified in the Service Use and Analysis report suite. Finance Council will evaluate if action is needed based on State comparisons.
- Improve accuracy of interim reporting and projections in order to plan for potential risk related to use of reserve funds.
- Monitor changes related to 1115 waiver and its impact on the region's funding.

TEAM NAME: Information Technology Council

TEAM LEADER: Steven Grulke, MSHN Chief Information Officer

REPORT PERIOD COVERED: 10.1.21-9.30.22

Purpose of the Council or Committee:

The MSHN IT Council (ITC) is established to advise the Operations Council (OC) and the Chief Executive Officer (CEO) and will be comprised of the Chief Information Officer (CIO) and the CMHSP Participants information technology staff appointed by the respective CMHSP CEO/Executive Director. The IT Council will be chaired by the MSHN CIO. All CMHSP Participants will be equally represented.

Responsibilities and Duties:

The responsibilities and duties of the ITC include the following:

- The IT Council will provide information technology leadership by collaborating for the purpose of better understanding MDHHS and other regulatory requirements, sharing knowledge and best practices, working together to resolve operational issues that affect both CMHSPs and MSHN, and achieve practical solutions. The IT Council will assist CMHSP IT staff in keeping up to date on current technology and with MDHHS and MSHN requirements by exchanging knowledge and ideas and promoting standard technology practices and efficiency throughout the region. The IT Council will advise the MSHN CIO and assist with MSHN IT planning that benefits both MSHN and the individual CMHSP Participants.

Defined Goals, Monitoring, Reporting and Accountability:

The IT Council shall establish metrics and monitoring criteria to evaluate progress on the following primary goals:

- Representation from each CMHSP Participant at all meetings
- Successfully submit MDHHS required data according to MDHHS requirements regarding quality, effectiveness, and timeliness
- Collaborate to develop systems or processes to meet MDHHS requirements (e.g., BH-TEDS reporting, Encounter reporting)
- Accomplish annual goals established by the IT Council and/or OC, such as:
  a. Work on outcome measure data management activities as needed.
  b. Improve balanced scorecard reporting processes to achieve or exceed target amounts.
  c. Transition health information exchange (HIE) processes to managed care information system, when appropriate, to gain efficiencies in data transmissions.
- Meet IT audit requirements (e.g., EQRO).

Annual Evaluation Process:

a. Past Year (FY22) Accomplishments:

Representation from each CMHSP Participant at all meetings

- There was almost 97% attendance rate during FY22 ITC meetings. 100% attendance occurred in 6 meetings. Participation remains active as we are a highly collaborative group, sharing expertise and project strategies.

Successfully submit MDHHS required data regarding quality, effectiveness, and timeliness

- We exceeded 95% compliance standard for submitting BH-TEDS with all three transaction types: mental health, substance use, and crisis records. (M, A, Q transactions)
- MSHN met the requirements for MDHHS performance incentives that included

evaluating Veterans Navigator quarterly reporting and Veteran's status in BH-TEDS reporting and submitting BH ADT records by ALL CMHSPs in the region to MiHIN.

Several initiatives that ITC assisted with during this fiscal year are:

- Continued trending telehealth events during pandemic.
- Assisted with encounter alignment to meet EQI reporting requirements.

Facilitate health information exchange processes

- Changed the active care relationship process (ACRS) to derive from CMHSP systems so that data exchange is timely.
- Implemented COVID-19 response file exchange.
- Transitioned LOCUS data exchange to HIE between CMHSP systems and MSHN.
- Admission, Discharge and Transfer records are received directly into CMHSP EMR.
- Continued pilot process with MDHHS and MiHIN for Substance Use Disorder eConsent in MI Gateway.

Goals established by Operations Council

- Improvements with balanced scorecard reporting.
- Continue trending COVID-19 and telehealth reports.
- Manage upgrades to MCG Indicia and guidelines.

Meet external quality review requirements

- Health Services Advisory Group conducted a review for MDHHS and evaluated performance measures and information systems capabilities. Both areas were successful and approved, with one compliance finding.

b. Goals for fiscal year ending September 30, 2023:

- Active participation by all CMHSP representatives at each monthly meeting.
- Meet current reporting requirements as defined by MDHHS.
- Improve Employment and Minimum Wage field values in BH-TEDS reporting process.
- Pilot CC360 API integration in EMRs.
- Provide analysis with Medicaid disenrollment impact.
- Work to achieve balanced scorecard target values.
- Work toward achieving goals established by Operations Council.
- Prepare for and pass audit requirements of the external quality review.

TEAM NAME: Quality Improvement Council

TEAM LEADER: Sandy Gettel, MSHN Quality Manager

REPORT PERIOD COVERED: 10.1.21 – 9.30.22

Purpose of the Council or Committee:

The Quality Improvement Council was established to advise the Operations Council and the Chief Executive Officer concerning quality improvement matters. The Quality Improvement Council is comprised of the MSHN Quality Manager, the CMHSP Participants' Quality Improvement staff appointed by the respective CMHSP Participant Chief Executive Officer/Executive Director and a MSHN SUD staff representing substance use disorder services as needed. The Quality Improvement Council is chaired by the MSHN Quality Manager. All Participants are equally represented on this council.

Responsibilities and Duties:

The responsibilities and duties of the QIC include the following:

- Advise the MSHN Quality Manager and assist with the development, implementation, operation, and distribution of the Quality Assessment and Performance Improvement Plan (QAPIP) and supporting MSHN policies and procedures.
- Recommend and monitor the development of internal systems and controls to carry out the Quality Assessment and Performance Improvement Program and supporting policies as part of daily operations.
- Development of valid and reliable data collection related to performance measures/indicators at the organizational/provider level.
- Identification of organization-wide opportunities for improvement including but not limited to the safety of consumers.
- Evaluating the effectiveness of the QAPIP.
- Determining the appropriate strategy/approach to promote compliance and detect potential violations and areas of risk as well as areas of focus.
- Reviewing audit results and corrective action plans, making recommendations when appropriate.

Defined Goals, Monitoring, Reporting and Accountability

The QIC established metrics and monitoring criteria to evaluate progress on the following primary goals:

- Implementation of the Quality Assessment and Performance Improvement Program (QAPIP) Plan.
- Performance Measures included within the QAPIP as required by MDHHS and identified through Operations Council.
- Improvement efforts as it relates to external reviews including but not limited to the External Quality Reviews and MDHHS reviews.
- Compliance and oversight of the above identified areas.

Additionally, the QIC seeks to assess and achieve the following secondary goals:

- Retained function contracts achieved defined results.
- Collaborative relationships are retained.
- Reporting progress through Operations Council.
- Regional collaboration regarding expectations and outcomes.
- Efficiencies are realized through standardization and performance improvement.
- Improved performance is realized through our collective strength.

Annual Evaluation Process:

a. Past Year's Accomplishments:

The QIC had twelve (12) meetings during the reporting period and in that time completed the following tasks:

- Reviewed and approved the FY21 Quality Assessment and Performance Improvement Report
- Reviewed, revised, and approved the FY21 Quality Assessment and Performance Improvement Plan.
- Reviewed and revised current regional policies and procedures in areas of Quality.
- Reviewed the FY21 Annual Medicaid Event Verification Report.
- Reviewed and approved the FY23 Delegated Managed Care Site Review Tools.
- Analyzed the following key performance measures quarterly:
  - Critical Incident Data including timeliness of reporting quarterly. Modified the analysis to include cumulative data.
  - Follow Up to Hospitalization (FUH) including the analysis of racial disparities.
  - Michigan Mission Based Performance Indicator System (MMBPIS) data quarterly report identifying trends and actions steps for improvement.
    Developed categories of potential causal factors for "out of compliance" for Indicator 2, Indicator 2e and 2b, and Indicator 3- Michigan Mission Based Performance Indicator System (MMBPIS).
  - Behavior Treatment Data quarterly specific to compliance with the standards and emergency interventions in collaboration with the Behavior treatment Plan Work group and Clinical Leadership Committee.
  - Stakeholder feedback and satisfaction for representative populations served, identifying trends and growth areas for development of focused improvement efforts.
- Developed and received approval from Operations Council for the following two new Performance Improvement Projects for CY22-CY25, which included the incorporation of racial disparities.
- Participated in the External Quality Reviews
  - Performance Improvement Project-Received 100% met score for the validation of the project.
  - Performance Measurement Validation-Received a status of "Reportable".
  - Compliance Review-Completed corrective action plan and progress reports of the 21 CAP for the 2021 Compliance Review.
- Completed the annual review and update of QIC charter with no substantive changes.
- Completed and submitted corrective action plans for the MDHHS HCBS Federal Compliance Review

b. Upcoming Goals for Fiscal Year Ending, September 30, 2022

- Evaluate the process for incorporating consumer representatives in QIC Council and meetings.
- Complete and submit a MSHN Board approved QAPIP Plan and Report to MDHHS by the required due date (February 29, 2023).
- Ensure the Quality policies and procedures are compliant with regulatory requirements and have been communicated to the providers.
- Achieve the performance standards for each of the following areas within the QAPIP,

participating in quality improvement efforts as identified.
    - Behavior Treatment Review-Provide Data to BTPR Workgroup
    - Critical Incidents-Including Risk Events. Validate reported data through the CRM, develop and provide training related to the new CRM reporting process
    - Michigan Mission Based Performance Indicator System (MMBPIS)-Collaborate with MDHHS for recommended revisions and standards for Indicator 2, 3 and other indicators.
    - Consumer Satisfaction- Complete an RFP for administration and analysis by an eternal vendor.
    - Follow Up to Hospitalization (FUH)-Review Value Sets and advocate for the inclusion of relevant codes to accurately measure follow-up.
    - Reduce or eliminate the race/ethnic disparities between the black/African American and white population groups for those having access to, and engagement in PIHP covered services.
- Engage in a quality improvement process for the implementation and documentation of the Person-Centered Planning process.
- Develop standardized elements/form for mortality reviews and root cause analysis.
- Achieve a status of “Reportable" in the Performance Measure Validation Review.
- Demonstrate improvement in the External Quality Compliance Review.
- Achieve full compliance for the MDHHS 90-day Follow-up Review.
- Achieve a Performance Improvement Project Validation from the External Quality Reviewers.

b) MSHN Advisory Councils FY22 Annual Reports

Team Name: Regional Consumer Advisory Council
Team Leader: Cathy Kellerman, Chairperson
Report Period Covered: 10.1.21-9.30.22

Purpose of the Consumer Advisory Council:
The Consumer Advisory Council will be the primary source of consumer input to the MSHN Board of Directors related to the development and implementation of Medicaid specialty services and supports and coordinating agency requirements in the region. The Consumer Advisory Council includes representatives from all twelve (12) CMHSP Participants of the region.

Responsibilities and Duties:
Other responsibilities and duties of the CAC shall include the following:

- Provide representation to the MSHN CAC on behalf of the local consumer councils.
- Assist with effective communication between MSHN and the local consumer advisory mechanisms.
- Advise the MSHN Board of Directors relative to strategic planning and system advocacy efforts for public mental health.
- Advise MSHN Board of Directors related to regional initiatives for person-centered planning, self-determination, health care integration, independent facilitation, recovery, eligibility management, network configuration, and other consumer-directed options.
- Provide recommendations related to survey processes, customer satisfaction, consumer involvement opportunities, consumer education opportunities, quality and performance improvement projects and other outcome management activities.
- Focus on region-wide opportunities for stigma reduction related to mental health and substance use disorder issues.

Defined Goals, Monitoring, Reporting and Accountability

- The CAC shall review aggregate reports received from the Quality Assessment and Performance Improvement Program (QAPIP), provide recommendations, and give guidance and suggestions regarding consumer-related managed care processes.
- Provide feedback for regional initiatives designed to encourage person-centered planning, self-determination, independent facilitation, anti-stigma initiatives, community integration, recovery and other consumer-directed goals.
- Share ideas and activities that occur at the local CMHSP level and create an environment that fosters networking, idea sharing, peer support, best practices, and resource sharing.

Annual Evaluation Process:

a. **Past Year's Accomplishments:** The Consumer Advisory Council had 6 meetings during the reporting period and in that time, they completed the following tasks:

- Reviewed the changes to the FY22 MSHN Consumer Handbook
- Reviewed Quality Improvement Performance Measure Reports that included Performance Indicators, Behavior Treatment Review and Oversight, Critical Incidents, Grievance and Appeals, and Medicaid Fair Hearings
- Reviewed and provided feedback on the MSHN Satisfaction Survey results

- Reviewed and provided feedback on the MSHN Compliance Plan
- Reviewed and provided feedback on the 2021 MSHN Delegated Managed Care Reviews
- Reviewed and provided feedback on the 2022-2023 MSHN Strategic Plan
- Reviewed and provided feedback on the Quality Assessment and Performance Improvement Plan
- Education and discussion on Implicit bias, Health Disparities & MSHN Activities on Diversity, Equity, and Inclusion
- Education and discussion on Certified Community Behavioral Health Clinic
- Education and discussion on MSHN SUD Prevention Services
- Education and discussion on the outcomes from the Health Services Advisory Group (HSAG) Performance Measure Validation (PMV) and Compliance reviews
- Reviewed and revised the RCAC Council Charter
- Reviewed and revised the RCAC Policy
- Discussion and feedback on coordination of care and transition planning for individuals wanting/needing to change treatment providers
- Discussion and explored advocacy opportunities regarding the Public Behavioral Health System Redesign
- Improved practices for ongoing communication between MSHN and local councils
- Ongoing discussion on ways to strengthen Person Centered Planning, Independent Facilitation and Self Determination Implementation
- Reviewed and approved RCAC annual effectiveness report
- Continued online meetings through Zoom

b. Upcoming Goals for Fiscal Year 2023 Ending, September 30, 2023:

- Provide input on regional educational opportunities for stakeholders
- Provide input for ongoing strategies for the assessment of primary/secondary consumer satisfaction
- Review regional survey results including SUD Satisfaction Survey and external quality reviews
- Review annual compliance report
- Annual review and feedback on QAPIP
- Annual review and feedback on Compliance Plan
- Annual review of the MSHN Consumer Handbook
- Review and advise the MSHN Board relative to strategic planning and advocacy efforts
- Provide group advocacy within the region for consumer related issues
- Explore ways to improve Person Centered Planning, Independent Facilitation and Self Determination Implementation
- Improve communication between the Regional Consumer Advisory Council and the local CMH consumer advisory groups
- Explore ways to get more consumers involved in the RCAC and local consumer councils
- Explore safely adding a face to face option for the bi-monthly CAC meetings
- Public Behavioral Health System Redesign Advocacy
- Explore system improvements for services directed to youth.
- Improve access to peer support specialists through the CMHSPs for individuals served.
- Improve the relationship between first responders and persons served.
- Explore additional ways to assist individuals who are struggling with suicide.
- Learn more about the Rights of individuals when they are medically detained.

c) MSHN Oversight Policy Board FY22 Annual Report

Team Name: Substance Use Disorder Oversight Policy Board

Team Leader: Chairman John Hunter, SUD Board Member

Report Period Covered: 10.1.21-9.30.22

Purpose of the Board:

The Mid-State Health Network (MSHN) Substance Use Disorder (SUD) Oversight Policy Board (OPB) was developed in accordance with Public Act 500 of 2012, Section 287 (5). This law obliged MSHN to "establish a substance use disorder oversight policy board through a contractual agreement between [MSHN] and each of the counties served by the community mental health services program." MSHN/s twenty-one (21) counties each have representation on the OPB, with a designee chosen from that county.

The primary decision-making role for the OPB is as follows:

- Approval of any portion of MSHN's budget containing local funding for SUD treatment or prevention, i.e. PA2 funds
- Has an advisory role in making recommendations regarding SUD treatment and prevention in their respective counties when funded with non-PA2 dollars.

Annual Evaluation Process:

a. Past Year's Accomplishments:
   - Received updates and presentations on the following:
     - MSHN SUD Strategic Plan
     - MSHN SUD Prevention & Treatment Services
   - Approval of Public Act 2 Funding for FY22 & related contracts
   - Approved use of PA2 funds for prevention and treatment services in each county
   - Received presentation on FY23 Budget Overview
   - Received PA2 Funding reports – receipts & expenditures by County
   - Received Quarterly Reports on Prevention and Treatment Goals and Progress
   - Received Financial Status Reports on all funding sources of SUD Revenue and Expenses
   - Provided advisory input to the MSHN Board of Directors regarding the overall agency strategic plan and SUD budget
   - Received new written updates from Deputy Director including state and federal activities related to SUD
   - Received updates on MDHHS proposed future of Behavioral Health
   - Provided input and received information/updates on Block Grant Reduction Strategies
   - Received updates on MDHHS State Opioid Response Site Visit Results
   - Received information on COVID-19 and Provider Status
   - Shared prevention and treatment strategies within region
   - Received information and education on opioid settlement and strategies

b. Upcoming Goals for FY23 ending, September 30, 2023:
   - Approve use of PA2 funds for prevention and treatment services in each county
   - Improve communications with MSHN Leadership, Board Members and local coalitions
   - Orient new SUD OPB members as reappointments occur

- Receive information and education on opioid settlement and strategies
- Provide input into COVID related funding specific to Substance Use Disorder Treatment and prevention
- Monitor SUD spending to ensure it occurs consistent with PA 500.

d) MSHN Committee FY22 Annual Reports

Team Name: Clinical Leadership Committee

Team Leader: Todd Lewicki, Chief Behavioral Health Officer

Report Period Reviewed: 10.1.21-9.30.22

Purpose of the Clinical Leadership Committee (CLC):

The MSHN Operations Council (OC) has created a CLC to advise the Prepaid Inpatient Health Plan's (PIHP) Chief Executive Officer (CEO) and the OC concerning the clinical operations of MSHN and the region. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the CEO and OC to bring local perspectives, local needs, and greater vision to the operations of MSHN so that effective and efficient service delivery systems are in place that represent best practice and result in good outcomes for the people served in the region.

Responsibilities and Duties

The responsibilities and duties of the CLC shall include the following:

- Advise the CEO and OC in the development of clinical best practice plans for MSHN (including implementation and evaluation);
- Advise the CEO and OC in areas of public policy priority including high risk, high cost, restrictive interventions, or that are problem prone.
- Provide a system of leadership support, collaborative problem solving and resource sharing for difficult cases.
- Support system-wide sharing though communication and sharing of major initiatives (regional and statewide).
- Assure clinical policies and practices are operational, effective, efficient and in compliance with applicable contracting and regulatory bodies
- Undertake such other duties as delegated by the CEO or OC.

Defined Goals, Monitoring, Reporting and Accountability

The CLC shall establish metrics and monitoring criteria to evaluate progress on the following primary goals:

- Improved health outcomes.
- Increased use of evidence-based practices.
- Improved collaboration of the region's clinical leadership including member satisfaction with the committee process and outcomes.
- Increased use of shared resources and problem solving for difficult cases.

Additionally, the CLC seeks to assess and achieve the following secondary goals:

- CEO and OC satisfaction with CLC advisory role,
- Staff perception and sense of knowing what is going on, and
- Efficiencies are realized through standardization, performance improvement and shared resources.

Annual Evaluation Process

a. **Past Year's Accomplishments**: Goals for Fiscal Year 2022; Ending September 30, 2022
The CLC was involved in monitoring, developing, and recommending improvements to:
- Started focus on 1915i service oversight transition to PIHP for annual eligibility authorizations.
- Completion and approval of the 11 1915(i) service protocols.
- Continued work relating to Parity for all CMHSP services.
- Focus on state inpatient hospital issues and assistance, continue to discuss options for difficult placement situations and established protocol.
- Explore and recommend opportunities for innovative service models including telehealth and others as allowed by state rule.
- Continued oversight of regional HCBS compliance and related issues
- Continued work on crisis residential unit for adults in MSHN region.
- Addressed workforce shortage and special program exceptions.
- ICSS CMH staffing status and issues and advocacy to MDHHS.
- MiCARE/OpenBeds Registry.
- Consistent review of BTPRC data.
- Service range issue and advocacy with MDHHS.

b. **Upcoming Goals** (FY2023)
- Carry forward some goals from previous year
- Address workforce shortage.
- Address crisis resources uniformly across the region.
- Address implementation of 988/MiCAL.
- 1915(i) service oversight transition to PIHP for annual eligibility authorizations
- Address psychiatric residential treatment facility (PRTF) as MDHHS begins implementation, as appropriate.
- Regional input into Conflict Free Access and Planning.
- Advocate for crossover multi-discipline process for ICSS.
- Convert region to use of the CANS.
- Address Wraparound services as appropriate.
- Complete appeal of service range issue with MDHHS and waiver versus non-waiver service use.

Sources

a. MSHN Operating Agreement
b. MSHN Policy: Councils, Committees and Workgroups

Team Name: Regional Medical Director's Committee

Team Leaders: Dr. Zakia Alavi

Report Period Covered: 10.1.21-9.30.22

Purpose of the Regional Medical Directors Committee (MDC)

As created by the MSHN Operations Council (OC), the MDC functions to advise the MSHN Chief Medical Officer (CMO), the MSHN Chief Executive Officer (or designee), the MSHN Chief Behavioral Health Officer (CBHO), and the OC concerning the behavioral health operations of MSHN and the region. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the CMO, CEO (or designee), CBHO, and OC to bring local perspectives, local needs, and greater vision to the operations of MSHN so that effective and efficient service delivery systems are in place that represent best practice and result in good outcomes for the people served in the region.

Responsibilities and Duties

The responsibilities and duties of the MDC shall include the following:

- Contribute to regional plan development as well as review, advise, and recommend approval of the regional plans as appropriate but specifically the following:
  - Population Health and Integrated Care Plan
  - Utilization Management Plan
  - Quality Assurance and Performance Improvement Plan
- Advise MSHN and the OC in the selection, monitoring and improvement initiatives related to regional performance measures.
- Advise MSHN and OC in the development of clinical best practice guidelines for MSHN (including implementation and evaluation).
- Provide a system of leadership support, collaborative problem solving and efficient resource sharing for high risk cases.
- Support collaboration with Primary Care/Physical Health Plans related to Population Health Activities as well as local community efforts
- Support system-wide sharing though communication and sharing of major initiatives (regional and statewide).
- Assure clinical policies and practices are operational, effective, efficient, and in compliance with applicable contracting and regulatory bodies; and
- Undertake such other duties as may be delegated by the CMO or OC.

Defined Goals, Monitoring, Reporting and Accountability

The MDC shall establish metrics and monitoring criteria to evaluate progress on the following primary goals:

- Improved health outcomes.
- Increased use of clinically targeted evidence-based practices and promising practices.
- Improved collaboration of the region's Regional Medical Directors including member satisfaction with the committee process and outcomes.
- Improved collaboration with primary care physicians and health plans
- Increased use of shared resources and collaborative problem solving for difficult cases.

Additionally, the MDC seeks to assess and achieve the following secondary goals:

- CMO and OC satisfaction with MDC advisory role,
- Staff education, inclusion and information related to regional strategies; and
- Efficiencies realized through standardization, performance improvement and shared resources.

Annual Evaluation Process

a. Past Year's Accomplishments:

- Moved meetings to a bi-monthly format.
- Continued attention to Behavior Treatment Plan Review Committee feedback on medication guidelines.
- Foster care psychotropic medication oversight review with MDHHS.
- Input into Population health and Integrated Care Plan and Quarterly Reports.
- Review of the MiCARE/OpenBeds platform for inpatient psychiatric hospitalizations.
- Input into Conflict Free Access and Planning discussion.
- Input into Emergency and Post-Stabilization Services policy.
- Provided input into the MSHN Methamphetamine Psychosis Practice Guideline.
- Recommendations related to regional youth suicide prevention.
- Review and input into regional crisis residential service.
- Review and input into data, including MSHN performance improvement projects, health equity analysis.

b. Upcoming Goals

- Regional youth suicide prevention planning.
- Continued input into behavior treatment processes.
- Ongoing input into population health and integrated care.
- Ongoing input into data-related decisions.
- Review OpenBeds process and data and related access to crisis services.
- Incorporate medical point of view into resource decisions, care decisions, increasing collaborative efforts. (Includes grant opportunities). Provide input into clinical leadership processes, improve linkages with Clinical Leadership Committee. Protect time to ensure that there is medical director input and address with Operations Council.
- Improve relationship with MDHHS around processes related to CMH functions (i.e., determination of hospitalization). Address improving collaboration in the authorities that exist in the CMH and MDHHS.

TEAM NAME: Utilization Management Committee

TEAM LEADER: Skye Pletcher**,** MSHN Director of Utilization and Care Management

REPORT PERIOD: 10.01.2021 – 9.30.2022

Purpose of the Council or Committee: The Utilization Management Committee (UMC) exists to assure effective implementation of the Mid-State Health Network's UM Plan and to support compliance with requirements for MSHN policy, the Michigan Department of Health and Human Services Prepaid Inpatient Health Plan Contract and related Federal & State laws and regulations.

Responsibilities and Duties: The responsibilities and duties of the UMC include the following:

- Develop and monitor a regional utilization management plan.
- Set utilization management priorities based on the MSHN strategic plan and/or contractual/public policy expectations.
- Recommend policy and practices for access, authorization and utilization management standards that are consistent with requirements and represent best practices.
- Participate in the development of access, authorization and utilization management monitoring criteria and tools to assure regional compliance with approved policies and standards.
- Support development of materials and proofs for external quality review activities.
- Establish improvement priorities based on results of external quality review activities.
- Recommend regional medical necessity and level of care criteria.
- Perform utilization management functions sufficient to analyze and make recommendations relating to controlling costs, mitigating risk and assuring quality of care.
- Review and monitor utilization patterns and analysis to detect and recommend remediation of over/under or inappropriate utilization; and
- Recommend improvement strategies where adverse utilization trends are detected.
- Ensure committee coordination and information sharing to address continuity and efficiency of PIHP processes.

Defined Goals, Monitoring, Reporting and Accountability- As defined by the MSHN Utilization Management Plan:

- Define specifics of regional requirements or expectations for CMHSP Participants and SUD Providers relative to prospective service reviews (pre-authorizations), concurrent reviews and retrospective reviews for specific services or types of services, if not already addressed in policy.
- Define any necessary data collection strategies to support the MSHN UM Program, including how the data resulting from the completion of any mandatory standardized level of care, medical necessity or perception of care assessment tools will be used to support compliance with MSHN UM policies.
- Define metrics for population-level monitoring of regional adherence to medical necessity standards, service eligibility criteria and level of care criteria (where applicable).
- Define expected or typical population service utilization patterns and methods of analysis to identify and recommend possible opportunities for remediation of over/under utilization.
- Implement policies and systems to ensure consistency with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
- Set annual utilization management priorities based on the MSHN strategic plan and/or contractual/public policy expectations.
- Recommend improvement strategies where service eligibility criteria may be applied inconsistently across the region, where there may be gaps in adherence to medical necessity

standards and/or adverse utilization trends are detected (i.e., under or over utilization).

- Identify focal areas for MSHN follow-up with individual CMHSP Participants and SUD Providers during their respective on-site monitoring visits.

Annual Evaluation Process:

a. **Past Year's Accomplishments**: The UMC had eleven meetings during the reporting period. In that time the following tasks were completed:

- A thorough review of the UMC annual report schedule was conducted in order to evaluate the ongoing relevance and effectiveness of the data being reviewed by the committee. A number of recommendations were made related to eliminating areas of redundancy where similar data is being monitored by more than one regional committee or certain regional processes have become more automated and standardized over time resulting in there no longer being a need for data monitoring by the committee.
- Ongoing review of data reports related to performance on regional UM and integrated health priority measures with CMH participants reporting on change strategies when performance is outside of established expected thresholds
- Continued to refine outlier data reports with TBD Solutions in order to monitor service variance between CMHSP organizations as well as individual consumer outliers. This will continue to be addressed as a goal in FY23.
- Ongoing cross-functional dialogue with Quality Improvement Council and Clinical Leadership Committee (CLC).
- Deployed the 26th edition of the MCG Behavioral Health Guidelines.
- Completed quarterly retrospective reviews for acute care services using the MCG Behavioral Health Guidelines and established a regional target of 95% or more correct application of medical necessity criteria. During FY22 the target was achieved for all quarters in which reviews were conducted.
- Ongoing UMC discussion relative to prospective, concurrent, and retrospective UM processes. UMC members share best practices in order to promote efficiency and consistency throughout the region.
- Reviewed data relative to quarterly Balanced Scorecard
- Implemented improved tracking capabilities as a region to ensure authorization determinations are made within established timeframes (14 Days for Standard Requests, 72 Hours for Expedited Requests)
- Ongoing quarterly monitoring of ACT utilization data to evaluate if services are being delivered consistent with evidence-based practice guidelines for average hours of service per individual per week
- Continued to refine automated reporting process for the quarterly MDHHS Service Authorization Denials Report to ensure regional consistency and improve data accuracy
- Developed and implemented new regional Emergency Services and Post stabilization Policy
- Developed and implemented new Conflict Free Case Management Policy

b. Upcoming Goals for Fiscal Year Ending, September 30, 2023:

- Follow utilization management priorities based on the MSHN strategic plan and/or contractual/public policy expectations;
- Recommend policy and practices for access and authorization standards that are consistent with requirements and represent best practices;
- Ensure representative SUD presence on UMC by inviting SUD content experts on an ad hoc basis to provide input into issues affecting SUD service access and utilization
- Establish performance improvement priorities identified from monitoring of delegated utilization management functions;
- Recommend improvement strategies where adverse utilization trends are detected;
- Recommend opportunities for replication where best practice is identified;
- Continue to focus on population health measures related to care coordination;
- Ongoing integration of substance use disorder (SUD) into utilization management practices;
- Ensure there is synchronized (as able) content matter expert input into processes shared by UM (i.e. QI, Finance, Clinical, etc.).
- Address succession planning for UMC members relative to skill set needed by committee members.
- Input into HCBS data, findings, and system improvements, as appropriate
- Continued analysis of differences in amount/scope/duration of services received by individuals enrolled in waivers and non-waiver individuals

TEAM NAME: Regional Compliance Committee

TEAM LEADER: Kim Zimmerman, Chief Compliance and Quality Officer

REPORT PERIOD REVIEWED: 10.1.21-9.30.22

Purpose of the Compliance Committee:

The Compliance Committee will be established to ensure compliance with requirements identified within MSHN policies, 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 the 42 CFR 438.608.

Responsibilities and Duties:

The responsibilities and duties of the Compliance Committee shall include the following:

- Advising the MSHN Chief Compliance and Quality Officer on matters related to Compliance.
- Assist in the review of, and compliance with, contractual requirements related to program integrity and 42 CFR 438.608.
- Assist in developing reporting procedures consistent with federal requirements.
- Assist in developing data reports consistent with contractual requirements.
- Assisting with the review, implementation, operation, and distribution of the MSHN Compliance Plan.
- Reviewing and updating, as necessary, MSHN policies and procedures related to compliance.
- Evaluating the effectiveness of the Compliance Plan.
- Determining the appropriate strategy/approach to promote compliance and detect potential violations and areas of risk as well as areas of focus.
- Recommending and monitoring the development of internal systems and controls to carry out the Compliance Plan and supporting policies as part of daily operations.
- Reviewing compliance related audit results and corrective action plans, making recommendations when appropriate.
- Assisting in development and implementation of compliance related training.

Defined Goals, Monitoring, Reporting and Accountability

The Compliance Committee shall establish metrics and monitoring criteria to evaluate progress:

- As defined in the Compliance Plan

Annual Evaluation Process

a. Past Year's Accomplishments:

- Revised and approved the 2023 MSHN Compliance Plan
- Provided feedback and approval for the FY2021 Annual Compliance Summary Report
- Reviewed and updated the Committee Charter
- Review of MDHHS Waiver Site Review Process
- Reviewed the revised FY2023 OIG Quarterly Report changes, crosswalk and submission requirements
- Ensured compliance with Medicaid Telehealth requirements
- Reviewed new MDHHS Code Qualifications Chart and EDIT group updates
- Reviewed risk for use of legal name versus chosen names on medical record documents
- Reviewed requirements for Breach Notifications
- Confidentiality requirements for use of psychotherapy notes

- Ongoing review of 21st Century Cures Act for compliance with standards
- Ongoing review of CMH Patient Access Rule and InterOp Station for compliance with standards
- Reviewed trends in the OIG Quarterly Reports
- Reviewed information provided at the PIHP Compliance Officers meetings and MSHN Compliance Committee meetings
- Provided consultation on local compliance related matters
- Developed, implemented, reviewed, and made necessary corrections for quarterly data mining activities
    - Death to encounter data report
    - Comparison of Face-to-Face and Telehealth contacts
- Provided feedback on MSHN practices to include but not limited to:
    - Delegated Managed Care Review tools
- Review and revise compliance policies and procedures as needed

b. Upcoming Goals for Fiscal Year Ending, September 30, 2023:

- Identify compliance related educational opportunities including those aimed at training compliance officers
- Review data, trends, type/nature of findings for recommended quality improvement
- Strengthen review of Medicaid Policy Bulletins and Contract Revisions to assure compliance with changes and updates
- Review methods of assessing risks and findings for detection of fraud and abuse for potential improvements and efficiencies
- Review requirements of telehealth for compliance and identification risk points

TEAM NAME: Provider Network Management Committee

TEAM LEADER: Kyle Jaskulka, MSHN Contract Manager

REPORT PERIOD REVIEWED: 10.1.21-9.30.22

Purpose of the Provider Network Management Committee: PNMC is established to provide counsel and input to Mid-State Health Network (MSHN) staff and the Operations Council (OC) 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), 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 PNMC understands that provider network management is a Prepaid Inpatient Health Plan function delegated to Community Mental Health Service Programs (CMHSP) Participants. Provider network management activities pertain to the CMHSP direct operated and contract functions.

Responsibilities and Duties: The responsibilities and duties of the PNMC include the following:

- Advise MSHN staff in the development of regional policies for Provider Network Management;
- Establish regional priorities for training and establish training reciprocity practices for (CMHSP) Subcontractors;
- Support development of regional PNM monitoring tools to support compliance with rules, laws, and the PIHPs Medicaid contract with MDHHS.
- Provide requested information and support development of periodic Network Adequacy Assessment;
- Monitor results of retained functions contract for Network Adequacy Assessment;
- Support development and implementation of a Regional Strategic Plan as it relates to Provider Network Management functions;
- Establish regionally standardized contract templates and provider performance monitoring in support of reciprocity policy;
- Recommend and deploy strategies to ensure regional compliance with credentialing and recredentialing activities in accordance with MDHHS and MSHN policy; and
- Recommend and deploy strategies to ensure regional compliance with ensuring provider qualifications requirements are verified for all non-licensed independent practitioners.

Defined Goals, Monitoring, Reporting and Accountability: The PNMC shall establish goals consistent with the MSHN Strategic Plan and to support compliance with the MDHHS – PIHP contract including:

- Completion of a Regional Network Adequacy Assessment;
- Development of reciprocity agreements for sub-contract credentialing/re-credentialing, training, performance monitoring, and standardized contract language;
- Maintain a regional training plan in accordance with state requirements as identified in the MDHHS/MSHN Specialty Supports and Services Contract.

Annual Evaluation Process

Past Year's Accomplishments (FY22):

- Addressed findings from HSAG audit, specific to provider credentialing and recredentialing systems; revised policies and procedures
- Continued to refine and support the statewide and intra-regional provider performance monitoring protocols resulting in improved provider performance and administrative efficiencies;
- Established and continued with an intra-regional provider performance monitoring protocol for ABA/Autism provider network; continued regional provider performance monitoring for Fiscal Intermediary and Inpatient Psychiatric Services;
- Establish relevant key performance indicators for the PNMC scorecard;
- Continued to monitor and refine regional provider directory to ensure compliance with managed care rules;
- Reviewed, revised, and issued regional contracts for Autism/ABA, Inpatient Psychiatric, and Fiscal Intermediary Services;
- Improved and continued coordination with regional recipient rights officers to support contract revisions;
- Began implementation of statewide training reciprocity plan within the MSHN region;
- Development and continued support of regional training coordinators workgroup to support implementation;
- Began the development of regional web-based provider application;
- Provided input into PCE Provider Management Module enhancements.

Upcoming Goals (FY23):

- Address recommendations from the 2022 assessment of Network Adequacy as it relates to provider network functions; update the Assessment of Network Adequacy to address newly identified needs;
- Develop an action plan to address repeat findings related to provider credentialing and recredentialing process requirements through training/technical assistance and monitoring; monitoring and oversight of CMHSPs demonstrate improvement in credentialing and credentialing systems;
- Establish relevant key performance indicators for the PNMC scorecard;
- Monitor and implement Electronic Visit Verification as required by MDHHS;
- Initiatives to support reciprocity:
    - Contracting:
        - Develop regionally standardized boilerplate and statement of work for: Therapeutic Camps, Community Living Supports, Residential, Vocational; Independent Facilitation
    - Procurement:
        - Fully implement the use of a regional web-based provider application;
        - Publish provider selection processes on MSHN web;
    - Monitoring:
        - Fully implement specialized residential reciprocity provider monitoring plan;
    - Training:
        - All CMHSPs will have 100% of applicable trainings vetted in accordance with the training reciprocity plan;

- Advocate for direct support professionals to support provider retention (e.g. wage increase; recognition)
- Develop and implement regionally approved process for credentialing/re-credentialing reciprocity

TEAM NAME: Customer Service Committee

TEAM LEADER: Dan Dedloff, MSHN Customer Service & Rights Specialist

REPORT PERIOD COVERED: 10.1.21 – 09.30.22

Purpose of the Customer Service Committee: This body was formed to draft the Consumer Handbook and to develop policies related to the handbook, the Regional Consumer Advisory Council (RCAC), and Customer Services (CS). The Customer Services Committee (CSC) will continue as a standing committee to assure the handbook is maintained in a compliant format, and to support development and implementation of monitoring strategies to assure regional compliance with CS standards. This committee will be supported by the Director of Quality, Compliance, and Customer Service and will report through the Quality Improvement Council (QIC).

Responsibilities and Duties: The responsibilities and duties of the CSC will include:

- Advising the MSHN Director of Quality, Compliance, and Customer Service and assisting with the development, implementation and compliance of the Customer Services standards as defined in the Michigan Department of Health and Human Services (MDHHS) contract and 42 CFR including the Balanced Budget Act Requirements
- Reviewing and providing input regarding MSHN Customer Services policies and procedures
- Reviewing, facilitating revisions, publication, and distribution of the Consumer Handbook
- Facilitating the development and distribution of regional Customer Services information materials
- Ensuring local-level adherence with MSHN regional Customer Services policies through implementation of monitoring strategies
- Reviewing semi-annual aggregate denials, grievances, appeals, second opinions, recipient rights and Medicaid Fair Hearings reports
- Reviewing audit results from EQR and MDHHS site reviews and assisting in the development and oversight of corrective action plans regarding Customer Services.
- Assisting in the formation and support of the RCAC, as needed; and
- Individual members serving as ex-officio member to the RCAC.

Defined Goals, Monitoring, Reporting and Accountability

The CSC shall establish metrics and monitoring criteria to evaluate progress on the following primary goals:

- Customer Service Handbook completion, updates and SUD incorporation
- Regional Customer Service policy development
- Tracking and reporting Customer Service information; and
- Compliance with Customer Service Standards and the Grievance and Appeal Technical Requirement, PIHP Grievance System for Medicaid Beneficiaries.

Additionally, the CSC seeks to assess and achieve the following secondary goals:

- Retained function contracts achieved the defined results
- Collaborative relationships are retained
- Reporting progress through Quality Improvement Council
- Regional collaboration regarding customer service expectations and outcomes
- Efficiencies are realized through standardization and performance improvement; and
- Benefits are realized through our collective strength.

Annual Evaluation Process:

a. **Past Year's Accomplishments**: The CSC had six committee bi-monthly meetings during the reporting period in which they completed the following tasks:

- Reviewed, revised, facilitated publication of, and completed regional distribution for the MSHN FY22 Consumer Handbook
- Facilitated publication and electronic regional distribution of the MSHN FY22 Consumer Handbook: Spanish language version for each of the 12 CMHSP and the MSHN SUD Provider Handbook
- Reviewed, analyzed and reported regional customer service information for:
    - Denials
    - Grievances
    - Appeals
    - Medicaid Fair Hearings
    - Recipient Rights
- Updated, reviewed, and approved language updates for the bi-annual MSHN Customer Service Policies and Procedure
- Developed a standardized training for the Medicaid Adverse Benefit Determination process
- Established oversight & monitoring of regional Appeals and Grievances using the MDHHS data reporting, in accordance with customer service standards

b. Upcoming Goals for Fiscal Year 2023 Ending, September 30, 2023

- Conduct the annual review, revision, facilitate the publication of, and regional distribution for the MSHN FY23 Consumer Handbook for each of the 12 CMHSP and the MSHN SUD Provider Handbook versions
- Facilitate the translation, publication, and electronic regional distribution of the MSHN FY23 Consumer Handbook: Spanish language version for each of the 12 CMHSP and the MSHN SUD Provider Handbook versions
- Define what would be considered a cultural competency request to support network adequacy
- Develop a standardized regional process for the fulfillment of LEP requests
- Continue reporting and monitoring Customer Service information
- Continue to explore regional Customer Service process improvements
- Continue to develop, where applicable, MSHN standardized regional forms
- Continue to identify Educational Material/Brochures/Forms for standardization across the region

Team Name: Regional Equity Advisory Committee for Health (REACH)
Team Facilitators: Dani Meier (Chief Clinical Officer) &
Skye Pletcher (Director of UM & Care Integration)
Report Period Covered: 1.24.2022-9.30.2022

Purpose of the Council or Committee:

REACH is an advisory body of community stakeholders established for the following purposes:

- Ensure attention to issues of equity, including reducing health disparities in access and delivery of quality behavioral health and substance use disorder (SUD) prevention, treatment and recovery programs.
- Inform development and review of MSHN policies, procedures and practices through the lens of diversity, equity and inclusion (DEI).
- Incorporate a trauma-informed perspective that accounts for historical and racialized trauma.
- Address stigma and bias that may impact health outcomes.

Responsibilities and Duties: The responsibilities and duties of the REACH include the following:

- Review MSHN's Strategic Plan priority of "better equity" and offer input on defining better equity.
- Work to establish consensus around definitions and shared values relative to DEI in the space where MSHN does its work.
- Support and reinforce health equity as a perpetual focus across all departments, functions and strategic priorities.
- Offer guidance as it relates to performing an organizational diversity, equity, and inclusion (DEI) self-assessment.

Defined Goals, Monitoring, Reporting and Accountability

At the close of FY22, the REACH workgroup was 8 months old. As an advisory body to MSHN, goals will be shaped by MSHN's strategic priority of "better equity" which will reciprocally be informed by the REACH's advisory input. MSHN's focused strategic goal setting around equity will take place in FY23 in concert with REACH participation. MSHN's REACH Facilitators (MSHN staff) are charged with reporting out to Leadership and MSHN stakeholders in regard to REACH activities.

Annual Evaluation Process:

a. Past Year's Accomplishments:

- Established itself as a workgroup with a defined identity in support of improving and expanding equity in MSHN as an organization and reducing health disparities for Region 5's people served.
- Provided input and support for MSHN's organizational assessment process.

b. Upcoming Goals for Fiscal Year Ending, September 30, 2023:

- To be determined in FY23. MSHN's focused strategic goal setting around equity will take place in FY23 in concert with REACH participation.

e) MSHN Workgroups FY22 Annual Reports

Team Name: Autism Benefit Workgroup

Team Leader: Kara Hart, Waiver Coordinator

Report Period Reviewed: 10.1.21-9.30.22

Purpose of the Autism Workgroup:

The Autism Benefit Workgroup was established to initiate and oversee coordination of the autism benefit for the region. The Autism Benefit Workgroup is comprised of the Waiver Coordinator and the Community Mental Health Service Provider (CMHSP) autism benefit staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director. The Autism Benefit Workgroup is chaired by the Waiver Coordinator. All CMHSPs are equally represented on this workgroup.

Responsibilities and Duties:

The responsibilities and duties of the Autism Benefit Workgroup shall include the following:

- Advising the MSHN Waiver Coordinator.
- Assist with the development, implementation, and operation of the autism benefit within the region, and supporting MSHN policies and procedures.
- The workgroup representatives will be responsible for passing along pertinent information to impacted team members at their CMHSP.
- Reviewing and recommending changes and/or revisions to policies and procedures and developing new policies and procedures as needed.
- Evaluating the effectiveness of the autism benefit program.
- Determining the appropriate strategy or approach to promote compliance and detect potential violations and areas of risk as well as areas of focus, consistent with sound clinical documentation and service billing practices.
- Recommending and monitoring the development of internal systems and controls to carry out the supporting policies as part of daily operations.
- Reviewing audit results and corrective action plans, making recommendations when appropriate.
- Implementing processes that incorporate best practices and encourage continuous quality improvement for autism program operations and service-related outcomes.

Defined Goals, Monitoring, Reporting and Accountability

The established metrics and monitoring criteria originally identified in the replaced 1915(i) State Plan Amendment (iSPA) and as represented in the now-expanded Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit to evaluate progress on the following primary goals:

- Assess eligibility for autism services, including Applied Behavior Analysis (ABA)
- Ensure WSA access and efficiencies
- Carry out administrative tasks for Autism (including WSA)
  - Initial Eligibility, Application, and Service Start,
  - Dis-enrollments
  - Autism transfers (within and outside of MSHN region)
  - Tracking of pending cases (referred and awaiting an evaluation)
- Ensure that services are provided within the amount, scope, and duration as specified in the Individual Plan of Service (IPOS)
  - Direct ABA

    - Observation and Direction
    - Overdue re-evaluations
    - Overdue Individual Plans of Service (IPOS)
- Ensure each CMHSP has policies and procedures addressing the standards of the autism benefit
- Assist CMHSPs to ensure that rendering providers have appropriate training and credentialing
- Implementation of corrective action to both Mid-State Health Network (MSHN) and Michigan Department of Health and Human Services (MDHHS) Autism site review findings
- Ensure individuals begin services within 90 days of enrollment
- Increase provider network capacity to address continued increase of individuals enrolled to ensure better care, and better service
- Increase frequency of Family Training encounters for those enrolled
- Continuous efforts to support and encourage recruitment, training, and retention of qualified autism staff
- Oversight of implementation of behavior treatment standards for enrolled individuals, if intrusive or restrictive measures are being used and in the IPOS
- Support compliance and oversight of the above identified areas

Annual Evaluation Process

a. Past Year's Accomplishments:

- Shared information related to Autism Provider Workgroup and provider audit process, and ensured information was shared across both workgroups
- Served as a conduit of information from MDHHS which included sharing state plan, Appendix K, billing and code chart updates, changes in re-evaluation requirements, Best Practice Guidelines, telehealth, and any updated COVID-19 pandemic changes
- Significant enrollment growth in the program *<< MSHN will update and add percentage of growth using October 2022 data.>>*
- Regional response to changes in MDHHS AUT Section leadership and practices
- Collaboration with Autism Operations Workgroup on updating of standardized regional contract for autism services as needed
- Coordination of ABA provider audits and credentialing reciprocity
- Regional response and coordination of modifications to service delivery during the COVID-19 pandemic
- Updated policies and procedures to reflect changes in benefit language
- Shared relevant and timely information from Michigan Autism Council and Autism Alliance of Michigan meetings

b. Upcoming Goals:

- Continue to monitor and modify processes related to COVID-19 service delivery, particularly as the Public Health Emergency is terminated
- Adjust to code changes and new policy language
- Continue to work to improve quality provider network capacity and decrease wait times across all service areas
- Continue to monitor, improve, and develop solutions to ensure timely service delivery
- Encourage attendance and participation in Michigan Autism Council and Autism Alliance of Michigan meetings
- Serve as advocates for the region while working to inform and collaborate with newly formed MDHHS autism section

Team Name: Child Waiver Program (CWP) Workgroup

Tam Leader: Tera Harris

Report Period Reviewed: 10.1.2021-9.30.2022

Purpose of the CWP Workgroup:

The CWP Workgroup was established to initiate and oversee coordination of the CWP for the region. The CWP Workgroup is comprised of the MSHN Waiver Coordinator and the Community Mental Health Service Provider (CMHSP) CWP staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director and other subject matter experts as relevant. The CWP Workgroup is chaired by the MSHN Waiver Coordinator. All CMHSPs are equally represented.

Responsibilities and Duties:

The responsibilities and duties of the CWP Workgroup shall include the following:

- Advising the MSHN Waiver Coordinator.
- Assist with the development, implementation, and operation of the CWP within the region, and supporting MSHN policies and procedures.
- The workgroup representatives will be responsible for passing along pertinent information to impacted team members at their CMHSP. Reviewing and recommending changes and/or revisions to policies and procedures and developing new policies and procedures as needed.
- Evaluating the effectiveness of the CWP program.
- Determining the appropriate strategy or approach to promote compliance and detect potential violations and areas of risk as well as areas of focus, consistent with sound clinical documentation and service billing practices.
- Recommending and monitoring the development of internal systems and controls to carry out the supporting policies as part of daily operations.
- Reviewing audit results and corrective action plans, making recommendations when appropriate.
- Implementing processes that incorporate best practices and encourage continuous quality improvement for CWP program operations and service-related outcomes.

Defined Goals, Monitoring, Reporting and Accountability

The intent of this program is to provide Home and Community Based Waiver Services, as approved by Centers for Medicare and Medicaid Services (CMS) for children with developmental disabilities who meet a certain level of care, along with state plan services in accordance with the Medicaid Provider Manual.

- Assess eligibility for the CWP
- Carry out administrative tasks for CWP
  - Initial Pre-Screen Eligibility, Application, and Service Start,
  - Annual Recertification,
  - Disenrollments,
  - Age-Offs,
  - CWP Slot Transfer (as appropriate), and
  - CWP Financial Monitoring
- Ensure that services are provided within the amount, scope, and duration as specified in the Individual Plan of Service (IPOS)
- Ensure each CMHSP has policies and procedures addressing the standards of the CWP,
- Assist CMHSPs to ensure that rendering providers have appropriate training and credentialing

- Implementation of corrective action to Michigan Department of Health and Human Services (MDHHS) CWP site review findings
- Support compliance and oversight of the above identified areas

Annual Evaluation Process

a. Past Year's Accomplishments:

- Regional monitoring of CWP standards for each CMHSP and completion of third year of delegated site reviews for CWP program specific standards as well as a CWP clinical chart (Average score across CMHSPs for program specific reviews = 95.74%)
- Development and distribution of monthly CWP reports
- Development and distribution of monthly overdue and coming due CWP certifications
- Serve as conduit of information from MDHHS- sharing trainings, updated policies, billing and code changes, overnight health and safety, and any updated COVID-19 pandemic changes
- Continued to implement adjustments related to service delivery and administrative tasks due to COVID-19 pandemic
- Assisted with preparation for MDHHS Site Review records review related to CWP
- Completed 2022 MDHHS Site Review and submitted Corrective Action Plans for related findings
- Attendance at meetings increased (On average, 10 out of 12 (83%) of CMHSPs were present for each meeting

b. Upcoming Goals:

- Complete two separate CWP 101 trainings, with a virtual option, in partner with MDHHS
- Ensure full implementation of corrective action plan related to MDHHS and MSHN CWP findings
- Demonstrate continued improvement on DMC reviews as evidenced by increased compliance scores
- Continue to obtain verification documents for flexibilities associated with the COVID-19 pandemic (i.e., verbal signatures, less than monthly habilitative services)
- Continue to increase attendance rates at quarterly workgroup meetings to ensure all CMHSPs are adequately informed and have the resources available to enroll and maintain a youth in the CWP

Team Name: Home and Community Based Services (HCBS) Workgroup

Team Leader: Todd Lewicki

Time Period Reviewed: 10.1.21-9.30.22

Purpose of the HCBS Workgroup:

The HCBS Workgroup was established to initiate and oversee coordination of the HCBS program for the region. The HCBS Workgroup is comprised of the Waiver Manager, Waiver Coordinators, and the Community Mental Health Service Provider (CMHSP) HCBS staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director. The HCBS Workgroup is chaired by the Waiver Manager. All CMHSPs are equally represented.

Responsibilities and Duties:

The responsibilities and duties of the HCBS Workgroup shall include the following:

- Advising the MSHN Waiver Manager/Coordinators.
- Assist with the development, implementation, and operation of the HCBS program within the region, and supporting MSHN policies and procedures.
- The workgroup representatives will be responsible for passing along pertinent information to impacted team members at their CMHSP.
- Reviewing and recommending changes and/or revisions to policies and procedures and developing new policies and procedures as needed.
- Evaluating the effectiveness of the HCBS program.
- Determining the appropriate strategy or approach to promote compliance and detect potential violations and areas of risk as well as areas of focus, consistent with sound clinical documentation and service billing practices.
- Recommending and monitoring the development of internal systems and controls to carry out the supporting policies as part of daily operations.
- Reviewing audit results and corrective action plans, making recommendations when appropriate.
- Implementing processes that incorporate best practices and encourage continuous quality improvement for HCBS operations and service-related outcomes.

Defined Goals, Monitoring, Reporting and Accountability

- Monitoring and oversight to ensure compliance with all federally mandated HCBS standards.
- Assessing for policy and procedure development and updates.
- Review of any HCBS data including status related to project completion timelines.
- Review of any new HCBS related MDHHS requirements and updates.
- Review of best practice strategies to address potential barriers to attaining full HCBS resolution.
- Promote discussion of any HCBS related items to assist in promoting regional consistency in interpretation of HCBS standards.
- Review of specific CMHSP/provider HCBS accomplishments and best practices.
- Monitoring and guidance related to Behavior Treatment standards for HCBS individuals with such interventions.
- Bring the region to full HCBS resolution before March 2023
- Updates and discussion in target areas of compliance, such as PCPs and BTPs
- Assess for policy/procedure development
- Coordinate with other PIHP/MDHHS systems as appropriate- HCBS Leads, BTPRC Workgroup, Recipient Rights, etc.
- Disseminate information from MDHHS/BDHHA on HCBS Issues

- Field questions
- Gain Workgroup feedback
- HCBS-pandemic updates
- HCBS FAQ updates
- BTPRC FAQ updates
- WSA/Optum updates

- Monitoring and reporting of current survey projects
  - Trends, themes
  - Documentation issues
  - Progress & Deadlines
- Heightened Scrutiny Updates
- REMI Audit Module Updates and discussion and training (as appropriate)
- Dissemination of conferences and trainings

Annual Evaluation Process

a. **Past Year's Accomplishments**:

- Updated, reviewed, and approved a new Workgroup Charter.
- Completed Heightened Scrutiny-Out of Compliance remediation.
- Surveyed, assessed, and remediated, when necessary, individuals/providers identified on the non-Responder survey list.
- Identification of providers who have received provisional approval status between June 2020 through October 2022.
- Developed and implemented a REMI tool to conduct HCBS reviews.
- Shared and discussed MDHHS expectations when they instituted a new state-review process for residential providers presumed to be Heightened Scrutiny (HS).
- Facilitated discussion on the expectations relating to the MDHHS Community Transition Program (MCTP) releasing individuals into HS facilities.
- Disseminated information and guidance to increase participation in the HS Public Comment process as Region 5 was the first in the state to undertake this effort.
- Reviewed upcoming timelines in preparation for MDHHS site review to be held June 13th through July 29th, and shared State link for detailed information.
- Reviewed and obtained input into Region 5 HCBS Policies & Procedures.
- Discussed and disseminated new *BTPRC FAQ 6.6.22;* facilitated and provided on-going guidance regarding BTPRC issues/questions.
- Discussed and disseminated new *MDHHS-LARA Joint Guidance Document – Update 6/2022.*
- Promoted increased CMHSP access and updates to WSA.

b. **Upcoming Goals**:

- Ensure full implementation of corrective action plan related to MDHHS and MSHN HCBS findings
- Survey of providers who have received provisional approval status beginning June 2020.
- Bring the region to full HCBS resolution before March 2023.
- Establish a region-wide transition plan for individuals in lieu of providers unable/willing to come into HCBS Compliance.
- Establish a monitoring process to ensure settings maintain or achieve HCBS Final Rule compliance standards.

Team Name: Habilitation Supports Waiver (HSW) Workgroup

Team Leader: Tera Harris

Report Period Reviewed: 10.1.20-9.30.21

Purpose of the HSW Workgroup:

The HSW Workgroup was established to initiate and oversee coordination of the HSW program for the region. The HSW Workgroup is comprised of the Waiver Coordinator and the Community Mental Health Service Provider (CMHSP) HSW staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director and other subject matter experts as relevant. The HSW Workgroup is chaired by the Waiver Coordinator. All CMHSPs are equally represented.

Responsibilities and Duties:

The responsibilities and duties of the HSW Workgroup shall include the following:

- Advising the MSHN Waiver Coordinator.
- Assist with the development, implementation, and operation of the HSW program within the region, and supporting MSHN policies and procedures.
- The workgroup representatives will be responsible for passing along pertinent information to impacted team members at their CMHSP.
- Reviewing and recommending changes and/or revisions to policies and procedures and developing new policies and procedures as needed.
- Evaluating the effectiveness of the HSW program.
- Determining the appropriate strategy or approach to promote compliance and detect potential violations and areas of risk as well as areas of focus, consistent with sound clinical documentation and service billing practices.
- Recommending and monitoring the development of internal systems and controls to carry out the supporting policies as part of daily operations.
- Reviewing audit results and corrective action plans, making recommendations when appropriate.
- Implementing processes that incorporate best practices and encourage continuous quality improvement for HSW operations and service-related outcomes.

Defined Goals, Monitoring, Reporting and Accountability

The established metrics and monitoring criteria originally identified in the replaced 1915(c) Waiver to evaluate progress on the following primary goals:

- Monitoring and oversight of slot allocation utilization and achieving and maintaining 95% utilization;
- Identifying potential candidates for enrollment in the HSW;
- Monitoring and oversight of the annual re-certification process, including overdue re-certifications;
- Monitoring and oversight of overdue Individual plans of service (IPOS);
- Monitoring and oversight of overdue consents;
- Implementation of the agreed upon corrective actions related to the Michigan Department of Health and Human Services (MDHHS) HSW site review findings;
- Compliance and oversight of the above identified areas;
- Monitoring and guidance related to Behavior Treatment standards for HSW enrollees with such interventions;
- Implementation, monitoring and guidance with the Home and Community Based Services (HCBS) rule change

Annual Evaluation Process

a. **Past Year's Accomplishments**:
   - Continued corrective action measures related to underutilization of HSW slot allocation including coordination with other programs (e.g. Autism benefit) to determine additional potential candidates for enrollment
   - Distribution of monthly HSW reports and monthly overdue and coming due data
   - Tracking and reporting on reasons for and number of HSW recertification pend backs from both MSHN and MDHHS
   - Regional monitoring of HSW standards for each CMHSP and completion of delegated site reviews for HSW program specific standards and clinical charts (Average score across CMHSPs for program specific standards = 97.33%)
   - Worked through continued challenges related to monitoring initial applications and recertifications for restrictive and intrusive technique and/or Behavior Treatment Plans
   - Served as conduit of information from MDHHS – sharing trainings, updated policies, billing and code changes, and any updated COVID-19 pandemic changes.
   - Continued to implement adjustments related to service delivery and administrative tasks due to COVID-19 pandemic
   - Assisted with preparation for MDHHS Site Review records review related to HSW
   - Completed 2022 MDHHS Site Review and submitted Corrective Action Plans for related findings

b. **Upcoming Goals**:
   - Ensure full implementation of corrective action plan related to MDHHS and MSHN HSW findings
   - Demonstrate continued improvement on DMC reviews as evidenced by increased compliance scores
   - Continue to identify potential HSW candidates for enrollment
   - Work toward achieving 95% utilization of allocated HSW slots
   - Increase the number of timely uploads of complete recertification packets based on established due dates from MSHN and MDHHS
   - Increase the number of packets that are complete and can be processed without a pend back from either MSHN or MDHHS
   - Increase the timeliness of responses to concerns coming from initial and recertification reviews
   - Continue to obtain verification documents for flexibilities associated with the COVID-19 pandemic (i.e., verbal signatures, less than monthly habilitative services, Level of Care extensions)

Team Name: Severe Emotional Disturbance (SED) Waiver Workgroup

Team Leader: Kara Hart

Report Period Covered: 10.1.21-9.30.22

Purpose of the SEDW Workgroup:

The SEDW Workgroup was established to initiate and oversee coordination of the SEDW for the region. The SEDW Workgroup is comprised of the MSHN Waiver Coordinator and the Community Mental Health Service Provider (CMHSP) SEDW staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director. The SEDW Workgroup is chaired by the MSHN Waiver Coordinator. All CMHSPs are equally represented.

Responsibilities and Duties:

The responsibilities and duties of the SEDW Workgroup shall include the following:

- Advising the MSHN Waiver Coordinator.
- Assist with the development, implementation, and operation of the SEDW within the region, and supporting MSHN policies and procedures.
- Reviewing and recommending changes and/or revisions to policies and procedures and developing new policies and procedures as needed.
- The workgroup representatives will be responsible for passing along pertinent information to impacted team members at their CMHSP.
- Evaluating the effectiveness of the SEDW program.
- Determining the appropriate strategy or approach to promote compliance and detect potential violations and areas of risk as well as areas of focus, consistent with sound clinical documentation and service billing practices.
- Recommending and monitoring the development of internal systems and controls to carry out the supporting policies as part of daily operations.
- Reviewing audit results and corrective action plans, making recommendations when appropriate.
- Implementing processes that incorporate best practices and encourage continuous quality improvement for SEDW program operations and service-related outcomes.

Defined Goals, Monitoring, Reporting and Accountability

The intent of this program is to provide Home and Community Based Waiver Services, as approved by Centers for Medicare and Medicaid Services (CMS) for children with Serious Emotional Disturbances, along with state plan services in accordance with the Medicaid Provider Manual.

- Assess eligibility for the SEDW
- Ensure WSA access and efficiencies
- Carry out administrative tasks for SEDW (including WSA)
  - Initial Eligibility, Application, and Service Start,
  - Annual Recertification,
  - 3rd year Recertifications (higher scrutiny reviews)
  - Dis-enrollments
  - SEDW transfers, and
  - SEDW Financial Monitoring
- Ensure that services are provided within the amount, scope, and duration as specified in the Individual Plan of Service (IPOS)
- Ensure each CMHSP has policies and procedures addressing the standards of the SEDW
- Assist CMHSPs to ensure that rendering providers have appropriate training and credentialing

- Implementation of corrective action to Michigan Department of Health and Human Services (MDHHS) SEDW site review findings
- Provide support to ensure appropriate payments rendered for SEDW enrollees receiving services
- Support compliance and oversight of the above identified areas

Annual Evaluation Process

a. **Past Year's Accomplishments**:
   - Regional monitoring of SEDW standards for each CMHSP
   - Completion of third year of delegated site reviews for SEDW program specific standards as well as SEDW clinical charts
   - Distribution of monthly SEDW reports
   - Distribution of monthly overdue and coming due SEDW certifications
     - Monthly monitoring includes addition of tracking of 45-day pending information and missing Medicaid ID
   - Serve as conduit of information from MDHHS- sharing trainings, updated policies, billing and code changes, overnight health and safety, foster care county of jurisdiction, information related to CAFAS and PECFAS scoring requirements, disenrollments, and any updated COVID-19 pandemic changes
   - Adjusted processes related to service delivery due to COVID-19 pandemic
   - Shared MSHN strategic plan

b. **Upcoming Goals**:
   - Ensure full implementation of corrective action plan related to MDHHS and MSHN SEDW findings
   - Continue to work to increase overall regional enrollments of SEDW, particularly in CMHSPs without enrollees
   - Expand SEDW enrollment and provide support of SEDW enrollment to all CMHSPs in the region
   - Emphasize the importance of and encourage participation in regional SEDW based trainings, including those CMHSPs without any enrolled SEDW individuals
   - In collaboration with MDHHS, provide two SEDW 101 trainings to the CMHSP system, with local and virtual opportunities
   - Ensure that as the COVID-19 pandemic and Public Health Emergency end, the region is following all pre-pandemic policies

IV. Performance Measurement Review and QAPIP Work Plan FY22

Performance measures are monitored on a quarterly or annual basis dependent on the measure. A status of "Met" indicates the desired performance has been achieved for the measurement period. A status of "Not Met" indicates the desired performance has not been achieved for the measurement period. A status of "Not Met" results in the identification causal factors/barriers interfering with obtaining/sustaining the desired performance. The assigned committee/council in collaboration with other relevant committees/councils develop interventions designed to improve the performance of the measure. Effectiveness of the interventions are monitored through performance measure reporting or other as specified in the improvement plans. Specific information can be found in the performance summaries attached to this report and referenced below for each indicator. **Indicates data that has not been finalized.

a) Performance Indicators

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, MSHN is responsible for ensuring that its CMHSP Participants and Substance Use Disorder Providers are measuring performance through The Michigan Mission Based Performance Indicator System in addition to key performance indicators established by MSHN. Performance is monitored quarterly. When minimum performance standards or requirements are not met, CMHSP Participants/SUD Providers will submit a form identifying causal factors, interventions, implementation timelines, and any other actions they will take to correct undesirable variation. Regional trends are identified and discussed at the QIC for regional planning efforts and coordination. The effectiveness of the action plan will be monitored based on the re-measurement period identified. A status of "met" indicates MSHN met the standard for FY22. A status of "not met"' indicates the standard was not met. Data is through FY22Q3. Indicator 2b is calculated by MDHHS and currently does not have a standard. no standards.

Goal: MSHN will meet or exceed the Michigan Mission Based Performance Indicator System standards for Indicators 1, 4, 10 as required by MDHHS.

Status: MSHN met the standards as indicated below.

Recommendations:

- Continue to analyze quarterly and complete improvement plans to remediate systemic issues when performance is below standard.
- Continue to share best practices across the provider network
- Continue to complete primary source verification and validations in the regional electronic medical information system to ensure the quality and accuracy of the data reported.
- Continue to address access to services through the Network Adequacy Assessment and Work Plan, and the Provider Stabilization Plan.

Attachment 2: MSHN MMBPIS Performance Summary

Strategic Priority	Indicator	Committee/ Council Review	FY21	FY22	Status/ Recommendations
	Michigan Mission Based Performance Indicator System (MMBPIS)				
Better Care	MSHN will meet or exceed the standard for indicator 1: Percentage of Children who receive a Prescreen within 3 hours of request (>= 95% or above)	QIC	98.86%	97.75%	Met/Continue
Better Care	MSHN will meet or exceed the standard for indicator 1: Percentage of Adults who receive a Prescreen within 3 hours of request (>= 95% or above)	QIC	99.22%	98.90%	Met/Continue
Better Care	Indicator 2. a. Effective on and after April 16, 2020, 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)	QIC	67.39%	62.35%	No Standard/ Continue
Better Care	Indicator 3: Effective April 16, 2020, 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)	QIC	71.34%	62.44%	No Standard/ Continue
Better Care	MSHN will meet or exceed the standard for indicator 4a1: Follow-Up within 7 Days of Discharge from a Psychiatric Unit-Children (>= 95%)	QIC	98.90%	97.36%	Met/Continue
Better Care	MSHN will meet or exceed the standard for indicator 4a2: Follow-Up within 7 Days of Discharge from a Psychiatric Unit- Adults (>= 95%)	QIC	97.02%	95.72%	Met/Continue
Better Care	MSHN will meet or exceed the standard for indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (>=95%)	QIC/SUD	96.68%	97.34%	Met/Continue
Better Care	MSHN will meet or exceed the standard for indicator 10a: Re-admission to Psychiatric Unit within 30 Days-Children (standard is <=15%)	QIC	7.97%	4.04%	Met/Continue
Better Care	MSHN will meet or exceed the standard for indicator 10b: Re-admission to Psychiatric Unit within 30 Days- Adults (standard is <=15%)	QIC	12.62%	10.24%	Met/Continue

b) Behavioral Health Treatment Episode Data (BH-TEDS)

It is the expectation of the Michigan Department of Health and Human Services (MDHHS) that MSHN will monitor the completion and quality of the Behavioral Health Treatment Episode Data Set (BH-TEDS). The BH-TEDS is used to support the identification of Veterans within our provider network, and to support the MMBPIS. MSHN identified two areas related to the BH-TED to be included in the QAPIP Plan.

MDHHS requires MSHN to identify beneficiaries who may be eligible for services through the Veteran's Administration (VA). This is to be completed through a quarterly submission of the Veteran's Navigator (VN) Data Collection form, improving, and maintaining the data quality of the BH-Teds military and veteran's fields, and monitoring and analyzing the data discrepancies between the VN form and the BH-TEDS. A narrative report is completed on the comparison findings of the veterans reported on the VN form and BH-TEDS, including actions taken to improve the quality of the data submitted to MDHHS annually. MSHN QIC monitors the progress of the actions identified in the narrative.

Health Services Advisory Group, as the external auditor for MDHHS, provided recommendations related to the quality of the BH-TEDS fields specific to the MMBPIS. Recommendations include Mid-State Health Network and the CMHSP participants to continue to perform enhanced data quality and completeness checks before the data are submitted to the State. This review should target the data entry protocols and validation edits in place to account for discrepancies in wage and income values. MDHHS calculates annual indicators using the BH-TEDS data specific to employment, wages, and living arrangements.

Status: MSHN QIC in coordination ITC developed steps to monitor and improve the quality of the BH-TEDS submitted during FY22.

- BH-TEDS fields will be monitored during the DMC review-Complete/Continue
- A full review of the BH-TEDS is performed to identify any illogical combinations. As a result of validations put in place through MSHN and MDHHS no illogical combinations were present- Complete/Discontinue

Recommendations:

- Continue to implement quality improvement initiatives based on the results of the reviews
- Discontinue the additional report to identify illogical combinations
- Attachment 3 MSHN Veterans FY22 Q1Q2

	BH-TEDS Data	Committee/ Council	FY21	FY22	Status/ Recommendations
	MSHN will demonstrate an improvement with the quality of data for the BH-TEDS data. (Military fields, living arrangements and employment, LOCUS, Medicaid ID)	QIC	99%	100%	Complete/Discontinue

c) Performance Improvement Projects

MDHHS requires the PIHP to complete a minimum of two performance improvement projects per waiver renewal period. The QIC chooses performance improvement projects based on the methodology described in section VI Performance Management of this document which includes but is not limited to the analysis of data, analysis of process, satisfaction, and/or outcome trends that may have an impact on the quality of service provided. Once chosen, a recommendation is made to the MSHN Operations Council for approval. The PIP is presented to relevant committees and councils for collaboration during the duration of the PIP. One of the two is chosen by the department based on Michigan's Quality Improvement Council recommendations. This project is approved by MDHHS and subject to validation by the external quality review (EQR) organization, requiring the use of the EQR's form. In alignment with the MDHHS Comprehensive Quality Strategy, MDHHS has elected the focus of the PIP topic for FY22-FY25 to include the reduction of existing racial or ethnic disparities in access to healthcare or health outcomes.

Performance is reviewed as outlined in the performance improvement project description. The summary is submitted to the external quality review organization for a validation review, and to MDHHS through the QAPIP Annual Report and upon request. The measurement period is calendar year (CY), therefore CY 22 data is not currently available.

MSHN has approved the following Non-clinical Performance Improvement Project to address access to services for the historically marginalized groups within the MSHN region in FY22:

Study Topic-Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population.

Study Question-Do the targeted interventions reduce or eliminate the racial or ethnic disparities between the black/African American population and the white population who have increase the percentage of new consumers who received a medically necessary ongoing service within 14 days of completing a biopsychosocial assessment?

The second or additional PI project(s) is chosen by the PIHP. MSHN QIC has recommended and MSHN Operations Council has approved the following Non-clinical Performance Improvement Project to ensure time access to treatment:

Study Topic-The racial or ethnic disparities between the black/African American minority penetration rate and the index (white) penetration rate will be reduced or eliminated.

Study Questions-Do the targeted interventions reduce or eliminate the racial or ethnic disparities in the penetration rate between the black/African American minority penetration rate and the index (white) penetration rate?

Status: Interventions to address the identified barriers have been identified and are in development.
Recommendations:

- Implement interventions identified to address the barriers in CY2023.
- Monitor progress once interventions have been implemented in CY2023 and CY2024.
- Evaluate the progress of the interventions through quarterly monitoring of the outcomes data.

Attachment 4 External Quality Review Summary 2022
Attachment 5 PIP-Penetration Rate Project Description

Strategic Priority	Performance Improvement Projects	Committee/ Council	CY21	CY22	Status/ Recommendations
Better Care	PIP 1– Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population. Black/African American population White population	QIC	65.04% 69.49%	Gap year, Data not available	Continue
Better Care	PIP 2- Reducing or eliminating the racial or ethnic disparities between the black/African American minority penetration rate and the index (white) penetration rate. Black/African American population White population	QIC	7.45% 9.51%	Gap year, Data not available	Continue

d) Adverse Event Monitoring

Adverse Events include any event that is inconsistent with or contrary to the expected outcomes of the organization's functions that warrants PIHP review. Subsets of the adverse events will qualify as "reportable events" according to the MDHHS Critical Event Reporting System. These include MDHHS defined sentinel events, critical incidents, and risk events. MSHN also ensures that each CMHSP Participant/SUD Provider has a system in place to monitor these events, utilizing staff with appropriate credentials for the scope of care, and within the required timeframes. MSHN submits and/or reports required events to MDHHS including events requiring immediate notification as specified in the MDHHS-PIHP FY22 Contract.

MSHN delegates the responsibility of the process for review and follow-up of sentinel events, critical incidents, and other events that put people at risk of harm to its CMHSP Participants and SUD Providers.[5] MSHN will ensure that the CMHSP and SUD Providers have taken appropriate action to ensure that any immediate safety issues have been addressed, including the identification of a sentinel event within three business days in which the critical incident occurred and the commencement of a root cause analysis within two business days of the identification of the sentinel event. Following completion of a root cause analysis, or investigation, the CMHSP will develop and implement either a plan of action or 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.

MSHN provides oversight and monitoring of the CMHSP Participant/SUD Provider processes for reporting sentinel events, critical events, and risk events and/or events requiring immediate notification to MDHHS[6],[7]. In addition, MSHN oversees the CMHSP Participant/SUD Provider process for quality improvement efforts including analysis of all events and other risk factors, identified patterns or trends, the completion of identified actions, and recommended prevention strategies for future risk reduction. The goal of reviewing these events is to focus the attention of the CMHSP Participant/SUD Provider on potential underlying causes of events so that changes can be made in systems or processes in order to reduce the probability of such events in the future.

Goal: MSHN will demonstrate a decrease in the rate of critical incidents/sentinel events from previous reporting period.
Status: MSHN met the goals as indicated below.
Recommendations:

- Continue to monitor quarterly track and trend data, implementing action to prevent recurring events.
- Continue to complete primary source verification to ensure consistency and accuracy of reporting across the region.
- Implement control charting, utilizing upper and lower control limits to assist in identifying significant shifts in the data that warrant additional action to be taken.
- Develop dashboard and reports in the regional electronic medical information system (REMI) to monitor the process (timeliness), and outcomes.
- Develop standardized data elements and/or forms for the completion of the root cause analysis, and mortality reviews.
- Develop training documents, including policies/procedures based on the new requirements and process for reporting.

Attachment 6 MSHN Critical Incident Performance Summary FY22Q4
Attachment 7 MSHN Critical Incident Performance SUDTP Report FY22Q4

[5] Quality-Sentinel Events Policy
[6] Quality CMHSP Participant Monitoring & Oversight Procedure
[7] Quality Monitoring & Oversight of SUD Service Providers Procedure

Strategic Priority	Event Monitoring and Reporting	Committee	FY21	FY22	Status/ Recommendations
Better Care	The rate of critical incidents, per 1000 persons served will demonstrate a decrease from previous year. (CMHSP) (excluding deaths)	QIC	8.343	8.561	Not Met/Continue
Better Care	The rate, per 1000 persons served, of Non-Suicide Death will demonstrate a decrease from previous year. (CMHSP) (Natural Cause, Accidental, Homicidal)	QIC	7.721	6.405	Met/Continue
Better Care	The rate, per 1000 persons served, of Suicide Death will demonstrate a decrease from previous year. (CMHSP)	QIC	0.386	0.384	Met/Continue
Better Care	The rate, per 1000 persons served, of Sentinel Events will demonstrate a decrease from previous year. (SUDP)	QIC/SUD	4.198	1.535	Met/Continue

e) Behavior Treatment

MDHHS requires data to be collected based on the definitions and requirements that have been set forth within the MDHHS Standards for Behavioral Treatment Review and the MDHHS Quality Assessment and Performance Improvement Program Technical Requirement attached to the Pre-Paid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) contract.

MSHN delegates the responsibility for the collection and evaluation of data to each local CMHSP Behavior Treatment Review Committee, including the evaluation of the effectiveness of the Behavior Treatment Committee by stakeholders. Data is collected and reviewed quarterly by the CMHSP where intrusive and restrictive techniques have been approved for use with individuals, and where physical management or 911 calls to law enforcement have been used in an emergency behavioral situation. Only techniques approved by the Standards of Behavior Treatment Plan, agreed to by the individual or his/her guardian during the person-centered planning, and supported by current peer-reviewed psychological and psychiatric literature may be used.

By asking the behavior treatment committees to track these data, it provides important oversight to the protection and safeguard of vulnerable individuals. MSHN analyzes the data on a quarterly basis to address any trends and/or opportunities for quality improvements. MSHN also uses this data to provide oversight via the annual site review process at each of the CMHSPs. Data shall include numbers of interventions and length of time the interventions were used per person.

MSHN has utilized a regional behavior treatment work group to establish a consistent process for collecting data and implementing the MDHHS Behavior Treatment Standards. MSHN's waiver manager participates in the MDHHS BTPR Workgroup. This allows for a direct link to the region to address any questions and or issues related to the standards.

Following the MDHHS 2020 Waiver Site review, MSHN implemented the monitoring of compliance with the standards, and regional training. MSHN demonstrated a 38% compliance rate for FY20, and a 78% compliance rate for FY22.

Goal: MSHN will collect data as required by MDHHS, analyzing the data quarterly, identifying trends, patterns, strengths, and opportunities for improvement.
Status: MSHN has demonstrated an increase in compliance with the behavior treatment standards, however, continues to require improvement. MSHN has also demonstrated an upward trend for the use of emergency interventions.
Recommendations:

- To continue to monitor compliance with the Behavior Treatment Standards through the delegated management care site review.
- To continue the implementation of BTP Training Modules for the region.
- To formalize the Regional BTPR workgroup to allow for continued focused work by developing a charter identifying specific goals and objectives for the group.
- To develop control charts, identifying the upper and lower control limits to assist in identifying significant shifts in the data that warrant additional action.
- To develop a BTP module to assist in the compliance with the BTPR standards, and submission of data to MSHN; thereby improving the outcomes for individuals served.

Attachment 8 Behavioral Treatment Performance Summary FY22Q4

Strategic Priority	Behavior Treatment	Committee/ Council	FY21	FY22	Status/ Recommendations
Better Care	MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period. (Standard-95%)	CLC	61%	72%	Continue
Better Care	The percent of emergency physical interventions per person served during the reporting period will decrease from previous year.	QIC	0.59%	0.91%	Not Met/Continue

f) Stakeholder and Assessment of Member Experiences

The aggregated results of the surveys and/or assessments, and other data were collected, analyzed, and reported by MSHN in collaboration with the QI Council, the Clinical Leadership Committee, the Provider Network Management Committee, the Customer Services Committee, and Regional Consumer Advisory Council, who identified areas for improvement and recommendations for action as appropriate. Regional benchmarks and/or national benchmarks were used for comparison. The findings were incorporated into program improvement action plans as needed. Actions are taken on survey results of individual cases, as appropriate, to identify and investigate sources of dissatisfaction and determine appropriate follow-up at the CMHSP Participant/SUD Provider level. The reports have been presented to the MSHN governing body, the Operations Council, Regional Consumer Advisory Council, CMHSP Participants and SUD Providers, and accessible on the MSHN website, Findings are also shared with stakeholders on a local level through such means as advisory councils, staff/provider meetings and printed materials.

Goal: MSHN will provide opportunities for stakeholder/consumer feedback related to member (all populations served) experiences. MSHN will analyze trend patterns, strengths, and opportunities for improvement.

Status: MSHN met the goal based on the comprehensive score of each survey. Stakeholders did indicate a decrease in satisfaction with access to services through the surveys, and the appeals and grievance data. MDHHS did provide the NCI Report for FY 20-21. The report is being analyzed; however, concerns were identified with the delay in receiving the results and the inability to evaluate the MSHN region's data. MSHN currently has three CCBHC's that will be utilizing a standard experience of care survey identified by MDHHS. Performance as it relates to individual subscales can be found in the following attachments:

Recommendations:

- Continue to review compliance with processes established to obtain consumer feedback
- Implement a consistent survey for both CMHSP participants and SUD Treatment Providers.
- Establish a contract with an external vendor for administration and analysis of the surveys.
- Explore options for the implementation of an additional process for obtaining feedback from the individuals who experience an intellectual developmental disability.
- Continue to implement the workforce stabilization plan to address issues related to access to care and treatment services.

Attachment 9 MSHN Executive Summary Member Satisfaction FY22 Annual Report
Attachment 13 Behavioral Health Department Quarterly Report

Strategic Priority	Stakeholder and Assessment of Member Experiences	Committee/ Council	FY21	FY22	Status/ Recommendations
Better Care	Percentage of consumers indicating satisfaction with SUD services. (Standard 80%/3.50)	QIC	95%/4.61	95%/4.62	Met/Continue
Better Care	Percentage of children and/or families indicating satisfaction with mental health services. (Standard 80%)	QIC	87%	87%	Met/Continue
Better Care	Percentage of adults indicating satisfaction with mental health services. (Standard 80%)	QIC	85%	82%	Met/Continue
Better Care	Percentage of individuals indicating satisfaction with long term supports and services.(Standard 80%)	QIC	85%	82%	Met/Continue
Better Provider System	MSHN will demonstrate an increase in applicable providers within the network that are "in compliance" with the HCBS rule. (Baseline)	CLC	New	100%	Met/Discontinue
Better Provider System	MSHN will demonstrate full compliance with the completion of a SIS assessment in accordance with the MDHHS required guidelines. (1x every three years) (Baseline) MDHHS expectation 85% by 9/30/2023	CLC	23.18% (FY21Q4)	52.56%	Not Met/continue

Strategic Priority	Member Appeals and Grievance Performance Summary	Committee/ Council	FY21	FY22	Status/ Recommendations
Better Care	Percentage (rate per 100) of Medicaid consumers who are denied overall eligibility were resolved with a written notice letter within 14 calendar days for a standard request of service. (Standard 95%)	UMC	98.27%	93.94%	Not Met/Continue
Better Care	The percentage (rate per 100) of Medicaid appeals which are resolved in compliance with state and federal timeliness standards including the written disposition letter (30 calendar days) of a standard request for appeal. (Standard 95%)	CSC	98.82%	96.71%	Met/Continue
Better Care	The percentage (rate per 100) of Medicaid grievances are resolved with a written disposition sent to the consumer within 90 calendar days of the request for a grievance. (Standard 95%)	CSC	98.72%	95.12%	Met/Continue

g) Clinical Practice Guidelines

MSHN supports and requires the use of nationally accepted and mutually agreed upon clinical practice guidelines including Evidenced Based Practices (EBP) to ensure the use of research -validated methods for the best possible outcomes for service recipients as well as best value in the purchase of services and supports. Practice guidelines include clinical standards, evidenced-based practices, practice-based evidence, best practices, and promising practices that are relevant to the individuals served.

The process for adoption, development, and implementation is based on key concepts of recovery, and resilience, wellness, person centered planning/individual treatment planning and choice, self-determination, and cultural competency. Practices will appropriately match the presenting clinical and/or community needs as well as demographic and diagnostic characteristics of individuals served. Practice guidelines utilized are a locally driven process in collaboration with the MSHN Councils and Committees. Practice guidelines are chosen to meet the needs of persons served in the local community and to ensure that everyone receives the most efficacious services. Clinical programs will ensure the presence of documented practice skills including motivation interviewing, trauma informed care and positive behavioral supports.

Practice guidelines will be monitored and evaluated through data analysis and MSHN's site review process to ensure CMHSP participants and SUDT providers, at a minimum, are incorporating mutually agreed upon practice guidelines within the organization. Additionally, information regarding evidenced based practices is reported through the annual assessment of network adequacy. Fidelity reviews shall be conducted and reviewed as part of the local quality improvement program or as required by MDHHS.

The use of practice guidelines and the expectation of use are included in provider contracts. Practice guidelines are reviewed and updated annually or as needed and are disseminated to appropriate providers through relevant committees/councils/workgroups. All practice guidelines adopted for use are available on the MSHN website.

Status: MSHN did not meet the desired performance for the Behavior Treatment Standards and ACT utilization. Information related to the specific monitoring of the Behavior Treatment Standards can be found in the Behavior Treatment Section of this report.

Recommendations:

- Continue with the MSHN Workforce Stabilization Plan to address staffing issues.
- Identify barriers for ACT utilization in addition to potential staffing issues.
- Validate the ACT utilization data and identify any inconsistencies, monitoring on a quarterly basis.
- Explore the addition of adding ACT to the Program specific Delegated Managed Care Site Review.

Attachment 8 MSHN Behavioral Treatment Review Data FY22Q4
Attachment 11 ACT Utilization FY22

Strategic Priority	Clinical Practice Guidelines	Committee/ Council	FY21	FY22	Status/ Recommendations
Better Care	MSHN will demonstrate full compliance with the use of MDHHS required practice guideline. (PM) Inclusion, Consumerism, Personal Care in Non-Specialized Residential Settings, Family Driven and Youth Guided, Employment Works Policy and Practice Guidelines. (Baseline Development)	CLC	New	100%	Met/Discontinue
Better Care	MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period. (95% Standard) see Section IV. e	CLC	61%	72.2%	Not Met/Continue
Better Care	MSHN's ACT programs will demonstrate fidelity for average minutes per week per consumer (120 minutes).	UMC	1/7	2/7	Not Met/Continue

h) Credentialing and Re-credentialing

MSHN has established written policy and procedures[8] in compliance with MDHHS's Credentialing and Re-Credentialing policy for ensuring appropriate credentialing and re-credentialing of the provider network. Whether directly implemented, delegated, or contracted, MSHN shall ensure that credentialing activities occur upon employment/contract initiation, and minimally every two (2) years thereafter. MSHN written policies and procedures[9] 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.

[8] Provider Network Credentialing/Recredentialing Policy and Procedure
[9] Provider Network Non-Licensed Provider Qualifications

Credentialing, privileging, primary source verification and qualification of staff who are employees of MSHN, or under contract to the PIHP, are the responsibility of MSHN. Credentialing, privileging, primary source verification and qualification of CMHSP Participant/SUD Provider staff and their contractors is delegated to the CMHSP Participants/SUD Providers. MSHN monitors CMHSP Participant 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.

MSHN updated the Credentialing review process in 2021 to ensure compliance with staff credentialing within the MSHN provider network. The change included scoring the credentialing files reviewed. Any provider scoring less than 90% on the file review would be subject to additional review of credentialing and re-credentialing records. For CMH's, the review is taking place during the 2022 interim review year to allow time for corrective action implementation. The files are selected from the MDHHS semi-annual Credentialing reports submitted to MSHN by CMHs.

In 2021, four of the twelve CMHSPs scored just under the 90%. At the time of this report, one of the four CMHSPs has completed additional monitoring and was found to be over the 90% compliance threshold.

Overall Credentialing Review Score	2021- Full Review	2022 Interim Review
>90%	8	3
<90%	4	1

(FY22Q4 Compliance, CS, MEV, Quality Department Quarterly Report)

In 2021, 7 (seven) SUD providers scored under the 90% compliance threshold and were subject to additional reporting and monitoring. In that time, 2 (two) of the 7 (seven) providers are no longer reporting due to terminated contracts or locations outside of the MSHN region. MSHN has conducted additional monitoring for the remaining 5 (five) providers. Of those, 2 (two) providers did not meet the 90% compliance threshold.

Overall Credentialing Score	2021- Full Review Results	2022 Increased Monitoring Results
<90%	7	6
>90%	4	5

(FY22Q4 Compliance, CS, MEV, Quality Department Quarterly Report)

MSHN received finding for staff qualifications for the MDHHS FY20 Waiver Site review, and the HSAG Compliance Review. MSHN modified and developed regional policies and procedures to ensure compliance with the MDHHS Credentialing Policy and staff qualification

requirements. Additionally, MDHHS began to require quarterly reporting of providing credentialing information in FY21. MSHN had repeat findings for the Staff Qualification Section during the MDHHS FY22 Waiver Site Review. MSHN demonstrated a combined compliance rate during the MDHHS Waiver Site Review for licensed staff of 96% (FY20), and 88% (FY22) for non-licensed staff 63% (FY20) and 76% (FY22). MSHN demonstrated a 75% (12/16) for Provider Selection, specific to case file reviews during the FY22 HSAG Compliance Review.

Status: MSHN met the goals as indicated below, however, additional improvement is needed to ensure staff possess the appropriate and required qualifications for providing services.

Recommendations:

- Continue to complete primary source verification utilizing the credentialing report submitted to MDHHS.
- Continue to require individual remediation for records that are not in full compliance with the credentialing requirements, and additional monitoring for those CMHSPs that have a compliance rate of 90% or lower.
- Include primary source verification for professionals that have or require the designation of Qualified Intellectual Disability Professional (QIDP).
- Continue to update the training grid as required.
- Develop regional guidelines for training documentation consistent with MDHHS expectations for documentation.

Attachment 16 MSHN Compliance Review Summary
Attachment 17 Summary Results for MDHHS Waiver Review FY22

Strategic Priority	Staff Qualifications	Committee/ Council	FY20	FY22	Status/ Recommendations
Better Provider	Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements. MDHHS Review	Leadership	FY20 95.51%	FY22 88%	Not Met/Continue
Better Provider	Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements. MDHHS Review	Leadership	FY20 72.52%	FY22 89%	Met/Continue

i) Verification of Services

MSHN 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. MSHN 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 HCPC guidelines.

Data collected through the Medicaid Event Verification process is aggregated, analyzed, and reported for review at the QI Council 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.

Goal: MSHN will verify delivery of services through oversight of the claims and encounters submitted to Medicaid. MSHN will identify trends, patterns, strengths, and opportunities for improvement, reporting annually to MDHHS.
MSHN met the goal as indicated below for FY21.

Attachment 12 MSHN FY2022 Medicaid Event Verification Methodology Report

Strategic Priority	Medicaid Event Verification	Committee/ Council	FY21	FY22	Status/ Recommendations
Better Care	Medicaid Event Verification review demonstrates improvement of previous year results with the documentation of the service date and time matching the claim date and time of the service. CMHSP/SUD.	CCC	CMHSP: 99.30% SUD: 99.50%	CMHSP: 98.44% SUD: 97.21%	Not Met/Continue
Better Care	Medicaid Event Verification review demonstrates improvement of previous year results with the documentation of the service provided falls within the scope of the service code billed.	CCC	CMHSP: 98.76% SUD: 99.28%	CMHSP: 91.26% SUD: 94.28%	Not Met/Continue

j) Utilization Management

MSHN ensures access to publicly funded behavioral health services in accordance with the Michigan Department of Health and Human Services contracts and relevant Medicaid Provider Manual and Mental Health Code requirements.

Utilization review functions are delegated to CMHSP Participants in accordance with MSHN policies, protocols, and standards. This includes local-level prospective, concurrent, and retrospective reviews of authorization and utilization decisions and/or activities regarding level of need and level and/or amount of services, consistent with PIHP policy, standards, and protocols.

A Regional Utilization Management Committee comprised of each CMHSP Participant assists in the development of standards and reviews/analyzes region-wide utilization activity and trends. Communication with individuals regarding UM decisions, including adverse benefit determination notice, right to second opinion, and grievance and appeals will be included in this delegated function.

MSHN retains utilization review functions for substance use disorder (SUD) services in accordance with MSHN policies, protocols, and standards. This includes local-level prospective, concurrent, and retrospective reviews of authorization and utilization decisions and/or activities regarding level of need and level and/or amount of services, consistent with PIHP policy, standards, and protocols. Initial service eligibility decisions for SUD services are delegated to SUD providers through the use of screening and assessment tools.

MSHN ensures that screening tools and admission criteria are based on eligibility criteria established in contracts and policy and are reliably and uniformly administered. MSHN policies are designed to integrate system review components that include PIHP contract requirements and the CMHSP Participant's/SUD Provider roles and responsibilities concerning utilization management, quality assurance, and improvement issues.

MSHN has established criteria for determining medical necessity, and the information sources and processes that are used to review and approve provision of services. MSHN and its CMHSP Participants/SUD Providers use standardized population-specific assessments or level of care determination tools as required by MDHHS. Assessment and level of care tools guide decision making regarding medical necessity, level of care, and amount, scope, and duration of services. No one assessment shall be used to determine the care an individual receives, rather it is part of a set of assessments, clinical judgment, and individual input that determine level of care relative to the needs of the person served.

MSHN has mechanisms to identify and correct under-and over-utilization of services as well as procedures for conducting prospective, concurrent, and retrospective reviews. MSHN ensures through policy and monitoring of the CMHSP Participants/SUD Providers that qualified health professionals supervise review decisions and any decisions to deny or reduce services are made by health care professionals who have appropriate clinical licensure and expertise in treating the beneficiary's condition. Through policy and monitoring of CMHSP Participants/SUD Providers, MSHN shall ensure that reasons for treatment decisions are clearly documented and available to persons served; information regarding all available appeals processes and assistance through customer services is communicated to the consumer; and notification requirements are adhered to in accordance with the MDHHS/PIHP Contract.

Attachment 13 MSHN Behavioral Health Quarterly Report
Attachment 14 FY22Q4 Population Health Integrated Care Quarterly Report Final

k) Long Term Supports and Services for Vulnerable Adults

MSHN 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. MSHN 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 treatment plan and during transitions between care settings. In addition to the behavior treatment data, and adverse event data, MSHN monitors key priority measures as approved by Operations Council.

Goal: MSHN, through the CMHSPs, will demonstrate performance above the required standard for each priority measure to ensure optimal health, safety, and welfare of the individuals served. Identification of trends, patterns, strengths, and opportunities for improvement will be completed quarterly.

*Indicate partial year. CC360 through March 31, 2022, at the time of this evaluation.

Strategic Priority	Priority Measures	Committee/ Council	FY21	FY22	Status/ Recommendations
Better Value	Reduction in number of visits to the emergency room for individuals in care coordination plans between the PIHP and MHP (Target 100%)	UM/ IC	75%	78%	Not Met/Continue
Better Care	Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines. (Target 100%)	UM	99%	100%	Met/Continue
Better Care	Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person-centered plan. (Standard 100%)	UM	82%	85%	Not Met/Continue
Better Care	Service utilization remains consistent or increases over previous year due to improved access to services through the use of telehealth. (Standard 0% decrease over previous FY)	UM	+6%	+10%	Met/Continue
Better Value	Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages (Standard <=5%)	UM	1%	1%	Met/Continue
Better Care	MSHN will be in full compliance with the Adverse Benefit Determination notice requirements.	CSC	96.40%	95%	Not Met/Continue
Better Care	MSHN's Habilitation Supports Waiver slot utilization will demonstrate a consistent minimum or greater performance of 95% HSW slot utilization.	CLC	95.60%	94.90%	Not Met/Continue
Better Care	Percent of individuals eligible for autism benefit enrolled within 90 days with a current active IPOS. (Standard 95%)	CLC	92%	93%	Not Met/Continue

Strategic Priority	Priority Measures	Committee/ Council	FY21	FY22	Status/ Recommendations
Better Care	MSHN's CMHSP partners will report completing at least one community education activity on fetal alcohol spectrum disorder (FASD). (Standard 50%)	CLC	25%	42%	Not Met/Continue
Better Care	MSHN's provider network will demonstrate 95% compliance with trauma-competent standard in the site review chart tool. (Standard 100%)	CLC	100%	100%	Met/Discontinue
Better Health	MSHN will demonstrate improvement from previous reporting period of the percentage of patients 8-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. Diabetes Screening Report (Data Source-ICDP) Michigan 2020-84.43%	QIC	84.68%	81.74%	Not Met/Continue
Better Health	MSHN will demonstrate an increase from previous measurement period in the percentage of individuals 25 to 64 years of age with schizophrenia or bipolar who were prescribed any antipsychotic medication and who received cardiovascular health screening during the measurement year. Cardiovascular Screening (Data Source-ICDP) Michigan 2020-73.16%,	CLC	54.88%	43.10%	Not Met/Continue
Better Health	The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. (Data Source-ICDP) Michigan 2020-44.44%	CLC	60.52%	76.27%	Met/Continue
Better Health	The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended. (Data Source-ICDP) Michigan 2020 54.65%	CLC	97.12%	96.04%	Met/Continue
Better Care	Plan All-Cause Readmissions-The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. (<=15%) (Data Source-ICDP) Michigan 2020 9.09%	UM	11.59%	10.88%	Met/Continue
Better Care	The percentage of members 20 years and older who had an ambulatory or preventative care visit. Adult Access to Care (>=75%) (Data Source – ICDP) Michigan 2020 82.49%	UM	91.69%	86.35%	Met/Continue
Better Care	The percentage of members 12 months-19 years of age who had a visit with a PCP. Children Access to Care (>=75%) (Data Source-ICDP) Michigan 2020 89.64%	UM	95.68%	95.19%	Met/Continue

l) Performance Based Incentive Payments

Strategic Priority	Joint Metrics	Committee	FY21	FY22	Status/ Recommendations
Better Care	Percent of care coordination cases that were closed due to successful coordination (Standard-<= to 50%)	UMC/IC	100%	93%	Met /Continue
Better Value	Reduction in number of visits to the emergency room for individual in care coordination. (Standard 100%)	UMC/IC	75%	78%	Not Met/Continue
Better Care	J.2 The percentage of discharges for adults (18 years or older) who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge. FUH Report (Standard-58%) Data Source ICDP	QIC	75.34%	60.99%	Met/Continue
Better Care	J.2 The percentage of discharges for children (6-17 years) who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge. Follow-Up After Hospitalization Mental Illness Children (Standard-70%) Data Source ICDP	QIC	89.32%	74.06%	Met/Continue
Strategic Priority	**Joint Metrics**	**Committee**	**FY21**	**FY22**	**Status/ Recommendations**
Better Care	J.2 Racial/ethnic group disparities will be reduced. (*Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences) *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)*	QIC	0	0	Met/Continue
Better Care	J.3 Follow up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (Standard 27%) based on CY21	UMC/IC	28%	26%*	Not Met/Continue
Better Care	J.3 Reduce the disparity BSC 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.*	UMC	1	2*	Not Met/Continue
Strategic Priority	**Performance Based Incentive Payments**	**Committee**	**FY21**	**FY22**	**Status/ Recommendations**
Better Care	P.1 Identification of beneficiaries who may be eligible for services through the Veterans Administration. a. MSHN will demonstrate an improvement or maintain data quality on the BH-TEDS military and veteran fields. b. Monitor and analyze data discrepancies between VN and the BH-TEDS data.	ITC/QIC	Complete	Complete	Continue
Better Health	P.2 Increased data sharing with other providers (narrative report) (include action steps in work plan)	ITC	Complete	Complete	Continue
Better Care	P.3 The percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:-Initiation of AOD Treatment: The percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis. (Completion of the Validation only)	SUDT	Complete	Complete	Continue
Better Health	P.4 Increased participation in patient centered medical homes (Narrative)	UMC	Complete	Complete	Continue

m) Provider Monitoring and External Reviews

MSHN monitors stakeholder feedback from treatment providers through a survey process. Following the survey administration, providers develop an intervention plan to address any areas of deficiency. The following year is gap year , which allows for interventions to be fully implemented. The effectiveness of the interventions will be assessed during the next survey administration.

MSHN 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 Participants/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 MSHN, up to and including contract termination.

The PIHP is subject to external reviews through MDHHS and/or an external quality reviewer contracted by MDHHS to ensure quality and compliance with all regulatory requirements. MSHN collaborates with MDHHS and the external quality reviewer to provide relevant evidence to support compliance. In accordance 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. An action plan will be completed that includes the following elements: improvement goals, objectives, activities, timelines, and measures of effectiveness in response to the findings. The improvement plan will be available to MDHHS upon request.

Based on the results of the external reviews that occurred in FY21 a corrective action plan was developed by MSHN in coordination with the CMHSP participants and SUDTP. Areas identified and included in the work plan and respective section of the QAPIP Report are listed below.

- Credentialing and staff qualification requirements
- Qualitative and quantitative assessments for each representative population served annually with development of action plan to address findings.
- Adverse Benefit Determinations time frames
- Appeal Resolution Notice content requirements

The following external reviews were completed for FY22:

- HSAG Performance Measure Validation Review-Received a status of “Reportable”
- HSAG Compliance Review-“Partial Compliance”
- HSAG Performance Improvement Project-Received a status of “Met” the PIP received 100% validation.
- MDHHS HCBS Waiver Review- MSHN filed an appeal for standards The Corrective Action Plan has not been approved BY MDHHS as of the date of this review.
- MDHHS Substance use Disorder Review-Received “Full Compliance”

The findings and recommendations will be incorporated into the QAPIP Performance Measures and Work Plan for FY23.

Attachment 04 MSHN External Quality Review Summary 2022
Attachment 16 Summary Results for MDHHS HCBS Waiver Review FY22

Strategic Priority	Provider Monitoring	Committee/ Council	FY21	FY22	Status/ Recommendations
Better Provider	Provider surveys demonstrate satisfaction with REMI enhancements - Provider Portal (SUD Network) (Standard 80%)	Leadership	73%	NA	Continue
Better Provider	SUD providers satisfaction demonstrates 80% or above with the effectiveness and efficiency of MSHN's processes and communications (SUD Network) (Standard 80%)	Leadership	79%	NA	Continue
Better Provider	MSHN will demonstrate an increase in compliance with the External Quality Review-Compliance Review. (PM) Comprehensive Score.	QIC/CLC	85%	88%	Met/Continue
Better Provider	MSHN will demonstrate full compliance for the Autism Benefit Standards. (Program Specific Monitoring). DMC Program Specific	CLC	85.19%	92.59%	Continue DMC Program Specific monitoring/ Remove Regional monitoring from work plan.

n) Quality Priorities and Work Plan FY22

Organizational Structure and Leadership	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
MSHN will have an adequate organizational structure with clear administration and evaluation of the QAPIP	To develop in collaboration with the QIC the annual QAPIP evaluation and QAPIP plan. (QAPIP Description, QAPIP Work Plan and Organizational Chart of the QAPIP).	Quality Manager	11.30.2022	Complete/Continue in plan description
	Development of a process to monitor the progress of the quality workplan performance measures inclusive of other departments designated responsibilities in the QAPIP.	Quality Manager	9.30.2021	Complete/Continue in plan description
Governance	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**Status/ Recommendations**
Board of Directors will approve the QAPIP Plan and Report	To submit the annual QAPIP Plan and Report to the Board. (Attachment 17-MSHN Governing Board Form)	MSHN Deputy Director MSHN-CCQO	1.1.2022 1.31.2023	Complete/Continue in plan description
Board of Directors review QAPIP Progress Reports	To submit QAPIP progress reports to the Board.	MSHN Deputy Director MSHN CCQO	Quarterly	Complete/Continue in plan description
QAPIP will be submitted to Michigan Department of Health and Human Services	To submit the Board approved QAPIP Report and Plan to MDHHS. (via MDHHS FTP Site)	MSHN Quality Manager QIC	1.31.2022 1.31.2023	Complete/Continue in plan description
	Review reporting timeframes and submission deadline for QAPIP submission to MDHHS with contract negotiating team.	MSHN CEO	10.1.2021	Complete/Discontinue
Include the role of recipients of service in the QAPIP	QAPIP Description, and Organizational Chart of the QAPIP.	MSHN Quality Manager	1.31.2022 1.31.2023	Complete/Continue in plan description

Communication of Process and Outcome Improvements	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
The QAPIP Plan and Report will be provided annually to network providers and to members upon request.	To distribute the completed Board approved QAPIP Effectiveness Review (Report) through committee/councils, MSHN Constant Contact, and email. To post to the MSHN Website. To ensure CMHSP contractors receive the QAPIP.	MSHN Quality Manager	3.2.2022 2.28.2023	Complete/Continue in plan description
Guidance on Standards, Requirements, and Regulations	To complete MSHN Contract Monitoring Plan and Medicaid Work Plan, post updates to MSHN Website, and distribute through committee/councils, MSHN Constant Contact.	MSHN CCQO QIC, CLC, UM, ITC, CSC, SUDP, FC, OC	As needed, minimum annually	Complete / Continue in plan description
Consumers & Stakeholders receive reports on key performance indicators, consumer satisfaction survey results and performance improvement projects	To present reports on Consumer Satisfaction Survey Results, Key Priority Measures, MMBPIS, Behavior Treatment Review Data, Event Data, Quality policies/procedures and Customer Service Reports to RCAC.	MSHN Customer Services Manager	Quarterly	Complete/Continue in plan description
Performance Measurement and Quality reports are made available to stakeholders and general public	To upload to the MSHN website the following documents: QAPIP Plan and Report, Satisfaction Surveys, Performance Measure Reports; MSHN Scorecard, and MSHN Provider Site Review Reports, in addition to communication through committees/councils.	MSHN CCQO CC, QIC, UM, CLC, ITC, CSC, SUDP, FC, OC	Quarterly	Complete/Continue in plan description
MDHHS Performance Indicators	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**Status/ Recommendations**
MSHN will meet or exceed the MMBPIS standards for Indicators 1, 4, 10 as required by MDHHS. (PM)	Complete quality checks on data prior to submission through affiliate uploads in REMI. (Verify Medicaid Eligibility, Data Accuracy)	CMHSP Participants	Q1-3.15.2022 Q2-6.15.2022 Q3-9.15.2022 Q4-12.15.2022	Complete/Continue
	Submit MMBPIS data as required to MDHHS quarterly.	MSHN-Quality Manager	Q1 3.31.2021 Q2 6.30.2021 Q3 9.30.2021 Q4 12.31.2021	Complete/Continue in plan description
	Complete performance summary, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations). Review with relevant committees/councils.	MSHN-Quality Manager QIC, RMDC, CLC/UM	Q1 April Q2 July Q3 October Q4 January	Complete/Continue

MDHHS Performance Indicators	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
MSHN will meet or exceed the MMBPIS standards for Indicators 1, 4, 10 as required by MDHHS. (PM)	Document causal factors and interventions quarterly when performing below the standard.	CMHSP Participants SUD Providers	Q1-3.15.2022 Q2-6.15.2022 Q3-9.15.2022 Q4-12.15.2022	Complete/Continue
	Complete primary source verification of submitted records during the DMC review.	MSHN-Quality Assurance Performance Improvement (QAPI) Manager	Annually (Interim or Full Review)	Complete/Continue with targeted increase for those with findings during the HSAG PMV and/or the DMC review.
MSHN to verify Medicaid eligibility prior to MMBPIS submission to MDHHS (PMV-2021)	Validate logic in REMI for Medicaid Enrollment Dates /Medicaid Eligibility in the PI Output Report.	MSHN-QM MSHN-CIO	3.31.2022	Complete/Continue
MSHN will demonstrate an increase in compliance with access standards for the priority populations. (in addition to those included in the MMBPIS) (Compliance Review) (PM)	Establish a mechanism to monitor access requirements for priority populations.	MSHN-QM MSHN-UCM Director	4.30.2022	In progress/Continue
	Establish a mechanism to monitor access requirements for Individuals enrolled in CCBHC.	MSHN-QM MSHN-UCM Director	4.30.2022	In progress/Continue
BH-TEDS	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**Status/ Recommendations**
MSHN will demonstrate an improvement or maintain data quality for the BH-TEDS. (PM)	MSHN will identify areas of discrepancy for the BH-TEDS data for FY22. Veterans' data (military fields), Employment data-minimum wage, Living arrangements, LOCUS records, Medicaid IDs on update and M records.	MSHN-CIO ITC	6.30.2022	Military- Continue Employment, Living Arrangements, LOCUS, Medicaid IDs on Updates-Complete
	Causal factors with action steps will be determined to address incomplete data and/or illogical combination based on review BH-TEDS data. Veterans' data (military fields), Employment data-minimum wage, Living arrangements.	MSHN-Quality Manager MSHN CIO QIC/ITC	9.30.2022	Complete/Continue with military fields only
	Narrative completed comparing BH-TEDS (veteran's military fields) and VN Report for FY21/22 data, including actions steps.	MSHN QM-QIC MSHN CIO MSHN VN	1.31.2022 7.1.2022	Complete/Continue

Performance Improvement Projects	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
Will engage in two performance improvement projects during the waiver renewal period. PIP 1: The percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergency biopsychosocial assessment will demonstrate an increase. PIP 2: The racial or ethnic disparities between the black/African American penetration rate and the index (white) penetration rate will be reduced or eliminated.	Complete the design of the Required PIP addressing disparities-Penetration Rate.Identify baseline data, causal factors, and interventions. Submit to HSAG as required.Complete the design of the Optional PIP MMBPIS Indicator 3. Identify baseline data, causal factors and interventions	MSHN-QM MSHN-UM/Integrated Care Director QIC, UMC/CLC	6.30.2022	Complete/Continue in plan description
	Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations). Review with relevant committees/councils. Submit PIP 1 to HSAG as required for validation.	MSHN-QM MSHN-UM/Integrated Care Director QIC, UMC/CLC	12.31.2022 3.31.2023 6.30.2023 9.30.2023	Not Completed/Continue
Quantitative and Qualitative Assessment of Member Experiences	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**Status/ Recommendations**
MSHN 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, monitoring for effectiveness, communicating results. (PM)	Identify a qualitative process and distribute surveys and assessments based on the population and services received. (MHSIP/YSS) (SUD Satisfaction). Complete an annual report to include the trends, causal sources of dissatisfaction, and interventions in collaboration with relevant committees/councils. Develop proposal for the administration of qualitative and quantitative assessment of member experience, and provider satisfaction for the region.	MSHN-Customer Services Manager MSHN-Quality Manager	9.30.2022	In Progress/Continue
	Utilize the analysis of the National Core Indicator Data, provided by MDHHS, to identify trends and areas for improvement.	MSHN-QM MSHN-CBHO QIC, CLC	Annual as available	In Progress/Continue
MSHN will demonstrate an increase in applicable providers within the network that are "in compliance" with the HCBS rule. (PM)	Evaluate/remediate compliance with the HCBS Rule for individuals receiving services.Identify causal factors for not meeting the standard and remediate based on the results.	MSHN-Waiver Managers	Quarterly	In Progress/Continue

Quantitative and Qualitative Assessment of Member Experiences	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
MSHN will demonstrate full compliance with the completion of a SIS assessment in accordance with the MDHHS required guidelines. (1x every three years) (PM)	Review internal report for compliance rate, identify causal factors and interventions for not meeting the standard. (How many have received a SIS within 3 years. How many meet the criteria for the completion of a SIS assessment.) (Power Bi report)	MSHN-CBHO/SIS Assessor CMHSP Participants CLC	Quarterly	In Progress/Continue
MSHN will meet or exceed the standard for Appeals and Grievance resolution in accordance with the MDHHS standards. (PM)	Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations).	MSHN-Customer Services Manager CSC	Quarterly	Complete/Continue with quarterly review
Event Monitoring and Reporting	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**Status/ Recommendations**
MSHN 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.	CMHSP Participants MSHN-QM	Last day of each month	Complete/Continue in plan description
	Submit Sentinel Events (Provider Portal)	SUDPs (Residential Recovery Housing)	1.15.2022 4.15.2022 7.15.2022 10.15.2022	Complete/Continue with modifications to be consistent with the CRM reporting process
	Submit Sentinel Events to MDHHS as required.	MSHN-QM	4.30.2022 10.30.2022	Complete/ Continue
	Submit Sentinel Events (immediate notification) to MSHN based on notification requirements of the event. (24 hour, 48 hours, 5 days)	CMHSP Participants SUDPs (Residential)	As Needed	Complete/Continue with new process for reporting through the CRM
	Develop Dashboard for tracking and monitoring timeliness.	MSHN-QM	9.30.2022	Not Started/Continue
	Conduct oversight through the DMC review, ensure appropriate follow up is occurring for all events dependent on the type and severity of the event, including a root cause analysis, mortality review, immediate notification to MDHHS as applicable.Conduct primary source verification of critical incidents and sentinel events.	MSHN-QM	Annually (Interim or Full Review)	Completed/Continue in plan description
CMHSP Participants and SUD Treatment Providers will demonstrate a decrease in the rate of adverse events from previous reporting period. (PM)	Complete the CIRS Performance Reports (including standards, trends, barriers, improvement efforts, recommendations, and status of recommendations to prevent reoccurrence) quarterly.	MSHN-QM	1.31.2022 4.30.2022 7.31.2022 10.31.2022	Completed/Continue

Medicaid Event Verification	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
MSHN will meet or exceed a 90% rate of compliance of Medicaid delivered services in accordance with MDHHS requirements.	Complete Medicaid Event verification reviews in accordance with MSHN policy and procedure.	MSHN-MEV Auditor	See annual schedule	Complete/Continue in plan description
	Complete The MEV Annual Methodology Report identifying trends, patterns, strengths and opportunities for improvement.	MSHN-CQCO MSHN MEV Auditor	12.31.2022	Complete/Continue in plan description
	Submit the Annual MEV Methodology Report to MDHHS as required.	MSHN-CQCO	12.31.2022	Complete/Continue in plan description
Utilization Management Plan	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**Status/ Recommendations**
MSHN will establish a Utilization Management Plan in accordance with the MDHHS requirements	Complete/review the MSHN Utilization Management Plan.	MSHN-UCM Director	Bi-Annually 2023	Complete/Continue in plan description
	MSHN to 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.	MSHN-UCM Director	Quarterly/ Annually See UM Reporting Schedule	Complete/Continue in plan description
	Utilize uniform screening tools and admission criteria. LOCUS, CAFAS, MCG, ASAM, SIS, DECA	MSHN-UCM Director	Quarterly/ Annually	Complete/Continue
MSHN will demonstrate full compliance with timeframes of service authorization decisions in accordance with the MDHHS requirements. (PM)	Oversight of compliance with policy through primary source verification during Delegated Managed Care Reviews.	MSHN-UCM Director MSHN-QAPI Managers	Annually (Interim or Full Review)	Complete/Continue
	Development of REMI process for tracking timeliness of authorization decisions.	MSHN-UCM Director	3.31.2022	Complete/Continue
MSHN will meet or exceed the standard for compliance with the adverse benefit determination notices completed in accordance with the 42 CFR 438.404.(PM)	Develop ABD training for staff. Staff to complete training.	MSHN-Customer Service Manager CMHSP Participants, CSC	5.31.2022 9.30.2022	Complete/Discontinue
	Oversight of compliance during Delegated Managed Care Reviews.	MSHN-Customer Service Manager MSHN-QAPI Managers	Annually (Interim or Full Review)	Complete/Continue

Practice Guidelines	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
MSHN will adopt, develop, implement nationally accepted or mutually agreed upon (MSHN/MDHHS) clinical practice guidelines/standards, evidenced based practices, best practice, and promising practices relevant to the individual served.	Identify practice guidelines adopted/required for use in the MSHN region. Review guidelines currently in policy/procedure.	MSHN-CBHO MSHN-UCM Director CLC/UMC, RMDC	6.30.2022	Complete/Continue
	MSHN will communicate and disseminate the practice guidelines accepted for use on the MSHN website, as requested, and through regional committees/councils.	MSHN-CBHOMSHN-UCM DirectorCLC/UMC, RMDC	1.31.2022 1.31.2023	Complete/Continue in plan description
MSHN will demonstrate full compliance with the MDHHS required practice guidelines. (PM)	Oversight during DMC Review to ensure providers adhere to practice guidelines as required.	MSHN-CBHO MSHN-QAPI MSHN-CCO	Annually (Interim or Full Review)	Complete/Continue in plan description
MSHN will demonstrate an increase for individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person-centered plan. (PM BSC)	MSHN will complete and implement a regional training plan to address Person Centered Planning and the development of the Individual Plan of Service. The following elements will be incorporated into the planning process and document: · -Choice voucher/self-determination arrangements offered -Assessed needs in IPOS -Strategies adequately address health and safety and primary care coordination -Goals are measurable and include amount, scope and duration -Prior authorization of services corresponds to services in IPOS -IPOS is reviewed and updated no less than annually -Include guardian in PCP process -Category/intensity of Care (CWP)	MSHN-CQCO MSHN-UCM Director	2.17.2021 4.1.2022	Complete/Continue
MSHN will demonstrate an increase in fidelity to the Evidenced Based Practice-Assertive Community Treatment Michigan Field Guide, for average minutes per week per consumer. (PM)	Complete a quarterly utilization summary of the average minutes per week/per consumer that will include the identification of barriers, interventions, and progress.	MSHN-UCM DirectorUMC	Quarterly	Complete/Continue through data monitoring and compliance during DMC reviews.

Oversight of "Vulnerable People"/Long Term Supports and Services	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
MSHN will evaluate health, safety and welfare of individuals "vulnerable people" served in order to determine opportunities for improving oversight of their care and their outcomes.	MSHN will analyze performance measures-Behavior Treatment, Integrated Population Health Report, Key Performance Measures, Behavioral Health Report for trends and patterns and develop action for areas of concern.	MSHN-UCM Director MSHN-CBHO MSHN- Waiver Managers	Annually/ Quarterly	Complete/Continue in plan description
	Complete clinical record reviews during the delegated managed care review.	MSHN-QAPI Manager MSHN-Waiver Managers	Annually (Interim or Full Review)	Complete/Continue in plan description
MSHN 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 with those set forth in the members treatment/service plan. (PM)	Analyze performance reports (including barriers, improvement efforts, recommendations, and status of recommendations) completed for Behavior Treatment, Integrated Population Health Report, Key Performance Measures for efforts to support community integration.	MSHN-UCM Director MSHN-CBHO MSHN- Waiver Managers/ Coordinators MSHN-QAPI	Annually/ Quarterly	Complete/Continue
MSHN will establish conflict of interest standards for assessments and IPOS development.	Establish a board approved regional conflict free policy.	MSHN-UCM Director	5.31.2022	Complete/Discontinue
Behavior Treatment	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**Status/ Recommendations**
MSHN will demonstrate an increase in compliance with the MDHHS Behavior Treatment Standards. (PM)	Oversight will occur during Delegated Managed Care Site Reviews. Including primary source verification of reported incidents.	MSHN-Waiver Managers	Annually (Interim or Full Review)	Complete/Continue
Behavioral treatment plans are developed, approved or disapproved in accordance with the Standards for Behavior Treatment Plan Review Committees.	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 (physical management, 911 calls for behavioral assistance).	CMHSP Participants BTPR Work Group	Q1-1.31.2021 Q2-4.30.2021 Q3-7.31.2021 Q4-10.31.2021	Complete/Continue
	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).	MSHN-QM MSHN-Waiver Manager QIC, CLC/UM	Q1-2.27.2022 Q2- 5.31.2022 Q3- 8.31.2022 Q4-11.30.2022	Complete/Continue

Provider Monitoring	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
MSHN will be in compliance with PIHP Contract Requirements.	Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	MSHN-QAPI MSHN Content Experts	Annually (Interim or Full Review)	Complete/Continue in plan description
	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.	MSHN-QM Relevant committees/councils	9.30.2022 9.30.2023	Complete/Continue in plan description
MSHN will demonstrate an increase in compliance with the External Quality Review (EQR)-Compliance Review. (PM-specific to CAP areas)	Implement corrective action plans for areas that were not in full compliance, and quality improvement plans for recommendations. See CAP for specific action steps. Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	MSHN-CBHO MSHN-UCM Director MSHN-Customer Services MSHN-QM MSHN-Contract Manager MSHN-Lead QAPI Manager	9.30.2022 9.30.2023	Complete/Continue
MSHN 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.	MSHN-QM-QIC MSHN-CIO-ITC	9.30.2022 9.30.2023	Complete/Continue
MSHN will receive a score of "Met" for the EQR-Performance Improvement Project Validation.	No action needed at this time.	MSHN-Quality Manager	9.30.2022 9.30.2023	Complete/Continue in plan description
MSHN will demonstrate an increase in compliance with the MDHHS 1915 Review. (SEDW, CWP, HSW, HCBS, Autism)PM	Monitor systematic remediation for effectiveness through delegated managed care reviews and performance monitoring through data.	MSHN-QM MSHN-Waiver Managers/ Coordinators MSHN- CBHO	9.30.2022 9.30.2023	Complete/Follow up review in 2023
MSHN will demonstrate full compliance with the MDHHS Substance Use Disorder Protocols.(PM)	Provide evidence to support SUD requirements	MSHN-Quality Manager MSHN-CCO; SUD Tx Team	9.30.2022	Complete/Next Review 2024
MSHN will demonstrate full compliance with the Autism Benefit Standards. (PM)	Monitor systematic remediation for effectiveness through DMC reviews and performance monitoring through data.	MSHN-Waiver Manager MSHN-QAPI Managers	9.30.2022	Complete/Continue
MSHN will demonstrate assurances of adequate capacity and services for the region, in accordance with the MDHHS Network Adequacy standards.	Complete Network Adequacy Assessment including all required elements	MSHN-Contract Manager	9.30.2022	Complete/Discontinue

Provider Qualifications	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
MSHN will ensure physicians, other healthcare providers, and non-licensed individuals are qualified to perform their jobs. MSHN 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. MSHN ensures all delegates performing credentialing functions comply with all initial (including provisional/temporary) credentialing requirements according to the Initial Credentialing Audit Tool, re-credentialing, and organizational credentialing tool. Clinical service providers are credentialed by the CMHSP prior to providing services and ongoing.	An analysis will be completed to identify trends, and progress of the performance measure, including barriers and interventions.	MSHN-QAPI Lead Manager	Quarterly	Complete /Continue with performance measure
	Primary Source Verification and credentialing and recredentialing policy and procedure review will occur during the DMC Review.MSHN will increase monitoring for providers scoring less than 90% on the file review and will be subject to additional review of credentialing and re-credentialing records.	MSHN QAPI Managers	Annually (Interim or Full Review) Report-Quarterly	Complete/Continue
	Review semi-annual credentialing and re-credentialing report to ensure credentialing within the appropriate timeframes.	MSHN-QAPI Lead Manager	Semi-Annually (include months)	Complete/Discontinue
Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements. (PM)	Will conduct oversight during the DMC-Program Specific Review	MSHN-Autism Coordinator MSHN-Waiver Manager	Annually (Interim or Full Review)	Complete/Continue
Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements. (PM)	Will conduct oversight during the DMC-Program Specific Review	MSHN-Autism Coordinator MSHN-Waiver Manager	Annually (Interim or Full Review)	Complete/Continue

V. Definitions/Acronyms

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

CMHSP Participant refers to one of the twelve-member Community Mental Health Services Program (CMHSP) participant in the Mid-State Health Network.

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

Critical Incident Reporting System (CIRS): Suicide; Non-suicide death; Arrest of Consumer; Emergency Medical Treatment due to injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of physical management; Hospitalization due to Injury or Medication Error: Hospitalization due to injury related to the use of physical management.

Customer: For MSHN 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.

Long Term Services and Supports (LTSS)- 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 CQS – identify the Home and Community Based Services Waiver. MI-Choice to be recipients of LTSS.

Prepaid Inpatient Health Plan (PIHP): In Michigan a PIHP is defined as an organization that manages Medicaid specialty services under the state's approved Concurrent 1915(b)/1915(c) Waiver Program, on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR part 401 et al June 14, 2002, regarding Medicaid managed care. (In Medicaid regulations, Part 438. Prepaid Health Plans (PHPs) that are responsible for inpatient services as part of a benefit package are now referred to as "PIHP" The PIHP also known as a Regional Entity under MHC 330.1204b also manages the Autism ISPA, Healthy Michigan, Substance Abuse Treatment and Prevention Block Grant and PA2. "

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

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.

Root Cause Analysis (RCA): Root Cause Analysis: A root cause analysis (JCAHO) 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." (JCAHO, 1998)

Sentinel Event (SE): 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 (JCAHO, 1998). 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 CMHSP and/or SRE to provide services and/or supports.
SUD Providers: Refers to substance use disorder providers directly contracted with MSHN to provide SUD treatment and prevention services.
Vulnerable Person- An individual with a functional, mental, physical inability to care for themselves.

Acronyms

ABA: Applied Behavioral Analysis
BTPRC: Behavior Treatment Plan Review Committee
CBHO: Chief Behavioral Health Officer
CCC: Corporate Compliance Committee
CLC: Clinical leadership Committee
COFR: County of Financial Responsibility
CSC: Customer Services Committee
CMS: Center for Medicare/Medicaid Services
CQS: Comprehensive Quality Strategy
CWP: Child Waiver Program
EQR: External Quality Review
FC: Finance Committee
HCBS: Home and Community Based Standards
HSAG: Health Services Advisory Group
HSW: Habilitation Supports Waiver
ITC: Information Technology Committee
MEV: Medicaid Event Verification
MHSIP: Mental Health Statistics Improvement Program
MMBPIS: Michigan Mission Based Performance Indicator System
PNMC: Provider Network Management Committee
QIC: Quality Improvement Council
SEDW: Severe Emotional Disturbance Waiver
UMC: Utilization Management Committee
YSS: Youth Satisfaction Survey

VI. Quality Assessment and Performance Improvement (QAPIP) Priorities FY23

An effective performance measurement system allows an organization to evaluate the safety, accessibility and appropriateness, the quality and effectiveness, outcomes, and an evaluation of satisfaction of the services in which an individual receives. MSHN utilizes a balanced score card/dashboard and performance summaries to monitor organizational performance. Those areas that perform below the standard are included in the QAPIP Priorities and shall guide quality efforts for FY23. The FY23 QAPIP Priorities (Figure 1) include objectives approved to address the growth areas identified through external monitoring and the evaluation of the FY22 QAPIP Plan through performance measurement. Required activities related to the organizational structure, governance, communication of process and outcome improvements that do not require any action for improvement are included in the plan description.

Figure 1. QAPIP Priorities and Work Plan

MDHHS Performance Indicators	Objectives/Activities	Assigned Lead/Committee	Frequency/ Due Date
MSHN will meet or exceed the MMBPIS standards for Indicators as required by MDHHS.	Complete quality checks on data prior to submission through affiliate uploads in REMI. (Verify Medicaid Eligibility, Data Accuracy)	CMHSP Participants	3/15/2023 6/15/2023 9/15/2023 12/10/2023
	Complete performance summary reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations). Review with relevant committees' councils.	QIC	10/27/2022 1/27/2023 4/28/2023 7/28/2023
	Complete primary source verification of submitted records during the DMC review.	MSHN-QM	Annually
	Ensure accuracy of data through REMI validations, and increased sample for those that had findings during external reviews.	MSHN-QM	Annually
MSHN will demonstrate an increase in compliance with access standards for the priority populations.	Establish a mechanism to monitor access requirements for priority populations.	MSHN-QM MSHN-UCM Director	1/27/2023

Performance Improvement Projects	Objectives/Activities	Assigned Lead/ Committee	Frequency/ Due Date
PIP 1: Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population.	Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations). Review with relevant committees/councils. Submit PIP 1 to HSAG as required for validation.	MSHN-QM QIC	3/31/2023 6/30/2023 9/30/2023
PIP 2: The racial or ethnic disparities between the black/African American penetration rate and the index (white) penetration rate will be reduced or eliminated.	Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations). Review with relevant committees/councils. Submit to MDHHS upon request.	MSHN-QM QIC	1/27/2023 4/28/2023 7/28/2023
Quantitative and Qualitative Assessment of Member Experiences	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**
MSHN 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, monitoring for effectiveness, and communicating results.	Develop proposal for the administration of qualitative and quantitative assessment of member experience, and provider satisfaction for the region.	MSHN-Quality Manager, Customer Services Manager	3/31/2023
	Implement standard survey/assessment for all populations (SUD, CCBHC, MH, SED, IDD) that provides meaningful and actionable data.	QIC, MSHN Quality Manager	6/30/2023
	Document and CMHSP/Provider Network action steps for improvement in the QIC action plan	CMHSP participants	9/30/2023
	Complete member experience annual report with causal factors, interventions, and feedback provided from relevant committees/councils.	QIC, MSHN Quality Manager	8/30/2023

Quantitative and Qualitative Assessment of Member Experiences	Objectives/Activities	Assigned Lead/ Committee	Frequency/ Due Date
MSHN will demonstrate full compliance with the completion of a SIS assessment in accordance with the MDHHS required guidelines. (1x every three years)	Review internal report for compliance rate, identify causal factors and interventions for not meeting the standard. (How many have received a SIS within 3 years. How many meet the criteria for the completion of a SIS assessment.)	MSHN-CBHO CLC	Quarterly
MSHN will meet or exceed the standard for Appeals and Grievance resolution in accordance with the MDHHS standards.	Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations).	MSHN-Customer Services Manager CSC	Quarterly
Event Monitoring and Reporting	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**
MSHN will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths) are collected, monitored, reported, and followed up on as specified in the PIHP Contract.	Establish standard data element for mortality reviews	MSHN QM, QIC	4/30/2023
	Establish standard data elements/form for a Root Cause Analysis	MSHN QM, QIC	4/30/2023
	Develop Dashboard for tracking and monitoring timeliness	MSHN QM, QIC	4/30/2023
	Develop training documents, including policies/procedures based on the new requirements and process for reporting	MSHN QM, QIC	2/28/2023
	Develop control charting with upper and lower control limits	MSHN QM, QIC	2/28/2023
	Complete the CIRS Performance Reports (including standards, trends, barriers, improvement efforts, recommendations, and status of recommendations to prevent reoccurrence) quarterly.	MSHN QM, QIC	3/23/2023 6/22/2023 9/22/2023 12/15/2023
Medicaid Event Verification	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**
MSHN will meet or exceed a 90% rate of compliance of Medicaid delivered services in accordance with MDHHS requirements.	Complete Medicaid Event verification reviews in accordance with MSHN policy and procedure.	MSHN-MEV Auditor	See annual schedule
	Complete The MEV Annual Methodology Report identifying trends, patterns, strengths and opportunities for improvement.	MSHN-CQCO MSHN MEV Auditor	12/31/2022 12/31/2023

Utilization Management Plan	Objectives/Activities	Assigned Lead/ Committee	Frequency/ Due Date
MSHN will establish a Utilization Management Plan in accordance with the MDHHS requirements	Complete/review the MSHN Utilization Management Plan.	MSHN-UCM Dir.	2023
	MSHN to complete performance summary quarterly reviewing 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.	MSHN-UCM Director	Quarterly/ Annually
	Utilize uniform screening tools and admission criteria. LOCUS, CAFAS, MCG, ASAM, SIS, DECA	MSHN-UCM Director	Quarterly/ Annually
MSHN will demonstrate full compliance with timeframes of service authorization decisions in accordance with the MDHHS requirements. (PM)	Oversight of compliance with policy through primary source verification during Delegated Managed Care Reviews.	MSHN-UCM Director	Annually
	Monitor REMI process for tracking timeliness of authorization decisions, developing improvement plans	MSHN-UCM Director	Quarterly
MSHN will meet or exceed the standard for compliance with the adverse benefit determination notices completed in accordance with the 42 CFR 438.404.(PM)	Oversight of compliance during Delegated Managed Care Reviews.	MSHN-Customer Service Manager	Annually
Practice Guidelines	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**
MSHN will demonstrate an increase in the implementation of Person-Centered Planning and Documentation in the IPOS	Establish a Person-Centered Planning QI Team	MSHN-QM/QIC	1/31/2023
	MSHN will coordinate a regional training plan to address Person Centered Planning and the development of the Individual Plan of Service.		1/31/2023
MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period. (Standard-95%)	Monitor compliance with standards. DMC	MSHN Waiver Administrator, CLC	Annually
	Implement Behavior Treatment Training Modules	MSHN Waiver Administrator, CLC	1/31/2023
MSHN will demonstrate an increase in fidelity to the Evidenced Based Practice-Assertive Community Treatment Michigan Field Guide, on average minutes per week per consumer.	Complete a quarterly utilization summary of the average minutes per week/per consumer that will include the identification of barriers, interventions, and progress. Explore adding to the Program Specific DMC	MSHN-UCM Director UMC	Quarterly
Oversight of "Vulnerable People"	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**
MSHN will assess the quality and appropriateness of care furnished to members (vulnerable people) receiving Long Term Supports and Services(LTSS)	Analyze performance reports (including barriers, improvement efforts, recommendations, and status of recommendations) for community integration and assessment of care between settings.	MSHN-CBHO	Annually/ Quarterly

Behavior Treatment	Objectives/Activities	Assigned Lead/ Committee	Frequency/ Due Date
The percentage of emergency physical interventions per person served during the reporting period will decrease from the previous year.	Develop BTPR Module Specifications/Development (subgroup)	CLC/QIC	6/30/2023
	Develop control charting with upper and lower control limits for track and trend data.	QIC	2/28/2023
Provider Monitoring	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**
MSHN will be in compliance with PIHP Contract Requirements.	Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	MSHN-QAPI	Annually
	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.	Relevant committees	9/30/2023
MSHN will demonstrate an increase in compliance with the External Quality Review (EQR)-Compliance Review.	Implement corrective action plans for areas that were not in full compliance, and quality improvement plans for recommendations. See CAP for specific action steps. Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	MSHN QM	9/30/2023
MSHN 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.	MSHN-QM-QIC MSHN-CIO-ITC	9/30/2023
MSHN will demonstrate an increase in compliance with the MDHHS 1915 Review.	Monitor systematic remediation for effectiveness through delegated managed care reviews and performance monitoring through data.	MSHN-Waiver Managers, CBHO	9/30/2023
Provider Qualifications	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**
Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements.	Complete Primary Source Verification utilizing the Credentialing Report submitted to MDHHS	Leadership/ PNM	Quarterly
	Require individual remediation for records that are not in full compliance with the credentialing requirements, and additional monitoring for those CMHSPs that have a compliance rate of =<90%.	Leadership/ PNM	Annually
	Primary Source Verification and review of the credentialing/recredentialing policy and procedure will occur during the DMC review. Providers who score less than 90% on the file review will be subject to additional review of credentialing and re-credentialing records.	Leadership/ PNM	Annually
	Include primary source verification for professionals that have/require the designation of Qualified Intellectual Disability Professional (QIDP).	QIC/PNM	Annually
Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements.	Develop regional guidelines for training documentation consistent with MDHHS expectations.	QIC	1/31/2023
	Continue to update the training grid as required.	QIC/PNM	1/31/2023

VII. Attachments

Attachment 1 MSHN QAPIP Communication

Attachment 2 MSHN MMBPIS Performance Summary FY22Q3

Attachment 3 MSHN Veterans Narrative FY22Q1Q2

Attachment 4 External Quality Review Summary 2022

Attachment 5 PIP Penetration Rate Project Description

Attachment 6 MSHN Critical Incident Performance Report FY22

Attachment 7 MSHN Critical Incident Performance Report SUDTP FY22Q4

Attachment 8 MSHN Behavior Treatment Review Data FY22Q4

Attachment 9 MSHN Member Satisfaction Annual Report FY2022

Attachment 10 UM Quarterly Report FY22Q4

Attachment 11 ACT Utilization FY22Q4

Attachment 12 MSHN FY2022 MEV Methodology Report

Attachment 13 Behavioral Health Department Quarterly Report FY22Q4

Attachment 14 MSHN Pop Health Integrated Care Report FY22Q4

Attachment 15 MSHN 2022 Compliance Summary Report

Attachment 16 Summary Results for MDHHS HCBS Waiver Review FY22

Attachment 17 MSHN Governing Body Form